Focal Point Ireland: national report for 2016 - 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 overarching 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 development of the next National Drugs Strategy (NDS) is ongoing. 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.

A range of treatment options is available for problem drug users, mainly in outpatient settings but also in residential settings. Almost all opiate substitution treatment (OST) provided is methadone. Buprenorphine in combination preparations is not routinely available in Ireland. In 1998 the first formal 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.

Trends

There were no changes in trends between 2014 and 2015. The majority of drug treatment (over 75%) is provided through publicly funded and voluntary outpatient services. Outpatient services include low-threshold and specialised OST GPs in the community. Inpatient treatment is mainly provided through residential centres run by voluntary agencies. In 2015, the proportion of clients attending inpatient services (excluding prisons) increased to 18%, compared with 14% in 2014. Opiates (mainly heroin) are the main problem illicit drug used by entrants to treatment; they are 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 48% in 2015. Over this period, cannabis was consistently reported as the second most common main problem drug, with the proportion increasing from 21% in 2004 to 28% in 2015. The numbers presenting for treatment for problem cocaine use increased again in 2015, rising to 11%, after a dropping to a new low in 2012. For new clients to treatment, cannabis continues to be the main problem drug, replacing opiates (mainly heroin) continuing a trend that started in 2010.

The majority of cases have been previously treated. The proportion of new entrants to treatment remained relatively unchanged in 2015, 39% compared with 40% in 2014. The proportion of new entrants has fluctuated from 39% in 2004, to a peak of 47% in 2009 and down to 39% in 2015.

The majority of OST clients receive methadone in specialist outpatient clinics, with a smaller number receiving it from specialist GPs and an even smaller proportion (less than 5%) receiving it in prison. The number of clients registered for OST on 31 December each year has increased from 3,689 in 1998 to 9,917 in 2015.

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 out in the National Drugs Strategy, including those for treatment and rehabilitation, are described in section 1.1.1 of the Drug Policy workbook. The 'priorities' for treatment and rehabilitation services between 2009 and 2016 as set out in the National Drugs Strategy are as follows

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*
- *Maximise operational synergies between Drug Addiction Services, Alcohol Treatment & Rehabilitation Services, General Hospital Services and Mental Health Services*
- *Expand the availability of detox facilities, opiate substitution services, under-18 services and needle exchange services where required*
- *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)*
- *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*

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

Quality and standards framework
- *Develop a clinical and organisational governance framework for all treatment and rehabilitation services*

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*

The Department of Health has published its annual report for 2015 on progress in implementing the actions included in the National Drugs Strategy. The report is a descriptive account of activities over the period – in some cases they are reported at a national level, whereas in others they are reported at the level of Community Healthcare Organisations (CHOs). See a more detailed description in section 1.2.2 of the Drug Policy workbook (Department of Health 2016).

A new strategy is currently being developed (see section 4.2 of the Drugs Policy workbook)

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 healthcare at different levels across the statutory and voluntary sectors,

including the development of integrated care planning and case management approaches between all relevant agencies and service providers.
The HSE supports the non-statutory sector to provide a range of health and personal social services, including the drug projects supported by the local and regional 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.

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). Addiction services are provided by Social Inclusion Services, the core objective of which is to improve health outcomes for the most vulnerable in society, including Irish Travellers and Roma, asylum seekers, refugees and lesbian, gay, bisexual, transgender (LGBT) service users. Issues of addiction, substance misuse, homelessness and domestic, sexual and gender-based violence are overarching themes within the service user groups (Health Service Executive 2015). Progress in implementing these actions in the annual service plan are reviewed regularly throughout the year, and actions to address variances are considered. The priorities and key actions to improve health outcomes for people with addiction issues include the following (p. 56):

- implement the outstanding actions in the National Drugs Strategy (2009–2016);
- ensure that adults deemed appropriate for treatment for substance abuse receive treatment within one calendar month;
- ensure that children deemed appropriate for treatment for substance abuse receive treatment within one week;
- ensure that addiction services operate within the person-centred care planning processes of the Drugs Rehabilitation Framework;
- audit drug services in line with the Drugs Rehabilitation Framework on care planning, assessment, key working and referrals; and
- strengthen clinical governance structures by the appointment of an Addiction Clinical Lead (achieved).

The progress on these indicators for 2015 show:

- Substance misusers (under 18 years) for whom treatment has commenced within one week following assessment: 100%
- Average waiting time from referral to assessment for opioid substitution treatment: 14 days
- Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced: 28 days

The most recent Department of Health progress report on the NDS shows that there was little change in relation to the coordination pillar, with many of the proposed structures already in place (Department of Health 2016) also see section 1.1.1 and 1.2.2 in the Drugs Policy workbook. Some progress was made in developing engagement with specifically identified at-risk groups, including Travellers, new communities, LGBT people, homeless people and sex workers. A subgroup of the National Coordinating Committee for Drug and Alcohol Task Forces reviewed and updated the 2009 NDS Traveller Framework Document, and was identifying lead agencies to implement the recommendations in the document.

1.1.3 Further aspects of drug treatment governance

In order to address problem opiate use and standardise treatment, in 1998 a more formalised methadone treatment protocol (MTP) was introduced to ensure that treatment for problem opiate use could be provided wherever the demand exists (Methadone Treatment Services Review Group 1998, Methadone Prescribing Implementation Committee 2005). 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 their experience.

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.

1.2 Organisation and provision of drug treatment

1.2.1 Outpatient drug treatment system – main providers

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also sections 1.1.2, 1.2.3 and section 1.4 in this workbook). Many of the non-statutory, voluntary agencies are partly funded by the HSE. In a revision of what was reported in the previous workbook (2014 data) services provided in prisons are now included in this outpatient section. This is because most of the treatments provided in prisons which are reported through TDI are in-reach counselling sessions and do not involve the client staying overnight in the prison medical unit – for example, for detoxification. There are an unknown number of private organisations that also provide outpatient addiction treatment such as counselling. Very few of the private organisations contribute data to the TDI figures.

Some addiction treatment is also provided and/or funded through the Mental Health Division of the HSE. Data from these services are not included in the TDI figures.

1.2.2 Outpatient drug treatment system – client utilisation

Over the past number of years, most addiction treatment 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 the number of centres that do not report to TDI. Data from TDI have been used to populate Table 1.2.2. This shows that in 2015, 81.9% of all cases were treated in outpatient services. These figures can be considered the minimum number of cases treated.

Only stable opiate substitution treatment (OST) clients are treated by specialised OST GPs in the community (see also section 1.4.7).

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	299	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	72	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	30	See inpatient facilities
Other outpatient units	361	Specially trained general practitioners who provide OST in primary care

Other outpatient units		

Source: Standard table 24

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

	Total number of clients	National definition (Characteristics)
Specialised drug treatment centres	5,554	Treatment facilities where the clients are treated during the day (and do not stay overnight). They may open in the evening but they do not remain open through the night. Such facilities include OST clinics, counselling, therapeutic day care and socioeconomic training units
Low-threshold agencies	1,175	Low-threshold agencies 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 healthcare		Provided through the mental health directorate of the HSE or funded by the mental health directorate. Not included in the TDI data.
Prisons	774	In-reach provided by voluntary services funded by the Irish Prison Service and others. Additionally, addiction treatment, including methadone maintenance, provided by prison service medical unit in one prison.
Other outpatient units	270	Specially trained general practitioners who provide OST in primary care.
Other outpatient units		Not applicable

Source: TDI

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 2014.

Just under half (47.6%) of all cases entering treatment in 2015 reported opiates as their main problem drug (See Table 1.3.1 and Figure 1.3.1). This represents a slight decrease compared with 2014 (49.8%) and continues the overall downward trend in the representation of cases presenting with problem opiate use in treatment over the past number of years. Heroin continues to be the main drug in this category, representing 87.0% of all those reporting problem opiate use; this is similar to 2014, when 89.2% reported problem heroin use.

The next most common drug reported was cannabis. Twenty-eight per cent of cases reported cannabis as their main problem drug, identical to the percentage reported in 2014 (27.8%) (see also Section A of the Drug workbook). The number of cases presenting for cannabis treatment has stabilised over the past number of years. The majority (63.1%) of those reporting cannabis as their main problem drug had never been previously treated; the comparable figure for 2014 was 64.1%.

Cocaine was the next most illicit common drug reported. In 2015, 10.5% of cases reported cocaine as their main problem drug. This represents a slight increase compared with 2014 (8.7%) and a small but consistent increase since a peak of 11.5% in 2009. Additionally, 2015 marked the first time since 2010 that over 10% of cases in treatment presented with problem cocaine use. Just over half of cases had never been previously treated (51.5%); the comparable figure for 2014 was 51.5%. Amphetamines (0.6%) and ecstasy (0.5%) continue to account for a very small proportion of the

main problem drugs reported. This is almost identical to 2014, when 0.6% of cases reported amphetamines as their main problem drug, and 0.6% reported ecstasy as their main problem drug.

Benzodiazepines comprise the majority of the 'other drugs' category. Seventy-one per cent of cases reported benzodiazepines as their main problem drug in 2015, compared with 77% in 2014. Over half (56.2%) of these cases were previously treated in 2015; the comparable figure in 2013 was 49.1%.

1.3.2 Distribution of primary drug in the total population in treatment

See section 1.4.9 in this workbook for further information on clients with problem opiate use and OST.

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 ongoing feedback of problems and training to ensure the completeness and validity of the data

1.3.4 Characteristics of clients in treatment

For further information on characteristics of opioid dependent clients see section 1.4.9.

Table 1.3.1: Summary table – Clients in treatment

Opiates (mainly heroin)	4,515
Cannabis	2,681
Other drugs (mainly benzodiazepines)	1,191
Cocaine	996

Source: ST24 and TDI

	Number of clients
Total clients in treatment	9,489
Total OST clients	9,917
Total number of clients entering treatment	Data on OST and TDI are from different sources. These data are collected using different methodologies. Additionally, because there is some duplication, the data cannot be combined or compared meaningfully.

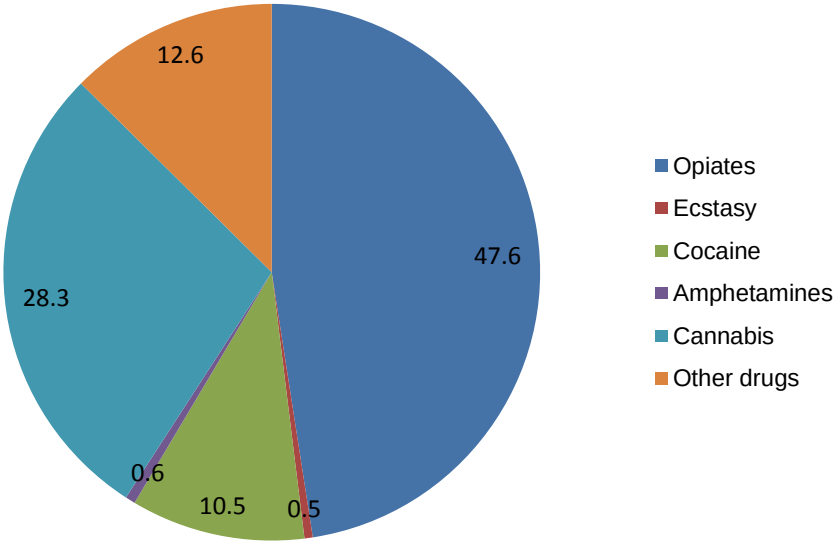

Figure 1.3.1 Proportion of treatment demands by primary drug
Source: TDI

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 1.4.7). Other services, which do not offer OST, may provide a wide variety of treatments including counselling, group therapy, socioeconomic training, complementary therapies, relapse prevention etc.

1.4.2 Further aspects of available outpatient treatment services

'BeLonG To' has been the national youth service for LGBT young people since 2003. In late 2007, it introduced a drug and alcohol service (Dillon 2016). This service was established in response to a national study of drug use among LGBT young adults in Ireland. It continues to be the only designated LGBT drug service in the country. The organisation 'envisions a future in which LGBT young people are safe and supported in their families, schools and communities, and all young people are equally cared for, valued, and respected' (personal communication, Gerard Roe, Drug Education and Outreach Worker, BeLonGTo, April 2016).

The service follows the model of harm reduction with an emphasis on support, awareness raising, education and empowerment. It aims to address concerns that LGBT young people may have about drug or alcohol use and it offers them the opportunity to access support in a dedicated 'safe' LGBT youth space. As outlined on its website, the drug service:

- supports young LGBT people in relation to issues of alcohol and drug use in a non-judgemental and confidential manner;
- delivers outreach work to young LGBT drug users to make people aware that the service is there and where to find it;
- carries out education, information and prevention work with the young LGBT community to raise awareness around issues to do with drug and alcohol use in the community;
- provides information and training on LGBT issues for mainstream drug services to support services in making their space safe for LGBT service users; and

• refers young LGBT to specialised agencies and services to enable them to access safe and positive support.

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 services 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 inpatient 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, whereas counselling is provided by in-reach services.

Inpatient psychiatric hospitals

Addiction treatment provided in psychiatric hospitals includes psychiatric treatment, detoxification and any other medical treatment required by the client.

1.4.4 Treatment outcomes and recovery from problem drug use

See description of inpatient programmes by Babineau and Harris (2006) in section 1.4.5.

1.4.5 Main providers/organisations providing Opioid substitution treatment

The results of a major longitudinal study of clients attending a therapeutic community have shown that, despite the many instances of relapse, all Coolmine Therapeutic Community (CTC) programmes had a very positive effect on clients (Babineau and Harris 2015). Overall, substance use declined, physical and mental health improved, and clients demonstrated improvements with regard to housing, employment, education and family relationships.

The primary aim of this study, titled Pathways through treatment: a mixed-methods longitudinal outcomes study of Coolmine Therapeutic Community, was to track CTC clients over two years, gathering data on treatment retention, substance use, physical and psychosocial health, social functioning and criminal activity. The study also aimed to compare outcomes for clients of three treatment programmes – male residential (the Lodge), female residential (Ashleigh House) and the mixed-gender drug-free day programme (DFDP).

The mixed-methods study included quantitative information on 144 participants, and 86 qualitative interviews with 28 participants, which allowed for in-depth exploration of issues.

Quantitative data collection commenced in February 2011, with interviews taking place at baseline and at six-monthly intervals over the next two years. At baseline, the 144 participants recruited to the study were entering a primary treatment service at Coolmine Therapeutic Community. Qualitative interviews also took place at six-monthly intervals, starting in March 2011 and continuing for two years.

Qualitative data were collected from voluntary participants ranging in age from 20 to 47 years through semi-structured interviews at six-monthly intervals. The average age of those in this sample was 32 years. CTC's three primary treatment programmes were almost equally represented in this

sample; programme participants comprised 16 males (58%) and 12 females (42%). While 86% of participants reported opiates as their primary problem drug, polydrug use was common.

The study found an improvement in almost all measured outcome areas over the two years of the study. Some programme-based and gender-based differences in treatment pathways, experiences and outcomes were uncovered.

At treatment intake, all 144 participants were actively engaged in one of CTC's three programmes. At the final 24-month data collection phase, 77.1 per cent (n=111) were retained in the study, and of these, 72% (n=80) were reported to be drug-free. Thirty-six per cent of this final sample (n=40) had graduated from their programmes, and 85% (n=34) of these reported being drug-free at 24 months. In other words, the number of clients reporting drug-free status was approximately double that of those who graduated.

The proportion of participants who reported illicit drug use in the 30 days preceding data collection fell from 43.1% per cent at baseline, to 35.5% at one year and 27.9% at two years. This relapse rate was relatively low compared with rates reported in a recent (2013) systematic review of therapeutic communities (between 25% and 55%).

Graduation rates varied by programme – from 26.7% (n=8) for female residential clients (Ashleigh House) to 36.5% (n=19) for male residential clients (The Lodge) to 50% (n=9) among those on the drug-free day programme (DFDP). Self-discharges were highest among residential women (53.3%, n=16), next highest among clients of the DFDP (44.4%, n=8), and noticeably lower among male residential clients (21.2%, n=11). However, discharge due to violation of a CTC protocol was highest among residential men (28.8%, n=15).

The authors comment that it is not clear to what extent women were discharged early due to the apparent lack of community cohesion and general incompatibility with key treatment elements in Ashleigh House (see paragraphs below which report on quality of life findings), or due to their own personal circumstances, such as family obligations or psychological needs. The authors suggest that these factors were, in all likelihood, interdependent.

The authors highlight how the circumstances surrounding an individual's entry into treatment influenced the treatment outcome – whether the entry was 'self-motivated' (the client decided individually and autonomously to enter treatment), 'incentivised' (the client entered following a negotiated, suspended prison sentence), or a combination of the two (the client was self-motivated to achieve abstinence but also faced tangible external pressure to comply with treatment). Those who had expressed high levels of self-motivation from the outset were more engaged with the therapeutic programme than those who entered out of a sense of obligation or pressure (i.e. incentivised clients), and this disparity became more apparent as time went on.

The authors also report that motivation was noticeably stronger among clients on the drug-free day programme than clients on the residential programmes. Clients on the day programme reported entering after completing a separate residential programme; they were thus entering treatment after a period of sobriety and with previously acquired knowledge of treatment programmes. In addition, as the day programme was an optional extra after the residential programme, these clients tended to be highly committed to actively practising recovery.

Although women's physical health, mental health and self-reported well-being on entry to treatment were all lower than those of men on entry to treatment, the mean physical health scores of both cohorts increased (males: 11.62 at baseline to 14.49 at two years; females: 10.28 at baseline to 13.05 at two years), as did the mean psychological health scores of both cohorts (males: 11.43 at baseline to 12.97 at two years; females: 9.6 at baseline to 13.18 at two years).

The participant interviews reflected the quantitative findings. While many reported ongoing health problems, including serious and chronic co-morbidities such as HIV and hepatitis C, most who

remained drug-free at the point of their final interview reported that their physical health was markedly improved. Positive mental health was often reported as having to be actively maintained, e.g. through participating in fellowship meetings or adhering to a structured daily routine. Female participants were more likely than males to report mental health issues, such as periods of depression, anxiety, self-harm, suicide ideation and suicide attempts.

The mean quality of life score showed a similar upward trend for both men and women (males: 11.62 at baseline to 13.91 at two years, females: 10.29 at baseline to 13.36 at two years). Improvement in overall quality of life was also reflected in the qualitative data. However, while engaged with CTC, men and women seem to have responded differently to some elements of the therapeutic programme.

Broadly speaking, men responded positively to group living, including the communal residential spaces, the shared chores, and the group therapy. Several of the women, however, struggled with the group element of residential treatment, including the group chores and group sessions. Some of the women who had their children with them in Ashleigh House reported that they felt detached from the group treatment experience, particularly unstructured group time, as they struggled to balance parenting and participation in the programme. Women who did not have children in residence with them in Ashleigh House did not report feeling detached from the group treatment experience.

The proportion of participants reporting acute housing difficulties rose from 21.7% at baseline to 22.8% at two years. According to the authors, this increase may have been related to the fact that at intake many clients were engaged in CTC or another formal treatment service and were not experiencing acute housing problems. The majority of participants who were interviewed reported relying on housing services for assistance in securing housing and many found clean, safe and comfortable places to live in. But for some, due to prior periods of homelessness and incarceration, the experience was challenging and far more precarious.

Both male and female clients were distinctly more active in their attempts to engage with education and the labour market after engaging with CTC. The proportion engaged in paid employment increased from 3.5% at intake to 25% at two years, and the proportion enrolled in education increased from 1.4% to 17%. Qualitative data revealed that the main difficulty in finding paid employment was a lack of formal education qualifications, leading many participants to consider returning to education. Because maintaining abstinence was viewed as the most immediate and important goal, a significant number of participants expressed a preference for employment that was not overly demanding or stress inducing. Some participants reported being unable to secure employment due to their past criminal activity.

Qualitative data revealed that most participants had a background involving some level of criminal activity, much of it associated with supporting a lifestyle largely focused on drug acquisition and use. This was particularly the case for male participants. The proportion of participants who reported committing a criminal act in the 30 days preceding data collection fell from 8.6% at baseline to 1.8% at two years.

Despite the many instances of relapse, the authors conclude that the positive impact of all CTC programmes on clients is undeniable. Overall, substance use declined, physical and mental health improved, and clients demonstrated improvements with regard to housing, employment, education and family relationships. Many clients cited the tools they had acquired in treatment as key mechanisms for continued change. Some participants suggested ways in which CTC services could be improved and the authors suggest that these ‘key messages’ could be applicable not only to CTC but to drug and alcohol therapeutic communities more generally. The suggested ways in which CTC services could be improved were as follows:

Flexibility in delivery of programmes, e.g. scheduling, structure, treatment timeline, multiple programming options

Additional one-to-one support

Smaller group sessions

More support for residential clients moving from residential treatment into community housing with peers

Day programme as step-down after completing a residential programme

1.4.6 Number of clients in OST

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 2015, according to data from the Central Treatment List (CTL) (see section 6.1) 53.9% of patients were receiving treatment in specialist outpatient clinics, 41.0% from GPs, 4.6% were receiving treatment in prison and less than 0.2% were receiving treatment in an inpatient setting (personal communication Caroline Comar, CTL). The proportion of clients receiving treatment from GPs has increased slowly but steadily over the years, from 31.7% in 2001 to 41.0% in 2015. The proportion of clients receiving treatment in specialist outpatient clinics has decreased, from 59.0% in 2008 to 53.9% in 2015. This change likely reflects the policy to move stable OST clients back to primary care, where they can receive all their care, including OST, from their own GP; the change may also reflect the increase in the number of specialist GPs in the community.

In 2015, the HSE reported that the average waiting time of clients from referral to assessment for OST was 14 days (Health Service Executive 2015). The average waiting time from OST assessment to exit from waiting list or treatment commenced was 28 days (Health Service Executive 2015). In 2015 there were no studies or evaluations of coverage of treatment or barriers to OST treatment.

1.4.7 Characteristics of clients in OST

The number of clients registered for methadone maintenance on 31 December each year is reported on the Central Treatment List (CTL) (see also Figure 2.1.3 in section 2.1, section 6.1 and Standard table 24). The CTL is a national register of all clients on methadone maintenance. On 31 December 2015, 9,917 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). This again represents a slight increase (1.8%) on the previous year.

Almost all clients receive methadone as their opiate substitute, as historically this has been the drug of first choice for treating opiate dependency in Ireland. In 2011 an expert group again concluded that methadone should remain the drug of first choice for treating opiate dependence (Expert Group on the Regulatory Framework 2011). Buprenorphine in combination preparations is not routinely available in Ireland. 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, although buprenorphine alone had been used in an extremely limited way in specialist addiction clinics before this time (Fitzgerald 2011). A feasibility study on the use of Suboxone was undertaken in 2009 (Fitzgerald 2011).

The expert group set up to consider the Regulatory Framework for products containing buprenorphine/naloxone and buprenorphine-only for the treatment of opioid dependence (Expert Group on the Regulatory Framework 2011) concluded that methadone was 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, for example:

- 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
- Patients whom the prescriber believes to have been stable for at least six months, particularly with regard to employment or education, and committed to compliance with the treatment.

To date, Suboxone has not been prescribed any more widely in Ireland and as of 31 July 2015 only 77 clients were on Suboxone, most of whom had been initiated on the drug in the 2009 feasibility study (Ó Caoláin 2015, 22 September). These clients are not currently recorded on the CTL and no additional information is known about them.

Suboxone is not prescribed widely because resolution on legislative and financial arrangements is needed. Suboxone must be given the same statutory basis as methadone and as such requires an amendment to the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations. This can only be amended by primary legislation (Chambers 2016, 12 June).

It is estimated that it would cost an additional €2,186 (per person per year in HSE addiction centres, based on a daily average of 80mls methadone/16mg buprenorphine/naloxone) (Ó Caoláin 2015, 22 September). However, according to the HSE, consideration of phased increased prescribing of Suboxone was being given for the 2016 service plan, depending on progress in the legislative agenda (Ó Caoláin 2015, 22 September). In 2015, the relevant legislation was not progressed.

1.4.8 Further aspects on organisation, access and availability of OST

Of the 9,917 clients registered on the CTL on 31 December 2015, the majority were male (69.1%). 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 2015, the largest proportion of clients (28.6%) was aged between 35 and 39 years; they were followed by those aged 40–44 years (22.6%); those aged 30–34 years (17.2%); and those aged 45–49 years (11.0%). This is slightly different from figures for 2014, when a slightly higher proportion of clients aged 40–49 years was registered. No other characteristics are available for analysis from the CTL data.

Psychological health of heroin-dependent teenagers in treatment

A recent Irish study examined the effects of psychologically supported OST on the psychological well-being of an adolescent population attending an outpatient clinic in Dublin for their heroin dependence (Smyth*, et al.* 2016). It is an important study because of the dearth of data reported in the literature on the psychological well-being of adolescents undergoing OST.

The authors hypothesised that psychological support during OST would result in improvements in the psychological health of adolescent patients. The study was carried out prospectively on individuals aged 18 years or younger who were seeking treatment for opiate addiction between May 2006 and December 2013 in Dublin. In addition to OST, participants in the study were also in receipt of individual counselling and group work that focused on life skills.

At baseline, structured clinical sessions were carried out to assess drug use, and the sociodemographic and clinical characteristics of the participants. Psychological well-being was measured at the beginning of the study (baseline) and again after four months of treatment (follow-up), using the Second Edition Beck Youth Inventory (BYI-II) (see section 6.2 for more information on methodology).

Of the 55 participants who were eligible at the beginning of the study, 32 completed treatment and had baseline and follow-up (BYI) questionnaires; 23 participants did not complete the follow-up BYI.

The most novel finding was that all five subscale scores improved during the OST period, and the improvements in the mean scores for depression, anxiety and anger were statistically significant. Interestingly, approximately one-third of the participants with 'abnormal' scores for anxiety and depression had follow-up scores that were categorised as 'normal'. In an attempt to further elucidate the relationship between improved scores for depression and heroin use, the authors conducted linear regression analysis, which revealed greater improvements in depression scores among those who were heroin abstinent.

Interestingly, there were stark differences between those who did not complete the follow-up BYI and those who did. The participants who did not complete the follow-up (n=23) were statistically significantly more likely to experience homelessness or imprisonment compared with those who did complete the follow-up ($p=0.02$ and $p=0.03$ respectively). Furthermore, the group who did not complete the follow-up BYI were more likely to be misusing methadone, heroin and cocaine ($p<0.001$, $p=0.001$ and $p=0.02$, respectively).

The results reported in this study highlight the importance of psychosocial support for adolescents undergoing OST. They mirror the results found in studies of adults receiving OST, where psychological support during treatment was found to have a positive impact on psychological well-being. Additionally, this study provides insight into the psychological health of teenagers seeking treatment for opiate addiction in Dublin and some of the problems experienced by this group, which remains poorly characterised. The sociodemographics of the adolescent cohort in this study is reflective of similar adolescent groups internationally, especially with regard to poor educational status, family difficulties and mental health problems.

Women in methadone treatment

A study conducted between 2006 and 2007 at the National Drug Treatment Centre, a large specialist addiction clinic in Dublin, sought to discover whether women in methadone maintenance treatment (MMT) had more unmet needs and a lower quality of life than men in MMT (Byrne*, et al.* 2015). Any service user who had been receiving MMT for three months or more was eligible for inclusion; however, those with a history of acute psychiatric problems or end-stage health difficulties were not eligible for inclusion. In total, 190 service users were eligible to participate in the study; of these, 108 (57%) agreed to participate. Of the 108 participants, 35 (32%) were women. No statistical difference was found in the demographic characteristics of those who did and did not participate in the study.

The mean age of participants was 32.7 years, with women slightly younger than men (30.7 years versus 33.7 years). There were no differences in the demographic and social characteristics of women and men, except that women were more likely to have accessed the support of a social worker. Recent drug use was assessed by self-report and urinalysis. Men self-reported more use of heroin in the past month and had a higher proportion of positive urines for cocaine.

Women were statistically more likely to report unmet needs and achieve lower psychological quality of life scores than men. This difference could not be explained by ongoing drug use, as the men in the study had higher levels of recent drug use.

The authors note the limitation of the small sample size. In addition, the findings may not be fully representative as the study was conducted in a specialist addiction service that treats the most complex cases. The generalisability of the study is also affected by the fact that the data were collected more than 10 years ago.

The authors suggest that the needs and quality of life of women in MMT warrant further research. They also call on addiction services to ensure that the psychological and social care needs of women clients are addressed.

Risk factors for death among MMT patients

Two studies published have looked at mortality among OST patients (Cousins*, et al.* 2016, Truszkowska*, et al.* 2015). Cousins et al (2016) found that a higher risk of mortality was associated with patients who had come off treatment (for whatever reason) as well as with age and increased

co-morbidity (Cousins*, et al.* 2016). The authors noted that in the unadjusted analysis, mortality was higher among those whose methadone consumption was not supervised, but this was not found to be statistically significant in the adjusted analysis. Truszkowska et al (2015) also identified non-attendance for treatment and a non-HIV/HCV medical condition as significant risk factors for mortality (Truszkowska*, et al.* 2015).

These findings have implications for national practice and policy, as they show that retention in treatment is important in reducing mortality among OST patients.

For more in-depth information see section 1.1.3 and 1.1.4, Harms and Harm Reduction workbook.

Methadone-maintained patients in primary care
The use of primary health services by methadone-maintained patients (MMPs) is an under-researched area internationally (O'Toole J*, et al.* 2014). The aim of the study described here, conducted by researchers in Trinity College Dublin (TCD), was to examine this issue in the Irish context using a matched case-control study. The researchers particularly looked at chronic disease and multi-morbidity among MMPs.

Thirteen practices in a research network of GP practices throughout the greater Dublin area which had electronic patient records and provide methadone maintenance treatment (MMT) agreed to participate.

An MMP had to have attended the practice for both MMT and primary healthcare for at least one year in order to be included in the study. In total, 207 MMPs met the criteria, and were matched with 207 controls according to sex, age, practice (to account for geographical variability), and eligibility for the General Medical Services scheme (GMS). The authors considered the combined sample size of 414 to be one of the major strengths of the study.

Information collected about participants from electronic records included demographic details, chronic disease data, repeat medications, and information relating to smoking, alcohol use, and non-opiate drug use. A number of variables related to health service utilisation were also recorded, such as the number of GP and nurse consultations, referrals to hospital, and use of the out-of-hours GP service. Data were extracted from the electronic system using an in-depth form, which included reading all consultation notes. The authors reported some issues with data collection that may have resulted in the under-estimation of some of the variables, especially MMP outpatient attendances. In addition, specialist medicines were excluded from the analysis due to a lack of systematic documentation in the research sites.

Statistical tests conducted included independent sample t-tests, Pearson chi-squared tests, risk estimation, odds ratios (OR), 95% confidence intervals (CI) and binary logistic regression.

There were no statistically significant differences in demographics between the MMP group and the control group: 43% of the sample was female, 57% was male; 16% were private patients, and 84% were GMS patients.

By comparing means using t-tests and by using OR, the authors presented evidence for the increased likelihood of chronic illness among MMPs versus controls. When compared with controls, MMPs were statistically significantly more likely to have:

- Chronic disease (OR 9.1 [CI 5.4 – 15.1])
- Multi-morbidity, i.e. two or more chronic diseases (OR 6.6 [CI 4.3 – 10.2])
- Repeat medications (OR 5.8 [CI 3.7 – 8.9])
- History of smoking (OR 4.8 [CI 3.2 – 7.2])
- Excess use of alcohol (OR 2.9 [CI 1.6 – 5.2])
- Non-opiate problem drug use (OR 141.2 [CI 63.3 – 315.3])
- Psychiatric disease (OR 6.1 [CI 3.9 – 9.3])
- Respiratory disease (OR 3.3 [CI 1.9 – 5.9])
- Infectious disease (OR 118.5 [CI 28.8 – 489.9])

It is of note that MMPs were significantly more likely to have a chronic disease (OR 9.1 [CI 5.4 – 15.1], (95% CI), compared with controls. If HIV, and hepatitis B and/or C were excluded, then the

OR was less emphatic, dropping to 4.2 (2.7–6.4). As expected, the OR for problem use of non-opiate drugs was highly significant, 141.2 (CI 63.3–315.3).

MMPs have a lower average incidence of cardiovascular disease (0.06 vs 0.14, p=0.04), although the OR for this same category is not significant. This seems to indicate that MMPs may have lower levels of cardiovascular disease than controls, which seems counter-intuitive given the reported differences in the incidence of chronic diseases, and the history of smoking and respiratory disease. While the authors did not explicitly comment, they did observe that often medical problems among MMPs emerge as 'unanticipated "door-handle symptoms" during time-pressured, protocol-driven methadone appointments'.

The authors constructed several binary logistic regression models. Of most interest was the model for chronic disease occurrences, age, sex, GMS status, current dose of methadone, and smoking. The model was restricted to MMPs only and the strongest predictor of chronic disease was being a GMS patient with an OR of 7.2 (CI 2.4–22.0). The authors concluded that the data suggested that GMS patients were sicker than non-GMS patients. A link to deprivation was also suggested, although the authors noted that non-GMS MMPs may have been part of a subgroup of MMPs who had shown increases in health and income following MMT.

MMPs used their primary care facility on average 32 times a year and, of these, 30 were for MMT. Controls, on the other hand, had an average of only three visits a year. Visits were divided into three non-mutually exclusive categories in order to allow comparison – 'medical', 'nursing' and 'methadone'. MMPs were more likely to have attended for medical or nursing assessments. The majority (87%) of medical assessments and 20% of nursing assessments took place during an MMT consultation.

The study concluded that MMPs cost the health service as a whole more than the baseline cost of MMT, as they had higher levels of health service utilisation. Their additional health needs created a higher workload for GPs and also in other hospital-based services.

The authors concluded that healthcare policy must reflect the fact that MMPs are attending GP practices more often than non-MMPs, the strain this places on those services, and the risks associated with a singular focus on drug-related issues. The main recommendations of the authors included a more holistic approach to integrating MMT with general medical needs, and the promotion of better record-keeping with regard to chronic diseases. The authors identified an opportunity to increase the role of the GP practice nurse, as the study suggested that this resource was under-used in MMT. They also suggested that GPs should be offered incentives to be trained in MMT and any formal review of MMT GP remuneration should take into account the additional workload involved in taking care of MMT patients.

Also see study on GPs attitudes to methadone treatment in section 1.1.10 (Delargy*, et al.* 2016).

1.4.9 Further aspects on organisation, access and availability of OST

One recently published study tested the feasibility of linking laboratory data and client intake data and their usefulness for modelling retrospectively five-year longitudinal drug treatment outcomes in an Irish opiate treatment setting (Comiskey and Snel 2016).

Longitudinal urinalyses were extracted from two national laboratories providing substance use screening tests to 17 drug treatment sites and to two buses providing mobile needle exchange services. During the five-year study period, a total of 1,734,283 test results were identified for 330,802 urine samples presented by a total of 4,518 unique individuals across Dublin.

In addition to the urinalysis database, data were extracted at a number of ad hoc time points from all treatment sites that use a client electronic record system, which is known as the Drugs and AIDS Information System (DAIS). This system records data about drug users seeking treatment, including their demographic characteristics, assessment prior to treatment, prescriptions, hepatitis C status, treatment programmes, needle exchange programmes and rehabilitation integration services. During the study period, 5,430 records relating to 2,832 unique individuals were recorded in DAIS; of these unique individuals, 97% were Irish, 72% were male, 60% had no children and 17 known

deaths were recorded. These data were linked, via a unique client identity number, at the individual client level to the longitudinal urinalysis data.

Once the full database of unique clients was created, with each repeat episode of treatment linked, captured and recorded for that client, the longitudinal outcome variables in the form of drug positive urinalyses results were derived. Outcomes were tracked sequentially, with the first urinalyses denoted as time point 1 (the intake/baseline measurement) and each subsequent urinalysis result was then recorded as test 1, 2, 3 … up to a maximum of 260.

Across the five-year study period 62% of the urine samples tested positive for benzodiazepines, 43% tested positive for cannabis, 40% tested positive for opiates and 11% tested positive for cocaine. Analysis of substances used at treatment intake, at six months and at one- to five-year follow-ups was conducted.

The study found that there were differences in urinalysis protocols between sites. Extraction of urinalysis data from the two national laboratories revealed that treatment sites varied considerably with regard to the number and frequency of urinalysis tests conducted; for example two of the seven DAIS treatment clinics requested more than 83% of analyses, but accounted for only 68% of all DAIS clients. The researchers attribute these variations to a difference in treatment site philosophy and practice rather than variations in client characteristics.

A further inconsistency occurred between the stated tests conducted as part of a routine urine test and what was found in the analysis: while 99.9% of urine samples were tested for opiates and cocaine, as required by policy, only 72% were tested for benzodiazepines.

Clients who did and did not test positive for opiate use at year five were compared on a number of variables. No significant difference was found, other than age at first drug use (mean age of 15.53 years vs. mean of 14.63 years, p=0.008).

The proportion of clients who tested opiate positive decreased from 61.8% at initial treatment intake to 12.5% at the end of the five-year period. Time series analysis had predicted 16% (95% confidence interval: between 7% and 25%) of clients would be opiate positive at the end of the five years.

Significant increases were found in benzodiazepine use, and significant increasing effects of concurrent cocaine and benzodiazepine use on the likelihood of using opiates. It was also possible to link and describe the changes in the methadone doses prescribed: analysis of the DAIS system revealed that there were only minor changes in the doses of methadone prescribed over the five years.

With this research the authors have demonstrated that data from existing multi-site, cross-sectional sources can be linked, matched, mined and modelled to develop prompt, retrospective, sequential outcome results that are useful for policy-makers, service providers and service users.

GP attitudes to methadone treatment

A recent study was conducted was to assess and compare GP perceptions of the scale of local illicit drug use, attitudes towards and obstacles in the provision of methadone treatment, and the preferred adjunct modalities alongside MMT (Delargy*, et al.* 2016).

Two surveys were carried out among GPs in 2006 and 2015. The surveys contained a series of descriptive and open-ended questions and was emailed to all GPs registered on the MTP database, irrespective of their current level of engagement in the MTP. The authors stated that, where possible, comparisons were drawn between the opinions of GPs who had patients receiving MMT in both 2006 (n=147) and 2015 (n=170).

In terms of response rate, 207 out of 600 (34.5%) GPs responded in 2006 and 217 out of 949 (22.87%) GPs responded in 2015. The authors acknowledged the response rate as a limiting factor in the study, but outlined that this response rate is typical of the GP population. The profile of participating GPs as predominantly male and aged between 35 and 60 remained largely unchanged between 2006 and 2015. Notably, there was an increase of 57% in the number of female participants in 2015.

When asked their opinion on the extent of illicit drug use in their area, 66.5% of GPs felt it was a major problem. This perception was more negative that that recorded among GPs in 2006 (53.2%). By linking perception to demographic location, the authors found that the majority of GPs who reported illicit drugs as a major problem were practising in urban locations. Similarly, the majority of GPs from rural areas reported minimal problems with illicit drug use in their practices. Notably, no statistical significance was observed between these two variables.

GPs who had patients enrolled in the MTP were asked to provide details about any perceived obstacles to recruiting new patients into the programme. The majority of GPs (54% in 2015; 71.8% in 2006) cited either no obstacles or no referrals in response to this question. Second choices included 'have enough already' (16.3% in 2015; 11.8% in 2006) or that they had reached their 'protocol maximum' (27.2% in 2015; 16.5% in 2006). GPs who did not have patients currently enrolled in the MTP were invited to provide more information as to why this was the case. In 2015, 85% of these GPs reported that there was either no demand for the service in their area or they had never been asked to take on any patients. This was largely similar to findings for 2006, where 83% of GPs cited the same reasons. Other reasons for not engaging with the MTP included a fear of violence, alienating private patients, a lack of knowledge, lack of community supports, and personal reasons such as a lack of empathy with addicts and discomfort with the topic of addiction.

In general, the majority of GPs who had patients in the MTP in 2006 and 2015 had a positive attitude towards the programme. GPs agreed that the MTP eliminates chances of double scripting, allows for a good relationship with patients, improves the health of the patients, and reduces criminality. Alongside the positive feedback for the MTP, GPs identified a lack of access to assessment and support services (including community liaison officers, literacy support, alcohol support services, and return to employment services) for patients receiving MMT. These were common issues between the 2006 and 2015 surveys. Furthermore, GPs highlighted a lack of accessible information about the types of services that are currently available and also the lack of a referral mechanism that can support the transfer of stabilised patients to primary care settings.

When asked to rank a list of services which they deemed necessary to further support the MTP, GP survey respondents in both 2006 and 2015 selected addiction counselling as their preferred choice (46.5% in 2015; 51.7% in 2006). GPs felt that inpatient rehabilitation detoxification beds, employment schemes and drop-in/social centres would also benefit patients in the MTP. The authors noted that the percentage of GPs who selected employment schemes and drop-in/social centres as their primary choice between 2006 and 2015 increased from 8.9% to 21.2% and from 0.7% to 11.76%, respectively.

Overall, the authors noted that this study highlighted a favourable opinion of Irish GPs towards participation in the MTP and obstacles and attitudes towards the provision of the programme. Notably, there was a perceived rise in the scale of local illicit drug use between 2006 and 2015. In addition, GPs provided a useful insight into the range of supplementary supports and services they believe are necessary for the correct care of patients on the programme. By comparing survey results from 2006 and 2015, the authors found that the majority of GPs' attitudes towards the MTP have remained largely positive. The authors concluded that there is a need for greater efficiency of referral mechanisms for stabilised patients and greater implementation of psychosocial, vocational and detoxification supports warranted in the Irish primary care setting.

Development of clinical guidelines for opiate treatment
The publication of the clinical guidelines for opiate treatment 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.

2. Trends

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

New treatment entrants (Figure 2.1.1)
In 2015, there were 3,742 new entrants recorded in the NDTRS (see also TDI table and Figure 2.1.1), almost identical to 2014 when there were 3,774 new entrants recorded. New treatment entrants represented 39.4% of all cases in 2015. 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 down to 39.6% in 2014 before stabilising at 39.4% in 2015.

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 continues. Cocaine peaked among new entrants in 2009 at 19.0%, dropping steadily thereafter until 2012 and then increasing again to 51.5% in 2015. Both amphetamines and ecstasy are reported only very rarely by new entrants to treatment.

In 2015, 'other drugs', mainly benzodiazepines, were the fourth largest group of drugs reported by new entrants as their main problem drug.

All treatment entrants (Figure 2.1.2)
In 2015, a total of 9,489 entrants were recorded in the NDTRS (see also TDI). This was almost identical to the number of cases reported in 2014 (9,523). Of these, the majority had been previously treated (57.5%).

In 2015, opiates, mainly heroin, were the main problem drug used by entrants to treatment. The absolute number presenting for problem opiate use decreased again slightly in 2015 to 4,515, compared with 4,745 in 2014.

In 2010, the number of cases reporting problem opiate use peaked at 4,929 cases. It then decreased between 2010 and 2013, and has continued to decrease further in the interim.

Looking at the proportion of opiate cases compared with the total number of cases treated, this has decreased year-on-year over the past 12 years, from 64.6% in 2004 to 51.6% in 2012, when it plateaued. Thereafter, it decreased slightly, dropping to 51.3% in 2013 and to 47.6% in 2015.

Between 2004 and 2015, cannabis was consistently reported as the second most common problem drug, with the proportion increasing slightly, from 21.2% in 2004 to 28.3% in 2015. The numbers presenting for treatment for problem cocaine use was highest in 2007 at 13.3%. Thereafter, it decreased steadily until 2012, when it stabilised. Since then, the number of cases has increased, and reached a new peak of 10.5% in 2015. Both amphetamines and, to a lesser extent ecstasy, are reported very rarely by entrants to treatment.

In 2015, 'other drugs', mainly benzodiazepines, were the fourth largest group of problem drugs reported.

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

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 9,917 in 2015 (personal communication, Caroline Comar, CTL) (see also Standard table 24). The increase is due to improvements in and expansion of services, with more clients availing of treatment and more facilities becoming available each year (Farrell and Barry 2010). Since 2008 the rate of increase has been less than 4% annually. The stabilisation in the number of clients registered on the CTL may in part be due to the decreasing number of younger clients (i.e. age 25 years or younger). 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 2.1% in 2015.

While the proportion of younger clients has decreased, the proportion of clients aged 45 years or older has steadily increased, from a low of 9.1% in 2009 to a peak of 21.0% in 2015. This is not surprising as it reflects the ageing cohort of opiate users in the country seen elsewhere.

However, further analysis of other data sources and primary research is necessary in order to improve our understanding of these trends.

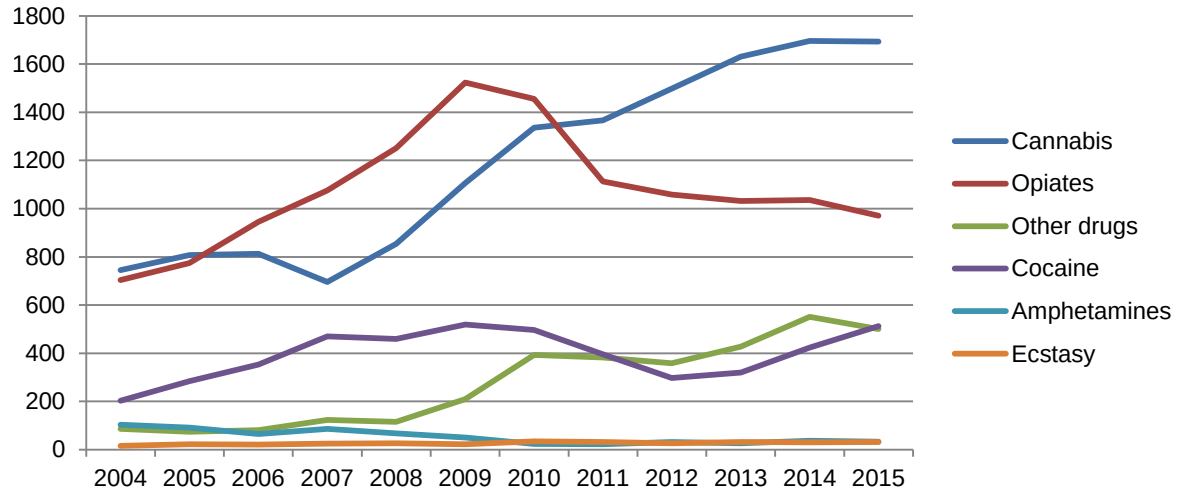

Figure 2.1.1 Trends in numbers of first-time clients entering treatment, by primary drug, 2004–2015
Source: TDI

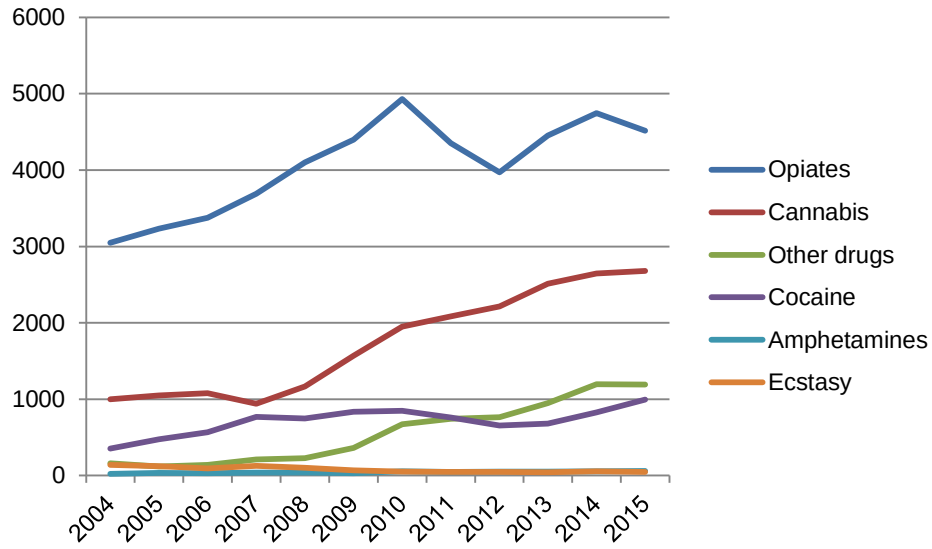

Figure 2.1.2. Trends in numbers of all clients entering treatment, by primary drug, 2004–2015
Source: TDI

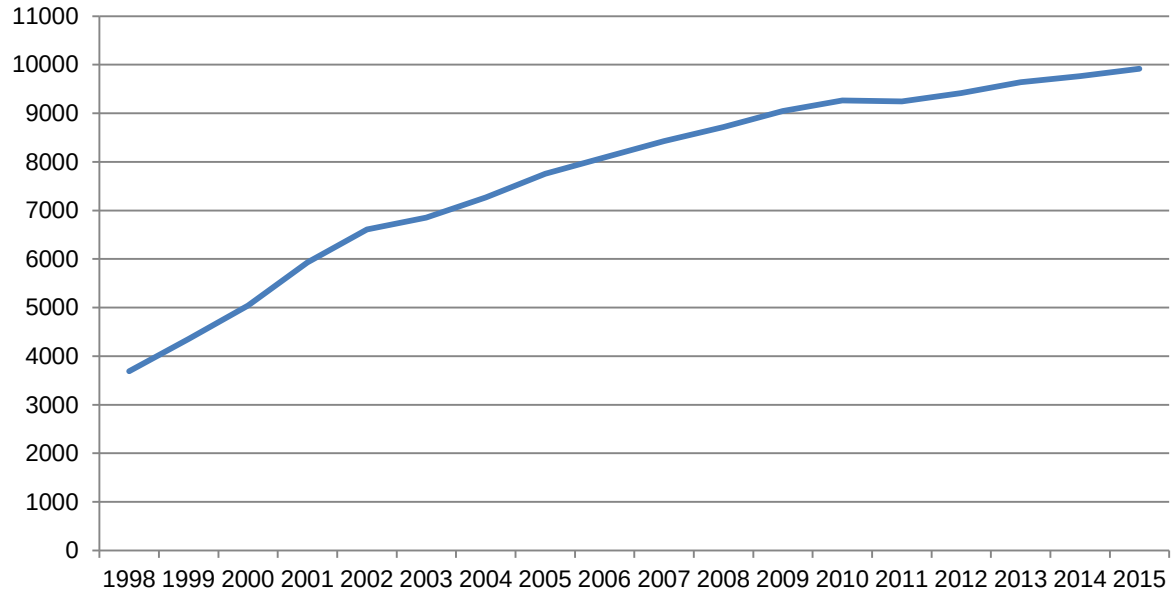

Figure 2.1.3 Trends in numbers of clients in opioid substitution treatment, 1998–2015
Source: CTL – Number of clients registered as of 31 December each year and ST 24

3. Sources, methodology 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.

3.2 Methodology

Methodology used for Smyth et al. (2016) for study on the psychological health of heroin-dependent teenagers in treatment (1.4.9).

Psychological well-being was measured at the beginning of the study (baseline) and again after four months of treatment (follow-up), using the Second Edition Beck Youth Inventory (BYI-II). The BYI-II is a self-reporting tool with 100 questions based on a Likert scale (never, sometimes, often, always), designed for use with people aged 18 years or younger. It was created to assess the participants' experience of the following five subscales:

Self-concept

Depression

Anxiety

Anger, and

Disruptive behaviour

For each parameter, scores are converted into a standardised score, known as a T-score, which enables score comparison between individuals. T-scores were compared to age- and gender-matched scores from a general population sample.

While these scores are not diagnostic of psychiatric disorders, Smyth and colleagues established 'normal' and 'abnormal' cut-off points. For the subscale of self-concept, scores of <44 were considered 'abnormal', and for the other four subscales a score of >55 was considered 'abnormal'.

3.3 References

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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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