

Focal Point Ireland: national report for 2017 - harms and harm reduction

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

Authors of the national report

Lucy Dillon, Brian Galvin, Ciara Guiney, Suzi Lyons, and Sean Millar

Head of Irish Focal Point

Brian Galvin

All of the documents used in the preparation of the national report are available on the HRB National Drugs Library's repository at www.drugsandalcohol.ie.

This document was prepared for publication by the staff of the HRB National Drugs Library

Please use the following citation:

Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (2018) ***Focal Point Ireland: national report for 2017 – harms and harm reduction***. Dublin: Health Research Board.

Other reports in this National report series can be found at

http://www.drugsandalcohol.ie/php/annual_report.php

(2018) *Focal Point Ireland: national report for 2017 – drug policy*.

(2018) *Focal Point Ireland: national report for 2017 – treatment*.

(2018) *Focal Point Ireland: national report for 2017 – drug markets and crime*.

(2018) *Focal Point Ireland: national report for 2017 – prevention*.

(2018) *Focal Point Ireland: national report for 2017 – legal framework*.

(2018) *Focal Point Ireland: national report for 2017 – prison*.

(2018) *Focal Point Ireland: national report for 2017 – drugs*.

Table of Contents

1. National profile.....	3
1.1 Drug-related deaths.....	3
1.1.1 Overdose deaths.....	3
1.1.2 Toxicology of overdose deaths.....	4
1.1.3 Mortality cohort studies.....	4
1.1.4 Trends.....	4
1.1.5 Additional information on drug-related deaths.....	5
1.2 Drug related acute emergencies.....	6
1.2.1 Drug-related acute emergencies.....	6
1.2.2 Toxicology of drug-related acute emergencies.....	8
1.2.4 Additional information on drug-related acute emergencies.....	10
1.3 Drug related infectious diseases.....	12
1.3.1 Main drug-related infectious diseases among drug users – HIV, HBV, HCV.....	12
1.3.2 Notification of drug-related infectious diseases.....	16
1.3.3 Prevalence data of drug-related infectious diseases outside the routine monitoring.....	17
1.3.4 Additional information on drug-related infectious diseases.....	20
1.4 Other drug-related health harms.....	22
1.4.1 Other drug-related health harms.....	22
1.5 Harm reduction interventions.....	24
1.5.1 Drug policy and main harm reduction objectives.....	24
1.5.2 Organisation of harm reduction services.....	25
1.5.3 Harm reduction services.....	25
1.5.4 Harm reduction services: availability and access.....	36
2. New developments.....	38
2.1 New developments in drug-related infectious diseases.....	38
2.2 New developments in harm reduction interventions.....	39
3. Additional information.....	40
3.1 Additional sources of information.....	40
4. Sources and methodology.....	41
4.1 Sources.....	41
4.2 Methodology.....	41
4.2 References.....	42
Acknowledgements.....	44

0. Summary

Ireland maintains a special register that is a complete census of all drug-induced deaths in the country. Established in 2005, the National Drug-Related Deaths Index (NDRDI), which is maintained by the Health Research Board (HRB), is an epidemiological database that records cases of death by drugs poisoning, as well as deaths among drug users in Ireland, extending back to 1998.

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

Newly diagnosed cases of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) are reported to the Health Protection Surveillance Centre (HPSC). Notification data for 2016 are included in this workbook.

The number of drug-induced deaths remained stable in 2015, at 224, compared to 223 deaths in 2014. The majority of those who died were male, aged in their thirties. Opiates were the most common drug associated with most drug-induced deaths as per the EMCDDA Filter D inclusion criteria.

The number of overdose cases admitted to Irish hospitals decreased from 4,256 in 2014. Trends over time show a general decrease in overdose cases, falling from 5,012 cases in 2005 to 3,956 cases in 2015.

Recent trends indicate that the number of cases of HBV and HCV diagnosed and reported in the Republic of Ireland is stabilising rather than continuing to decline. There has also been an overall increase in the number of reported HIV cases; the increased number of people who inject drugs (PWID) among HIV cases reported since 2014 was due to an outbreak of HIV among homeless drug users in Dublin.

Harm reduction services available in Ireland include needle exchanges from fixed sites, mobile units and outreach work provided by regional authorities and community-based organisations. In addition, there are pharmacies providing needle exchanges in each local and regional drug and alcohol task force (RDTF) area within Ireland apart from those covering counties Dublin, Kildare and Wicklow. At the end of 2016, there were 111 pharmacies providing needle exchanges, and an average of 1,614 individuals used pharmacy needle exchanges each month in 2016.

1. National profile

1.1 Drug-related deaths

1.1.1 Overdose deaths

In 2015, there were 224 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI) as per Selection D (also see ST 5 and ST 6). The number of deaths owing to poisoning over the past three years appear to have stabilisation in Ireland, with 223 deaths reported in 2014. It should be noted that annual data previously reported have been changed as the NDRDI figures have been updated as new information has become available.

Overall, the mean age of those who died (39 years) in 2015 owing to poisoning remained stable (39.1 years) compared to 2014 (35.2 years). The mean age is the highest recorded, driven by the increase in deaths in those aged 55 years and older (24, 11.0%) compared to 2014 (5, 2.2%). The reason for this increase is not yet known although 58% were female.

The majority of deaths were male (64.3%) similar to previous years. The NDRDI does not routinely report the intentionality of the death.

The overall trends in overdose deaths for the EMCDDA definition of Filter D remain the same, with opiates continuing to be associated with most poisoning deaths as opiates were found in 94% of cases who had a toxicology available (see Section 1.1.2 below).

Due to circumstances beyond the control of the Focal Point more in-depth analysis of the 2015 data is not possible at this juncture in time.

1.1.2 Toxicology of overdose deaths

Toxicology was available for 202 deaths in 2015 (also see ST5). Not all deaths reported in Filter D have a toxicology result. Opiates were found in the post-mortem toxicology of 95% (192/202) of these deaths. Due to circumstances beyond the control of the Focal Point more in-depth analysis of the 2015 data is not possible at this juncture in time.

1.1.3 Mortality cohort studies

There are no mortality cohort studies to report for 2016.

1.1.4 Trends

The number of DRD in Ireland has increased from 187 deaths in 2006 to 224 in 2015 (also see Standard Table 6). The numbers have fluctuated over the period, with a dip in 2010 but have been relatively stable since 2013.

The majority of deaths involve opiates. This is not surprising given the high prevalence of problem opiate use in Ireland (see TDI and Treatment workbook). The majority of opiate deaths involve heroin and methadone (either prescribed or street) or a combination of both (Health Research Board 2016). Up to 2010, more deaths involved heroin, but since then more deaths have involved methadone (as of 2014, the most recent year available). There has as yet been no analysis of why the numbers of methadone-related deaths have increased. The number of clients in opioid substitution treatment (OST) has increased steadily over the same period however studies have shown that retention in treatment has a protective effect (Cousins, *et al.* 2017, Cousins, *et al.* 2016). There was a recorded heroin drought in Ireland around 2010 (O'Keefe 2010, December 16) (Attewill 2011, 31 January) and this may have had some impact on this change.

Another significant factor in DRD has been the increase of polydrug deaths. In 2014 (the most recent year of data available), the majority of poisoning deaths (182, 85.0%) involved more than one drug. The majority (163/182, 89.6%) of polydrug poisoning deaths involved opiates. The most common other additional drugs involved were benzodiazepines, alcohol, antidepressants, and other prescriptions medications. The proportion of heroin-related deaths where polydrugs were implicated has risen from 60% in 2006 to 81% in 2014 (the most recent year data is available) (Health Research Board 2016).

Injecting is a significant factor for heroin-related deaths. In 2014 (the most recent year of data available), 48% of those who died where heroin was implicated were known to be injecting. However this has reduced from 65% in 2006. Nearly half (47%) of those who died while injecting heroin were in a private dwelling. Twenty-nine per cent of these who died because of heroin were homeless in 2014 (Health Research Board 2016). A naloxone demonstration project was conducted in 2015 (See T.1.5.3 below) which utilised NDRDI data to inform the methodology. The NDRDI will also be able to evaluate the effectiveness of the programme in reducing DRD in Ireland in the coming years.

Due to circumstances beyond the control of the Focal Point, a more in-depth analysis of the 2015 data is not possible at this time.

Data completeness/coverage; case ascertainment, changes in reporting

The NDRDI, the Irish Special Register for DRD has been in existence since 2007 utilising Filter D as a selector. Up to that point, DRD were reported through the GMR. However the NDRDI retrospectively collected data back to 1998. Therefore the NDRDI data supersedes any data previously reported between 1998 and 2007.

The NDRDI is a complete census of all drug-related deaths in Ireland, both direct drug deaths through overdose (known as poisoning) and deaths among drug users. Of note, it also collects additional deaths which do not meet the Filter D criteria but are of national importance, e.g. alcohol only and alcohol in combination with prescription drug overdose/poisonings deaths. The NDRDI is a national census as it collects information from all closed Coronial files, all deaths among hospital inpatients which meet the criteria, all deaths among those registered on OST and the general mortality registry (GMR). All of data these sources are matched to avoid duplication and to insure the greatest amount of information on each death. There has been no change in the process since the inception of the NDRDI.

1.1.5 Additional information on drug-related deaths

Overview of all drug-related deaths (including alcohol) in Ireland, 2014

The annual overview of all drug-related deaths in Ireland for 2014 showed that alcohol continued to be the drug most commonly implicated in poisonings deaths (Health Research Board 2016). This overview includes both illicit drugs (covered by Section D and reported through ST5 & 6) in addition to other drugs such as alcohol and prescription medication not reported in ST5 & 6. It also includes data on non-poisoning deaths among drug users.¹

The latest figures from the NDRDI show that a total of 697 deaths in Ireland during 2014 were linked to drug use. The NDRDI reports on poisoning deaths (also known as overdose), which are due to the toxic effect of a drug or combination of drugs, and on non-poisonings, which are deaths among people who use drugs as a result of trauma such as hanging, or medical reasons such as cardiac events.

In the eleven-year period from 2004 to 2014 inclusive, a total of 6,697 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 3,864 (58%) were due to poisoning and 2,833 (42%) were deaths among drug users (non-poisoning) (Table 1.1.5.1). There were 697 deaths in 2014, similar to the number reported in 2013 (698).

Many of these deaths were premature, with half of all deaths in 2014 aged 39 years or younger. Three in four (523) of all deaths in 2014 were male.

Some of the key findings of the report include the following:

- Prescription drugs were implicated in 259 (three in every four) poisonings during 2014.
- Two hundred and thirty-five people died in 2014 because they took a mixture of drugs, with an average of four drugs involved.
- Benzodiazepines were the most common drug group involved in polydrug deaths.
- Notwithstanding a small decrease in alcohol poisonings, alcohol is still implicated in one-in-three deaths and remains the single most common drug implicated in deaths over the reporting period 2004–2014.
- Opiates were the main drug group implicated in poisonings.
- Hanging was the main cause of non-poisoning deaths. There was a 21% increase in deaths due to hanging between 2013 and 2014.

Table 1.1.5.1 Number of deaths, by year, NDRDI 2004–2014 (N=6697)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
All deaths	431	503	554	620	628	656	607	643	660	698	697
Poisonings (3864)	266	301	326	387	386	372	340	377	358	397	354
Non-poisonings (2833)	165	202	228	233	242	284	267	266	302	301	343

Source: NDRDI, 2017

Poisoning deaths in 2014

¹ This annual overview is published only after DRD data is reported to the EMCDDA. Therefore the report reproduced here refers to 2013 data which was not published at the time the previous workbook was compiled. The national overview for 2015 is not yet published so cannot be included in this workbook

The annual number of poisoning deaths decreased by 11%, from 397 in 2013 to 354 in 2014 (Table 1.1.5.1). As in previous years, the majority (72%) were male. The median age of those who died was 39 years, again similar to previous years.

Prescription drugs were implicated in 259 (three in every four) poisoning deaths. With regard to prescription drugs:

- Benzodiazepines were the most common prescription drug group implicated.
- Diazepam (a benzodiazepine) was the most common single prescription drug, implicated in 115 (32%) of all poisoning deaths.
- Methadone was implicated in more than a quarter of poisonings (n=98, 28%).
- Zopiclone-related deaths (a non-benzodiazepine sedative drug) increased by 41% from 51 in 2013 to 72 in 2014.

Alcohol continues to be the single most common drug implicated over the reporting period. Alcohol was implicated in one-in-three of all poisonings, and alcohol alone was responsible for 13% of all poisoning deaths.

The number of deaths where illicit drugs were implicated increased. Of particular note:

- Heroin was implicated in one-in-four (n=90) deaths and 42% of these people were not alone at the time of the incident that led to their deaths.
- Cocaine-related deaths increased by 25% from 32 in 2013 to 40 in 2014.
- MDMA-related deaths continue to increase from less than 5 in 2010 to 15 in 2014.

Polydrug use is a significant risk factor for fatal overdose. In 2004, 44% or 118 deaths were due to a cocktail of drugs, with an average of two drugs taken. In 2014, this had risen to 66% or 235 deaths, with an average of four different drugs taken. Regarding polydrug use:

- 59% of deaths where alcohol was implicated involved other drugs, mainly opiates.
- 92% of deaths where methadone was implicated involved other drugs, mainly benzodiazepines.
- 81% of deaths where heroin was implicated involved other drugs, mainly benzodiazepines.
- Almost all deaths (98%) where cocaine was implicated involved other drugs.

Non-poisoning deaths in 2014

The number of non-poisoning deaths increased by 14%, from 301 in 2013 to 343 in 2014. (Table 1.1.5.1.). Non-poisoning deaths are categorised as being due to either trauma (n=177) or medical causes (n=116).

The main causes of non-poisoning deaths were hanging (27%) and cardiac events (15%). There was a 21% increase in deaths due to hanging between 2013 and 2014. More than two-thirds (67%) of people who died as a result of hanging had a history of mental health illness.

1.2 Drug related acute emergencies

1.2.1 Drug-related acute emergencies

Monitoring of drug-related acute emergencies in the Irish context refers to all admissions for non-fatal overdoses to acute general hospitals in Ireland. A description of the main monitoring systems and sources of data are included at the end of this workbook.

Drug-related emergencies – non-fatal overdoses

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses in patients discharged from Irish hospitals in 2015. In total, there were 4,023 overdose cases in that year. Of those cases, 67 died in hospital; only discharged cases are included in this analysis. The number of overdose cases in 2015 decreased from 4,256 cases in 2014, and trends over time indicate a general decrease in overdose cases admitted to Irish hospitals, falling from 5,012 cases in 2005 to 3,956 cases in 2015 (Figure 1.2.1.1).

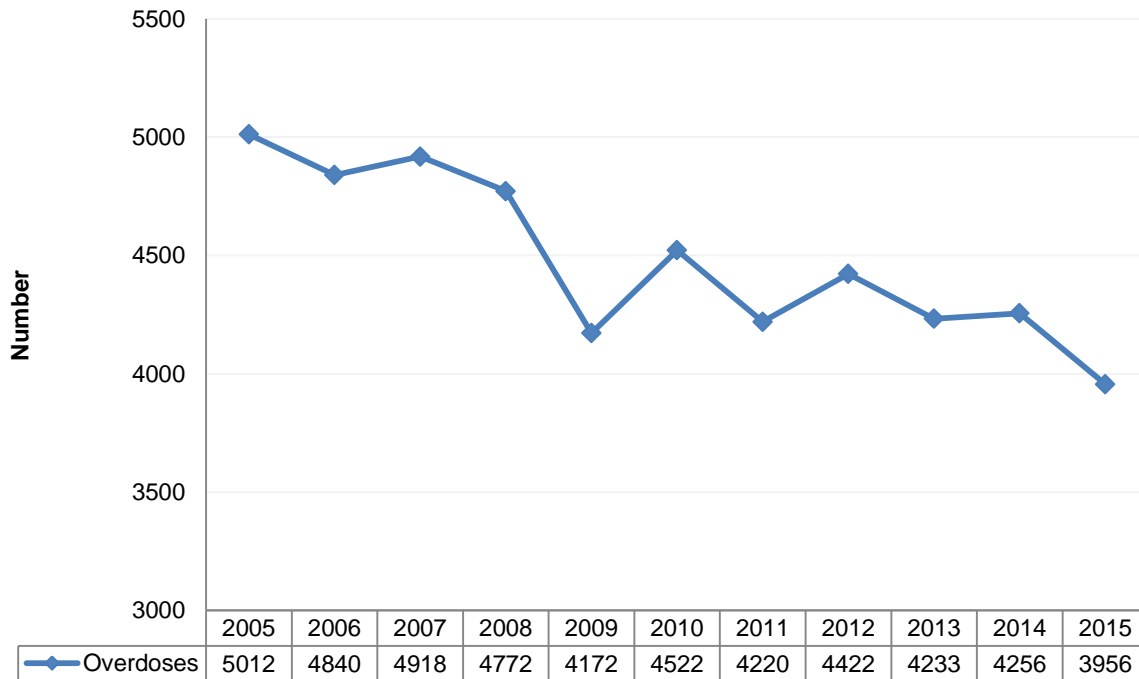


Figure 1.2.1.1 Number of non-fatal overdose cases admitted to Irish hospitals by year, 2005–2015
Source: HIPE, Healthcare Pricing Office, 2017

Gender

Between 2005 and 2015, there were more overdose cases among women than among men, with women accounting for 2,288 (58%) of all non-fatal overdose cases in 2015 (Figure 1.2.1.2).

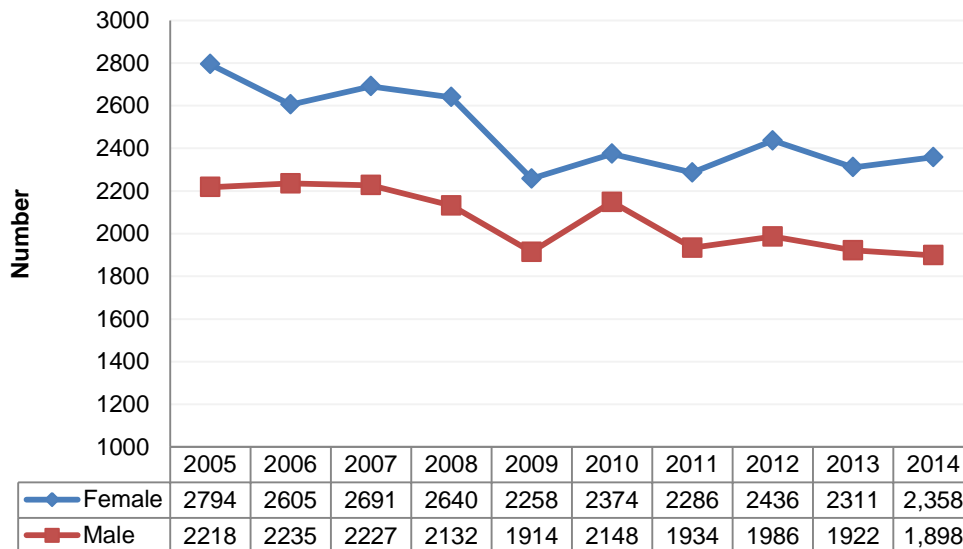


Figure 1.2.1.2 Number of non-fatal overdose cases admitted to Irish hospitals, by year and gender, 2005–2015
Source: HIPE, Healthcare Pricing Office, 2017

Age group

Between 2014 and 2015, there was a decrease in the number of non-fatal overdose cases among those aged 15 to 34 and in all age groups from 45 to 74 years. As noted in previous annual reports, the incidence of overdose cases peaks in the 15-24 age group, and thereafter decreases with age (Figure 1.2.1.3). Trends over time show that in 2005, 40% of cases involved patients younger than 25 years of age; the comparable figure in 2015 was 32%.

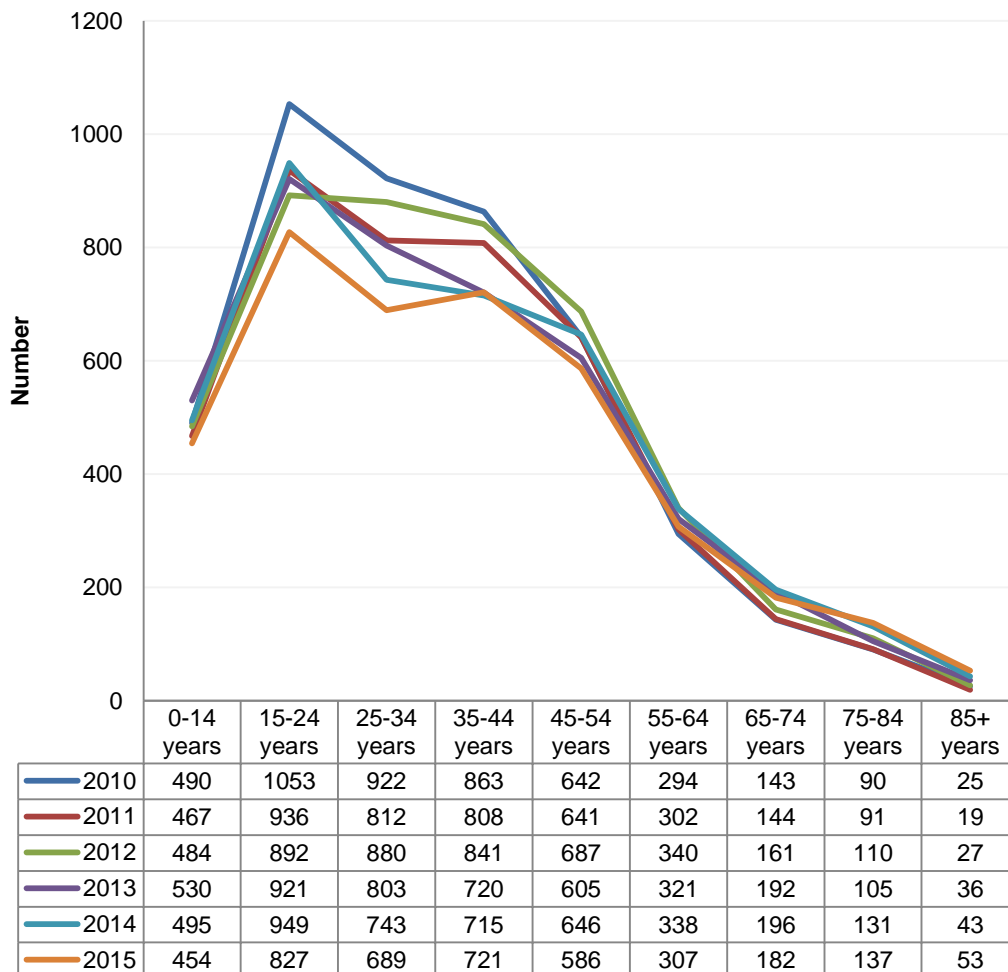


Figure 1.2.1.3 Non-fatal overdose cases admitted to Irish hospitals, by year and age group, 2010–2015

Source: HIPE, Healthcare Pricing Office, 2017

1.2.2 Toxicology of drug-related acute emergencies

Drugs involved

Table 1.2.2.1 presents the positive test results per category of drugs and other substances involved in all overdose cases in 2015.

Non-opioid analgesics were present in 35% (1,393) of cases. Paracetamol is included in this drug category and was present in 28% (1,118) of cases. Psychotropic agents were taken in 25% (986) of cases and benzodiazepines in 18% (716) of cases. There was evidence of alcohol consumption in 8% (331) of cases. Cases involving alcohol are included in this analysis only when alcohol was used in conjunction with another substance.

Table 1.2.2.1 Categories of drugs involved in non-fatal overdose cases admitted to Irish hospitals, 2015 (n=3,956)*

Drug category	Number	%
Non-opioid analgesics	1,393	35.2
<i>Paracetamol (4-Aminophenol derivatives)</i>	1118	28.3
Benzodiazepines	716	18.0
Psychotropic agents	986	24.9
Anti-epileptic/sedative/anti-Parkinson agents	1795	45.3
Narcotics and hallucinogens	662	16.7
Alcohol	331	8.4
Systemic and haematological agents	140	3.5
Cardiovascular agents	141	3.5
Autonomic nervous system	124	3.1
Anaesthetics	14	0.3
Hormones	116	2.9
Systemic antibiotics	65	1.6
Gastrointestinal agents	71	1.8

Drug category	Number	%
Other chemicals and noxious substance	280	7.0
Diuretics	54	1.4
Muscle and respiratory agents	27	0.6
Topical agents	35	0.8
Anti-infectives/anti-parasitics	18	0.4
Other gases and vapours	58	1.5
Other and unspecified drugs	790	20.0

Source: HIPE, Healthcare Pricing Office, 2017

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

Overdoses involving narcotics or hallucinogens

Figure 1.2.2.1 shows the number of positive test results for illicit substances among overdose cases in 2015. Opiates were used in 13% (528) of cases, cocaine in 2.4% (96) and cannabis in 1.6% (64) of cases. There were no overdose cases involving hallucinogenic substances.

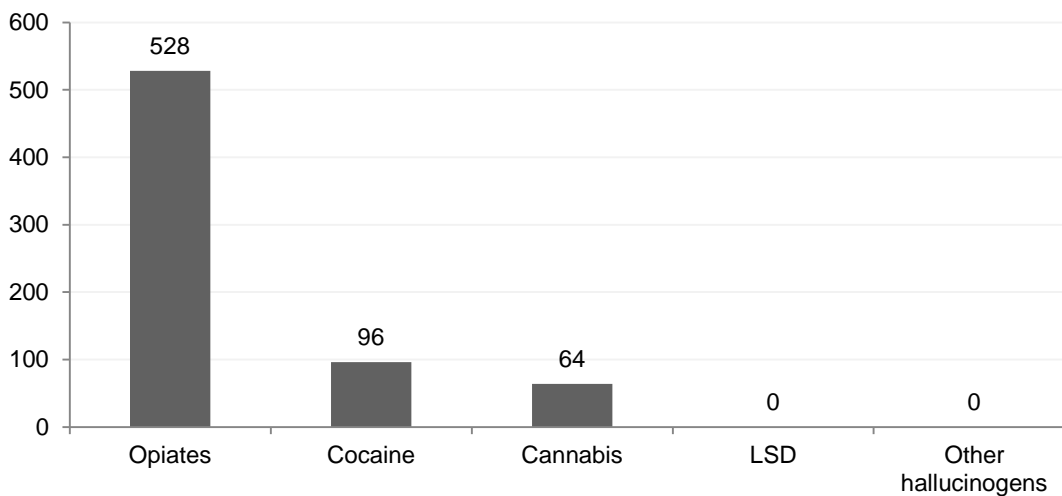


Figure 1.2.2.1 Narcotics and hallucinogens involved in overdose cases admitted to Irish hospitals, 2015

Source: HIPE, Healthcare Pricing Office, 2017

Overdoses classified by intent

In 63% (2,490) of cases in 2015, the overdose was classified as intentional (Figure 1.2.2.2). In 410 cases, the intent was not clear; these cases were not included in the analysis.

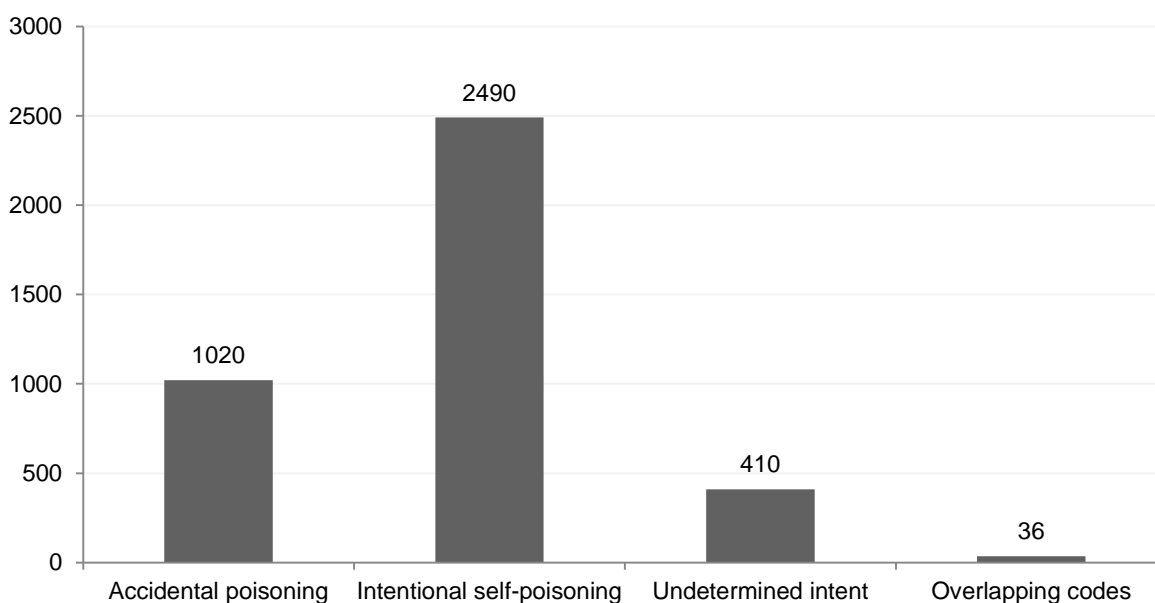


Figure 1.2.2.2 Overdose cases admitted to Irish hospitals, classified by intent, 2015

Source: HIPE, Healthcare Pricing Office, 2017

Table 1.2.2.2 the number of positive test results per category of drugs and other substances involved in cases of intentional self-poisoning (n=2,490) in 2015. Non-opioid analgesics were involved in 44% (1,098) of cases, benzodiazepines in 21% (532) and psychotropic agents in 30% (748) of cases.

Table 1.2.2.2 Categories of drugs involved in intentional self-poisoning cases admitted to Irish hospitals, 2015 (n=2,490)*

Drug category	Number	%
Non-opioid analgesics	1098	44.0
Benzodiazepines	532	21.4
Psychotropic agents	748	30.0
Anti-epileptic/sedative/anti-Parkinson agents	1331	43.5
Narcotics and hallucinogens	360	14.5
Alcohol**	248	10.0
Systemic and haematological agents	63	1.4
Cardiovascular agents	82	3.3
Autonomic nervous system	84	3.4
Anaesthetics	~	~
Hormones	75	3.0
Systemic antibiotics	45	1.8
Gastrointestinal agents	48	1.9
Other chemicals and noxious substance	102	4.1
Diuretics	31	1.2
Muscle and respiratory agents	14	0.6
Topical agents	9	0.4
Anti-infectives/anti-parasitics	14	0.6
Other gases and vapours	7	0.3
Other and unspecified drugs	427	1.7

Source: HIPE, Healthcare Pricing Office, 2017

* Some discharges may be included in more than one drug category; therefore, the total count in this table exceeds the total number of discharges.

** Alcohol was only included for cases where any code from any of the other drug categories in this table was also reported.

~ denotes five or fewer discharges reported to HIPE.

1.2.4 Additional information on drug-related acute emergencies

Drug admissions to psychiatric facilities

Drug and alcohol admissions to psychiatric facilities

Data from Activities of Irish Psychiatric Units and Hospitals 2015, the annual report published by the Mental Health Information Systems Unit of the HRB, has shown that the total number of first admissions to inpatient care for persons with an alcohol disorder has continued to fall (Daly and Craig 2016).

In 2015, 1,188 cases with an alcohol disorder were admitted to psychiatric facilities, of whom 437 were treated for the first time. Figure 1.2.4.1 presents the rates of first admission between 1995 and 2015. The overall trend observed since 1995 has continued, with a reduction in the rate of first admissions in 2015 compared to 2014. Slightly more than 33% of all cases hospitalised for an alcohol disorder in 2015 stayed for just under one week, and 28% of cases were hospitalised for between one and three months.

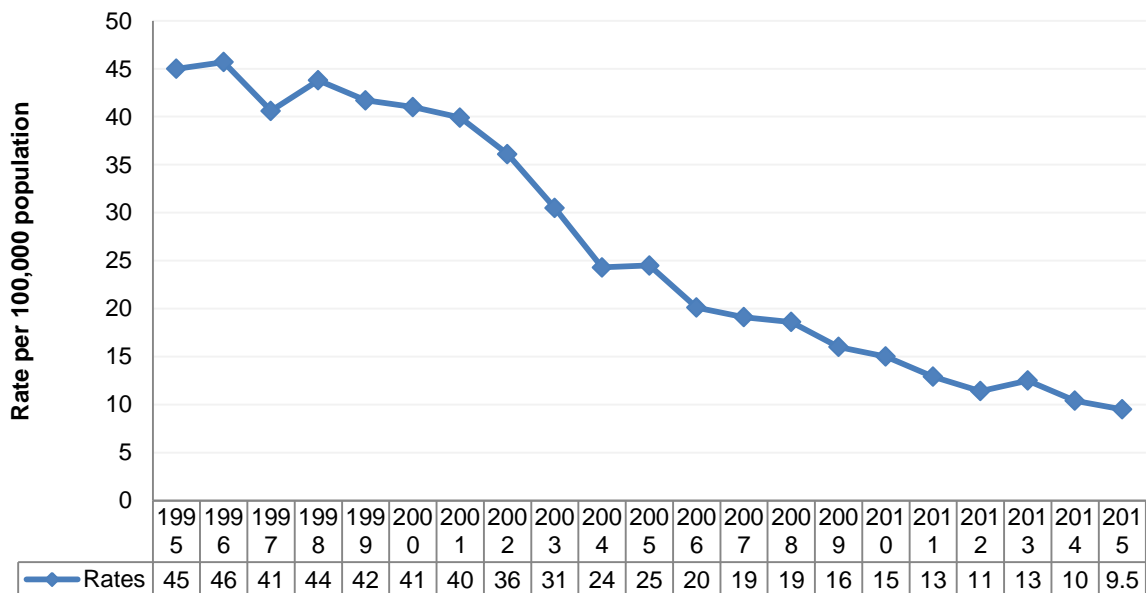


Figure 1.2.4.1 Rates of psychiatric first admission of cases with a diagnosis of an alcohol disorder per 100,000 of the population in Ireland, 1995 to 2015

Source: Daly and Craig, 2016

However, trends of first admissions for an alcohol disorder contrast with those observed for patients with a drug disorder. Figure 1.2.4.2 presents the rates of first admission between 1995 and 2015 for drug disorder cases. In 2015, 1,032 persons were admitted to psychiatric facilities with a drug disorder. Of these cases, 448 were treated for the first time, which represents a rate of 9.8 per 100,000 of the population, the highest rate recorded since 1995. Since 2006 there has been a general increase in the rate of first admissions. It should be noted, however, that the report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate.

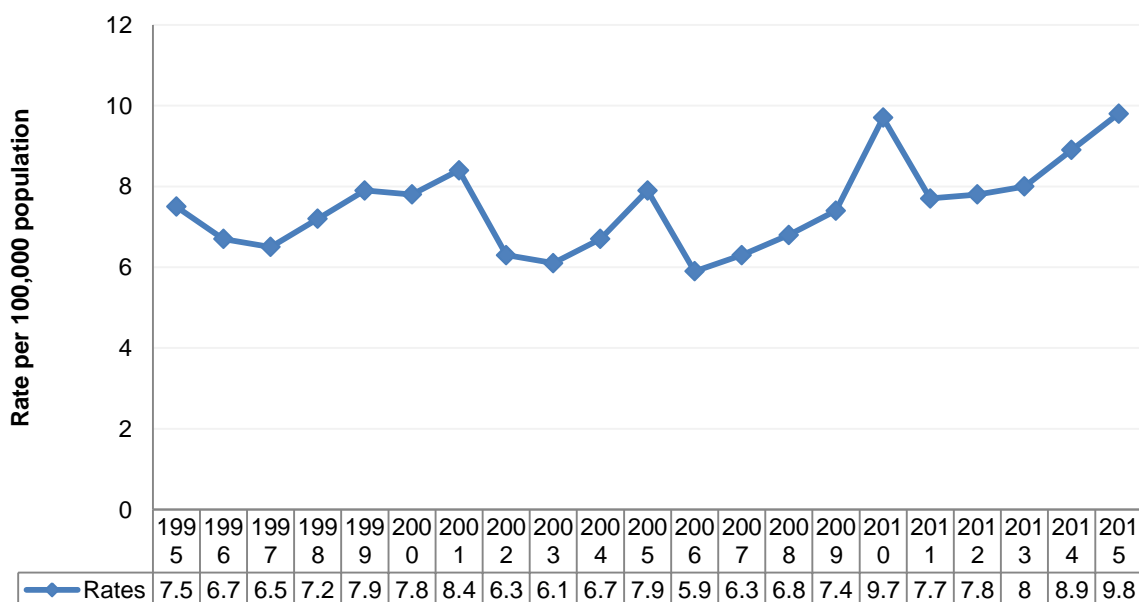


Figure 1.2.4.2 Rates of psychiatric first admission of cases with a diagnosis of a drug disorder per 100,000 of the population in Ireland, 1995–2015

Source: Daly and Craig, 2016

Other notable statistics on admissions for a drug disorder in 2015 include the following:

- Just under half (47.1%) of cases hospitalised for a drug disorder stayed for less than one week, and 98% were discharged within three months. It should be noted that admissions and discharges represent individual episodes or events and not persons.
- Eleven per cent of first-time admissions were involuntary.

- The rate of first-time admissions was higher for men (14.2 per 100,000 of the population) than for women (5.4 per 100,000 of the population).

The overall increase in the rate of drug-related first admissions between 1995 and 2015 may reflect an overall increase in problem drug use in Ireland and its increasing burden on psychiatric and mental-health services.

1.3 Drug related infectious diseases

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

New HIV notifications, 2016

According to data compiled by the Health Protection Surveillance Centre (HPSC), at the end of 2016, 512 people were newly diagnosed with HIV in Ireland, a notification rate of 11.2 per 100,000 population. This marks an increase of almost 6% compared to 2015, with 485 new HIV diagnoses (Figure 1.3.1.1).

The increased number of recent HIV infection among PWID is being investigated and may be partly explained by the changes in reporting procedures in HSE East. In addition, there was an outbreak in Dublin among PWID in 2014/15. A detailed review of the region of origin, mode of transmission, duration of drug use and co-infection is also being conducted.

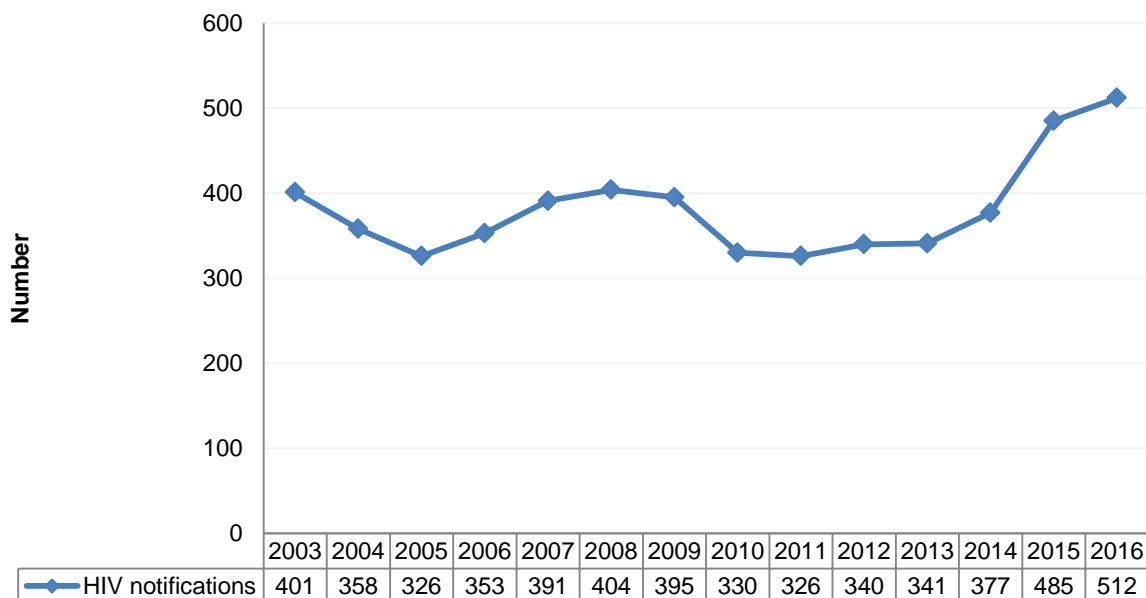


Figure 1.3.1.1 Number of new HIV notifications reported in Ireland, by year of notification, 2003–2016

Source: Health Service Executive (HSE) and HPSC, 2017

Of the new HIV notifications in 2016:

- 394 were male and 118 were female;
- 266 were born outside Ireland;
- 141 had previously been diagnosed HIV-positive in another country;
- 237 were men who have sex with men;
- 96 were classified as ‘other’ (including mother-to-child transmission); and
- for 31% (160) of new HIV notifications in 2016, there was no reported risk factor, although this is likely to change as more data become available.

In 2016, 19 new HIV notifications were people who inject drugs (PWID) (Table 1.3.1.1). This compares with 45 notifications in 2015. The figure for 2015 was the highest number of PWID among HIV notifications since 2008 (Figure 1.3.1.2).

Table 1.3.1.1 New HIV notifications reported to the HPSC by risk factor status, 2016

Risk factor status	n (%)
Total	512
Cases with reported risk factor data	352 (68.8)
Of which:	
Injecting drug users	19 (5.4)
Men who have sex with men	237 (67.3)
Recipient blood/blood products	0 (0)
Other risk factors	96 (27.3)
No known risk factor identified	0 (0)
Cases without reported risk factor data	160 (31.3)

Source: HSE and HPSC, 2017

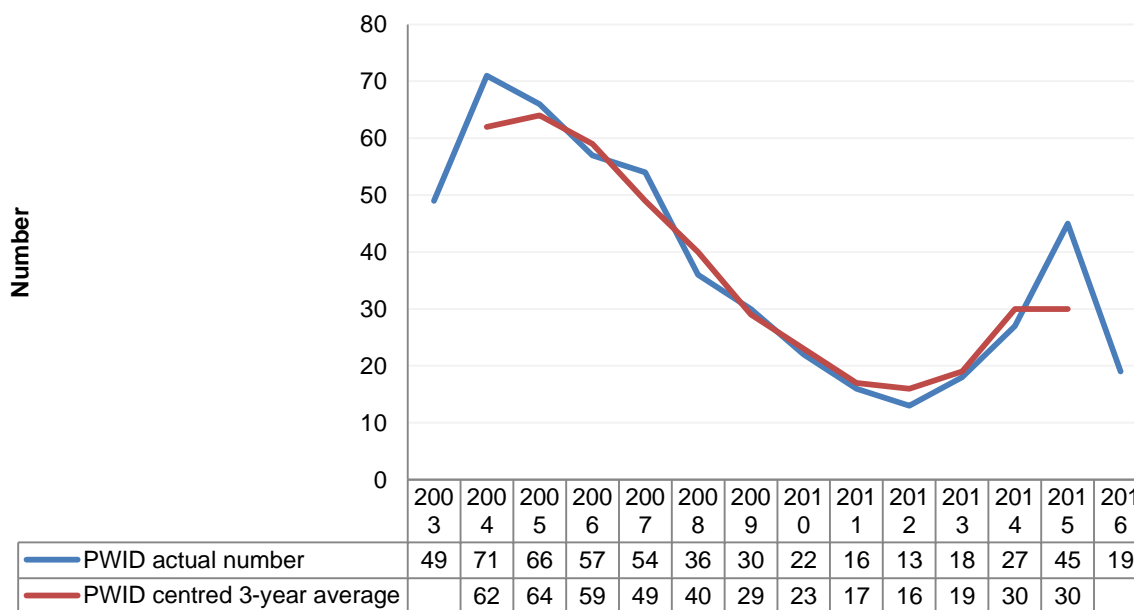


Figure 1.3.1.2 Number and rolling average number of PWID among HIV notifications reported in Ireland, by year of notification, 2003–2016

Source: HSE and HPSC, 2017

Of the PWID among new HIV notifications in 2016, 13 were male and six were female, with a median age of 35. Two subjects were under 25 years of age. The majority (84%) resided in Dublin, Kildare or Wicklow (Table 1.3.1.2).

Table 1.3.1.2 Characteristics of new HIV notifications who reported injecting drug use as a risk factor, 2016

Known injector cases	n (%)
Total	19
Gender	
Male	13 (68.4)
Female	6 (31.6)
Gender unknown	0 (0)
Age	
Mean age	36.2
Median age	35

Known injector cases	n (%)
Under 25 years	2 (10.5)
25-34 years	6 (31.6)
Age unknown	0
Place of residence	
Dublin, Kildare or Wicklow	16 (84.2)
Elsewhere in Ireland	3 (15.8)

Source: HSE and HPSC, 2017

The increased number of PWID among new HIV notifications in 2014/15 was due to an outbreak of HIV among homeless drug users in Dublin; see the 2016 National Report, Section 1.3.6.

HBV notifications, 2016

There were 488 notifications of HBV in 2016, a decrease of 11% from 2015, when there were 548 notifications. The notification rate for 2016 was 10.2 per 100,000 population. HBV notifications halved between 2008 (n=899, 21.2/100,000 population) and 2014 (n=442, 9.3/100,000 population), but recent trends suggest that the number of cases diagnosed and notified is stabilising rather than continuing to decline (Figure 1.3.1.3).

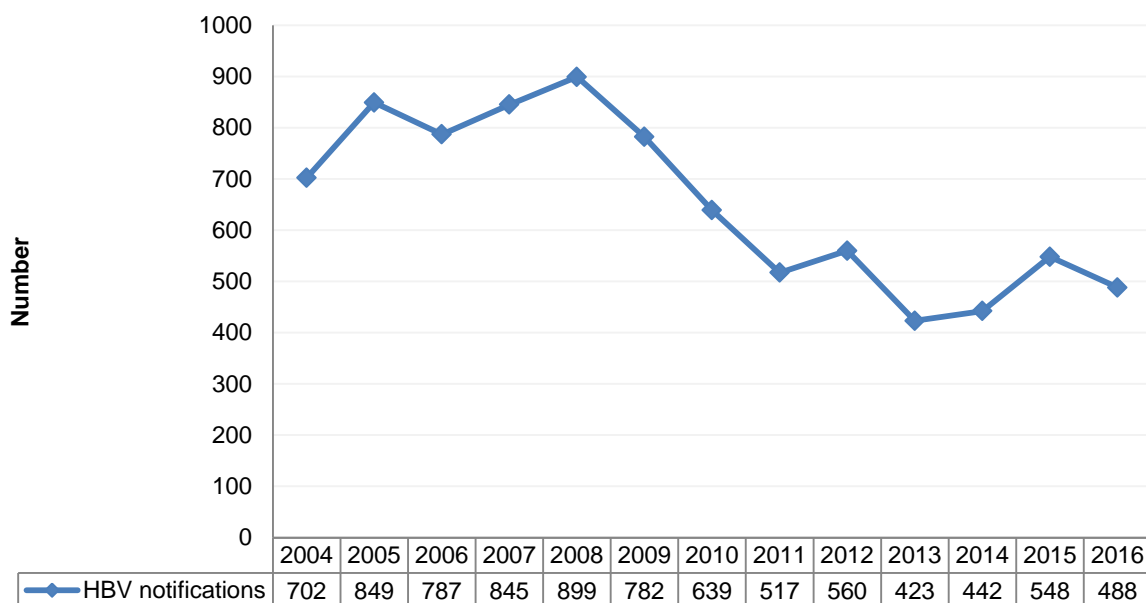


Figure 1.3.1.3 Number of HBV notifications reported in Ireland, by year of notification, 2004–2016

Source: HSE and HPSC, 2017

Ninety-three per cent (n=452) of the 488 new HBV notifications in 2016 contained information on acute/chronic status. Of these, 93% (n=420) were chronically infected (long-term infection) and 7% (n=32) were acutely infected (recent infection).

Seventy-eight per cent (n=25) of known acute cases in 2016 were male. Cases ranged in age from 26 to 69 years. The overall median age at notification was 36 years. Male cases were older on average, with a median age at notification of 37 years compared to 28 years for female cases.

Risk factor data were available for 81% (n=26) of the acute cases notified in 2016. Of these, 65% (n=17) were likely to have been sexually acquired (10 were heterosexual, seven were men who have sex with men). One notification was an injecting drug user (Table 1.3.1.3). A further two cases reported possible blood exposure when snorting cocaine.

Table 1.3.1.3 Acute and chronic new HBV cases reported to the HPSC, 2016

HBV status	Acute	Chronic	Unknown
	n (%)	n (%)	n (%)
Total number of cases	32	420	36
Percentage of cases by status	(6.6)	(86.1)	(7.4)
Cases with reported risk factor data	26	79	3
Percentage of cases with risk factor data	(81.3)	(18.8)	(8.3)
Of which:			
Injecting drug users	1 (3.8)	3 (3.8)	0 (0)
Cases without reported risk factor data	6	341	33
Percentage of cases without risk factor data	(18.8)	(81.2)	(91.7)

Source: HSE and HPSC, 2017

Two additional cases had a risk factor of snorting cocaine but were not PWID.

Two acute cases that did not have primary risk factor data reported that they were born in an endemic country or were asylum seekers.

New HCV notifications, 2016

There were 645 new HCV notifications in the Republic of Ireland in 2016, a decrease of 4% from 2015, when there were 675 notifications. The notification rate for 2016 was 13.5 per 100,000 population. There has been a downward trend in HCV notifications since peak numbers (1,538) were recorded in 2007, although recent trends indicate that the rate of decline is slowing (Figure 1.3.1.4). While notifications continued to decline slightly in 2016, trends in notifications of HCV are difficult to interpret, as acute and chronic infections are frequently asymptomatic, and most cases diagnosed and notified are identified as a result of screening in key risk groups. Therefore, notification patterns are highly influenced by testing practices, which may vary over time and may not reflect incidence very accurately.

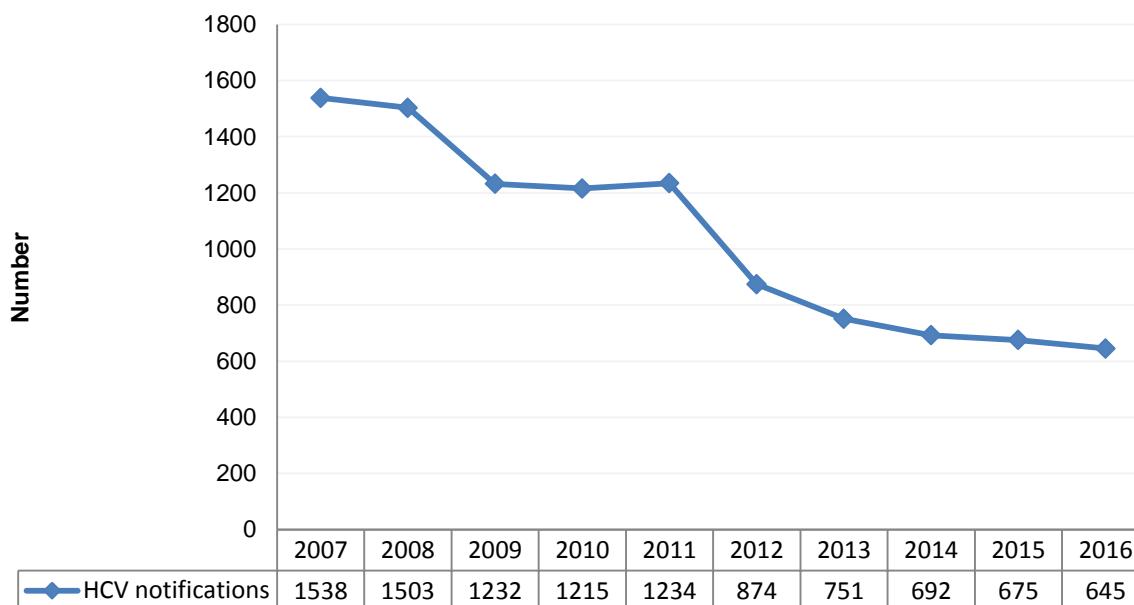


Figure 1.3.1.4 Number of HCV notifications reported in Ireland, by year of notification, 2007–2016

Source: HSE and HPSC, 2017

Information on the most likely risk factor was available for 47% (n=305) of cases in 2016 (Table 1.3.1.4). Sixty-seven per cent (n=205) of cases with risk factor data were PWID and 4% (n=13) were infected through contaminated blood products. No risk factors were identified for 26 cases for whom risk factor data were available despite Public Health follow up. Forty-seven of the cases with no risk factor data and 31 cases with risk factor data were from HCV-endemic countries or were known to be asylum seekers.

Table 1.3.1.4 New HCV cases reported to the HPSC, by risk factor status, 2016

Risk factor status	n (%)
Total	645
Cases with reported risk factor data	305 (47.3)
Of which:	
Injecting drug users	205 (67.2)
Recipient of blood/blood products	13 (4.3)
Other risk factors	61 (20.0)
No known risk factor identified	26 (8.5)
Cases without reported risk factor data	340 (52.7)

Source: HSE and HPSC, 2017

The proportion of cases attributed to injecting drug use has decreased from 88% in 2011 to 67% in 2016, but risk factor data were not available for a significant number of cases, so this finding is difficult to interpret. Data for 2016 will improve as further validation work is carried out in the coming months.

Of the PWID among HCV notifications in 2016, 155 were male and 50 were female, with a median age of 39. Seven subjects were under 25 years of age. The majority (71%) resided in Dublin, Kildare or Wicklow (Table 1.3.1.5).

Table 1.3.1.5 Characteristics of new HCV notifications who reported injecting drug use as a risk factor, 2016

Known injector cases	n (%)
Total	205
Gender	
Male	155 (75.6)
Female	50 (24.4)
Gender not known	0
Age	
Mean age	39.8
Median age	39
Under 25 years	7 (3.4)
25-34 years	56 (27.3)
Over 34 years	142 (69.3)
Age not known	0 (0)
Place of residence	
Dublin, Kildare or Wicklow	145 (70.7)
Elsewhere in Ireland	60 (29.3)

Source: HSE and HPSC, 2017

1.3.2 Notification of drug-related infectious diseases

Incidence of HCV among PWID in Ireland

Recent research examined the incidence of HCV infection among PWID in the Republic of Ireland over a 13-year period. In this study, which was published in the BMC journal Hepatology, Medicine and Policy (Carew, *et al.* 2017), anonymised data from the National Drug Treatment Reporting System (NDTRS) were used to identify all PWID who entered drug treatment for the first time between 1991 and 2014. A curve estimating the incidence of injecting was created to plot PWID by year of commencing injecting. The curve was adjusted for missing data on PWID in treatment, and for injectors who were never treated. An additional adjustment was made to account for PWID who had never shared injecting equipment. The incidence of HCV infection and chronic HCV infection among PWID was estimated by applying published rates.

It was found that between 1991 and 2014, 14,320 injectors were registered with the NDTRS. The majority were young (median age 25 years), male (74%), lived in Dublin (73%) and injected an opiate (94%). The estimated total number of injectors up to the end of 2014 was 16,382. The

authors estimated that 12,423 (95% CI: 10,799–13,161) individuals were infected with HCV, and that 9,317 (95% CI: 8,022–9,966) of these subjects became chronically infected. The estimated annual number of new HCV infections among PWID peaked in 1998 (Figure 1.3.2.1). By 2014, almost 30% of injectors were estimated to have been infected for over 20 years.

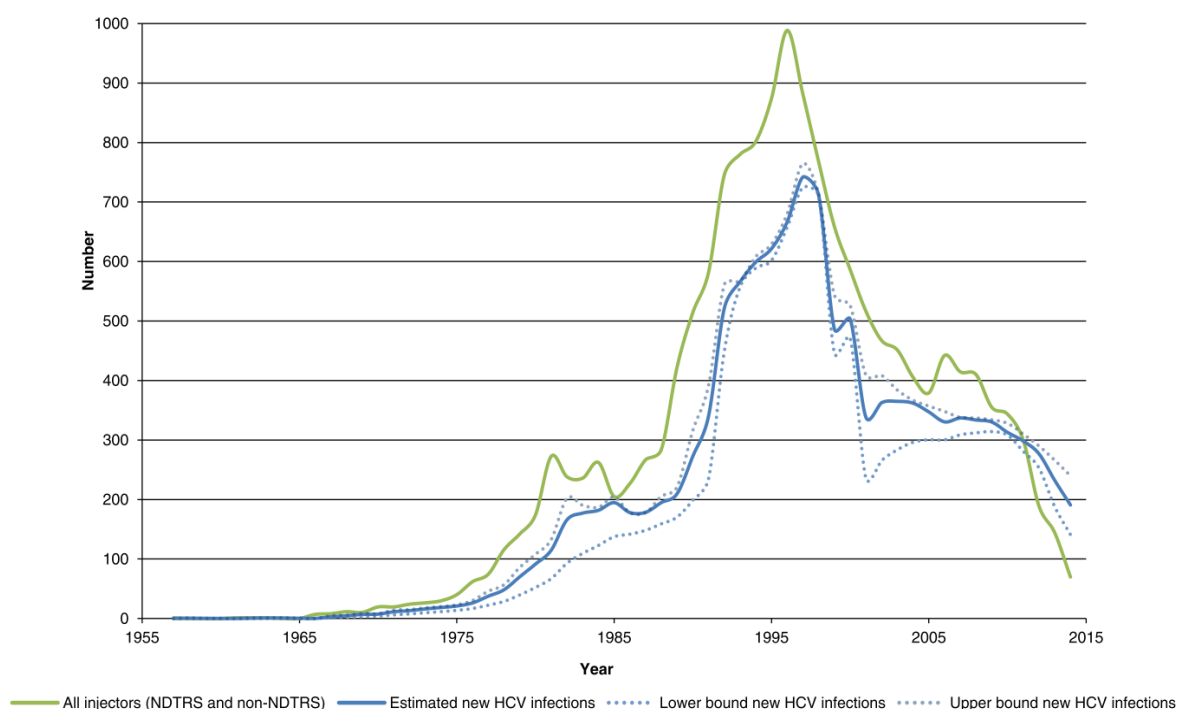


Figure 1.3.2.1 Estimates of new injectors by year commenced injecting and new HCV infections by year infected
 Source: Carew AM, Murphy N, Long J, Hunter K, Lyons S, et al., 2017

Research has indicated that the prevalence of opioid use in Ireland may have stabilised (Hay, *et al.* 2017) (see Drugs workbook, Section C, 1.1.2 and 1.1.3), and that the number of PWID entering drug treatment for the first time in Ireland has decreased slightly in recent years (European Monitoring Centre for Drugs and Drug Addiction 2011). Nevertheless, injecting drug use remains a significant issue. As the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recommends the collection of accurate data on the incidence of injectors entering drug treatment (Thanki and Vicente 2013), the study authors concluded that the analysis demonstrates the wider usefulness of routine drug treatment data collected by the NDTRS. This may help inform policy with regard to the use of highly effective, but expensive, new treatments for HCV that have recently become available.

1.3.3 Prevalence data of drug-related infectious diseases outside the routine monitoring Audit of HCV testing and referral, 2015

In 2014/15, an unpublished audit was carried out in Ireland of HCV testing and referral in addiction treatment centres in HSE Community Healthcare Organisation (CHO) Area 7 (formerly HSE Dublin Mid-Leinster). CHO Area 7 covers Dublin 2, 4 (part of), 6, 6W, 8, 10, 12, 16 (part of), 22 and 24. The audit was not carried out in the satellite clinics or in West Wicklow and Kildare, as services there are in community-based general practice. The number of patients attending the addiction treatment centres in CHO Area 7 at the time of starting the audit was 1,255.

The purpose of this audit was to inform the Audit Sub-Group of the Addiction Treatment Clinical Governance Committee of CHO Area 7 of compliance with the expected standard of care in relation to HCV, and to make recommendations for improvement where necessary. A secondary aim of the audit was to collect and collate data on the prevalence of HCV infection in this sample of patients.

Methods

A customised audit form was developed. One form was to be completed for each patient attending the centre. Data were requested on age, gender, and whether or not the patient was tested for HCV. Risk factors for infection, co-infection with HIV, referral to a specialist clinic (hepatology or infectious diseases), attendance at a specialist clinic and what level of treatment, if any, was provided were also requested. No personally identifiable information was collected on patients. In order to encourage cooperation and to avoid making comparisons between centres, the form did not contain the name of the doctor or the treatment centre.

A letter, accompanied by the audit form, was sent to 20 GPs in 11 addiction treatment centres in CHO Area 7 outlining the audit project and requesting their assistance in completing the forms. A total of 319 audit forms were returned, representing 25% of the patients attending the services at that time. It is not possible to determine how many doctors or treatment centres participated, as the study was anonymous. The main findings from this audit are outlined below.

Findings

Age and sex

Where data were available, 63% (198 out of 315 patients) of respondents were male; the age range of all respondents was 24 years to 65 years. The median age for males was 38 years, and the median age for females was 36 years. The majority of patients (81%) were between the ages of 25 and 44 years.

Risk factors for HCV infection

Information on possible risk factors for infection was available for 65% (208 out of 319) of patients (Figure 1.3.3.1); of those patients, 85.1% (177 out of 208) had a history of injecting drug use (PWID), 10.6% (22 out of 208) had non-injecting drug use risk factors, and 4.3% (nine out of 208) had no known risk factors. Of those with non-injecting drug use risk factors, 17 reported cocaine use, four reported unprotected sex with a HCV-positive person and one reported both cocaine use and unprotected sex with a HCV-positive person.

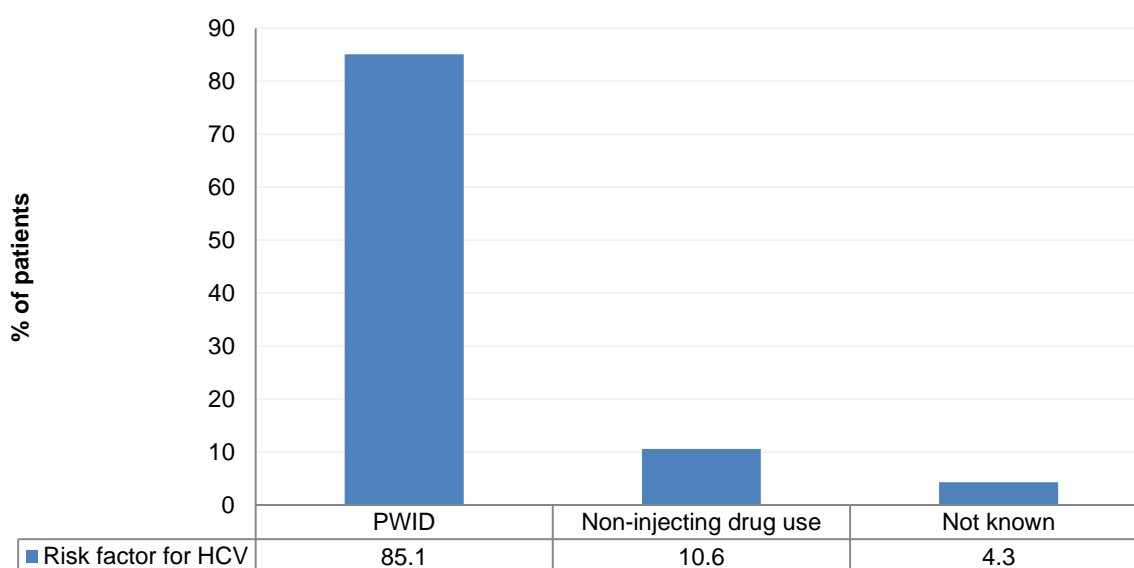


Figure 1.3.3.1 Risk factors for HCV infection among patients* in selected addiction treatment centres in Ireland, 2014/15

Source: Unpublished data from the HPSC, 2017

*Risk factor data available for 65% of patients.

Of the 177 patients who had a history of injecting drug use, 72% (128) were HCV antibody positive and 44% (78) were HCV antigen or Polymerase chain reaction (PCR) positive. In those with HCV antigen- or PCR-positive results, the age range was 24 years to 56 years, with a median age of 40 years. The likelihood of having HCV increased with age in those with a history of injecting drug use, with 63% (10 out of 16) of 25-34-year-olds testing positive for HCV antigen or PCR compared to 68% (45 out of 66) of 35-44-year-olds and 80% (20 out of 25) of 45-54-year-olds. Data on HCV testing were available for 14 patients, of whom five tested positive for HCV antibodies. Two of these five patients were also HCV antigen or PCR positive.

HIV infection

HIV status was recorded on 242 patients, of whom 39 (16%) were HIV positive. The median age of HIV-positive patients was 39 years (the full age range was 31 to 56 years). Of the HIV-positive patients, 37 were also HCV antibody positive, and 20 of these were HCV antigen or PCR positive. The majority (70%) of those co-infected with HIV were male. Where data were available, 97% (34 out of 35) of all HIV-positive patients were reported to have a history of injecting drug use. Overall, 19% (34 out of 177) of those with a history of injecting drug use were HIV positive.

Referral to and attendance at hepatology or infectious diseases clinics by gender and age

Where data were available, 86% (88 out of 102) of HCV antigen or PCR-positive patients were referred to a specialist clinic and, of those, 66% (52 out of 79) attended. Males were more likely than females to attend a specialist clinic following referral, with a 74% (39 out of 53) attendance rate, compared to just 50% (13 out of 26) of females. The likelihood of attendance at a specialist clinic also increased with age, with just 36% (four out of 11) of those in the 25-34 age group having attended following referral, compared to 68% (30 out of 44) of the 35-44-year-olds and 76% (16 out of 21) of the 45-54-year-olds.

Treatment uptake and completion

Data were collected on whether or not treatment was offered, accepted, completed and successful in HCV antigen-positive patients. Out of 105 patients who tested positive for the HCV antigen or PCR, data were available on offer of treatment for 57. Of those, 28 patients (49%) were recorded as having been offered treatment and 29 were not offered treatment. Of the 28 patients who were offered treatment, six were awaiting treatment at the time of the audit, three were still in treatment, four had refused treatment and seven had completed treatment; there was no further information on the remaining eight patients. Of the seven patients who had completed their treatment, it was successful in four, and no information was provided on the remaining three cases.

Conclusions and recommendations

One aim of this audit was to provide information on the current prevalence of HCV infection in patients attending addiction treatment clinics in Ireland. Two-thirds (67%) of patients who had been tested were positive for HCV antibodies. This figure is in keeping with previous studies in Ireland among PWID, which found the prevalence to be between 62% and 81% (HSE National Hepatitis C Strategy Working Group 2012). The prevalence was slightly higher (72%) in those with a recent history of injecting drug use. The prevalence of HCV markers was higher in older patients – this may reflect their longer injecting history and opportunity for exposure to HCV, or may indicate a reduction in incidence in recent years.

Data from nationally collated notifications of HCV infection show a substantial downward trend in notifications, and rising age at diagnosis, since peak levels in 2007. However, it must be borne in mind that, given the overall low response rate to this audit, the findings may not be representative of the population of patients attending addiction treatment services in this region, or in Ireland.

The following were among the recommendations suggested by the audit authors to further the understanding of infectious disease prevalence among drug users in Ireland:

- A computerised patient-management system for addiction treatment clinics is urgently needed. This would improve the efficiency of the clinics and make better use of staff resources, and would also improve quality of care for patients.
- The under-resourcing of clinics is an ongoing cause for concern and should continue to be highlighted on the HSE Risk Register.
- Improved communication from specialist hospital clinics to the referring doctors in the addiction treatment clinics regarding patients who have been offered treatment would be helpful to patient care. In particular, it would be useful for the referring doctor to have timely information on the uptake of treatment and response to treatment, and also to know if the patient has refused treatment. The HCV liaison nurses may have a role to play in improving this information flow.
- Individual doctors and clinics should be supported in maintaining compliance with HCV testing and referral.

- Attendance at specialist hepatology and infectious diseases clinics, particularly for younger patients, should be encouraged by referring doctors and by the HCV liaison nurses. The reasons for poor attendance should be investigated.
- Addiction treatment doctors and HCV liaison nurses have a role in educating patients about the risks and prevention of blood-borne virus transmission, and about the availability of new antiviral treatments.

In addition, the authors recommend that the audit should be repeated. It was suggested that the next audit should explore the practices in relation to re-testing those patients who initially test HCV negative but have ongoing risk-taking behaviour. It should also seek to gather more detailed information about treatment uptake and outcomes. A repeat study would be helpful to indicate if recently observed increases in the incidence of HIV infection among drug users has been mirrored by a rise in HCV infection. It is hoped that the circulation of this report may encourage a better response rate for the next audit. A better response would allow for more confidence in the representativeness of the findings and would more clearly indicate opportunities for improvement.

1.3.4 Additional information on drug-related infectious diseases

Pregnant women with blood-borne infections

DOVE clinic, Rotunda Hospital annual report, 2015

The DOVE clinic in the Rotunda Hospital, Dublin was established to meet the specific needs of pregnant women who have, or are at risk of, blood-borne or sexually transmitted bacterial or viral infections. Figures from the clinic for 2015 were published in the hospital’s annual report in 2016 (The Rotunda Hospital 2016).

The number of women admitted to the DOVE clinic for antenatal care for the years 2005–2015 by HIV, HBV, HCV or syphilis diagnosis is shown in Figure 1.3.4.1.

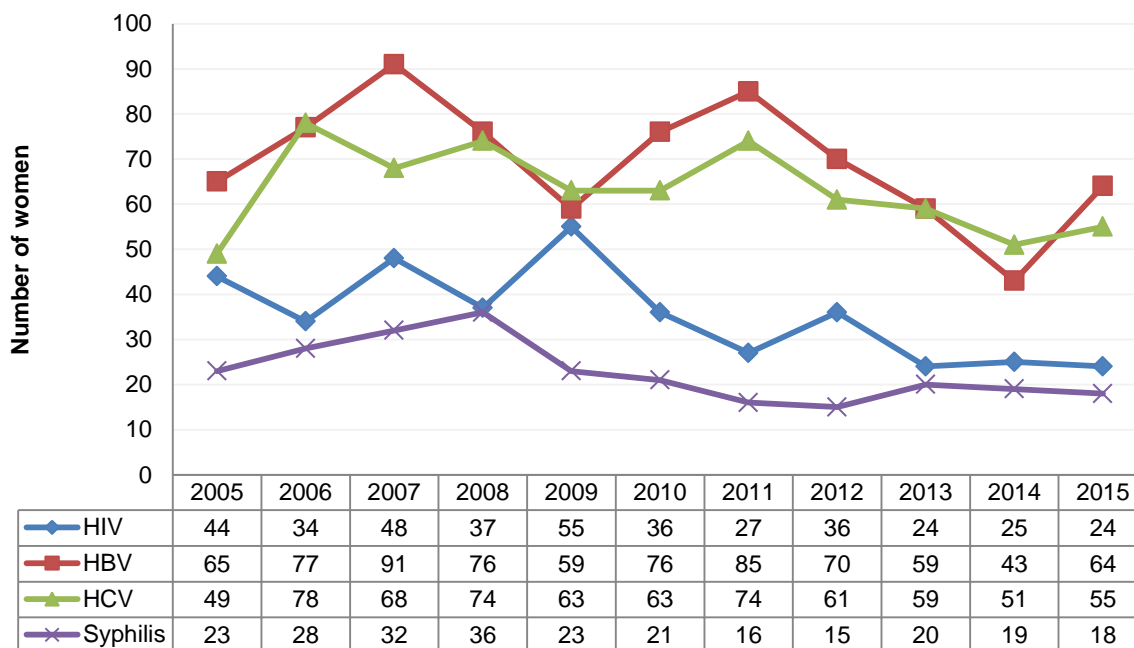


Figure 1.3.4.1 DOVE clinic bookings by year, 2005–2015

Source: The Rotunda Hospital Annual Report, 2016

During 2015, 203 women booked into the DOVE clinic for antenatal care. Of these:

- 24 (12%) were positive for HIV infection, a decrease of 4% compared to 2014;
- 64 (32% of bookings) were positive for the HBV surface antigen, representing an increase of 49% compared to 2014;
- 55 (27%) were positive for the HCV antibody, an increase of 8% compared to 2014;

- 18 (9%) had positive Treponemal serology, a decrease of 5% compared to 2014;
- 52 (26%) were known to be on prescribed methadone programmes, the same number as in 2014; and
- 67 women attended treatment for chlamydia trachomatis infection.

Deliveries to mothers attending the DOVE clinic in 2015 are outlined in Table 1.3.6.1. Twenty-five were HIV positive, 43 were HBV-positive and 50 were HCV-positive. A total of 69 deliveries were to mothers attending the Drug Liaison Midwife (DLM).

Table 1.3.6.1 Deliveries to mothers attending the DOVE clinic who were positive for HIV, HBV, HCV or syphilis or who were attending the DLM, 2015

Mothers status	HIV(+ve)	HBV(+ve)	HCV(+ve)	Syphilis (+ve)	DLM
Total mothers delivered	25	43	50	16	69
Total mothers delivered <500g (incl miscarriage)	1	3	2	1	7
Total mothers delivered ≥500g	24	40	48	15	62
Live infants	25*	40 [#]	50**	15	63*
Miscarriage	1	3	3*	1	7
Stillbirth	0	2 [#]	0	0	0
Infants <37 weeks gestation	2	3	7	4	11
Infants ≥37 weeks gestation	23	37	43	11	52
Caesarean section	11	14	20	2	24
HIV, HBV, HCV or syphilis positive infants	0	0	0	0	-
Maternal median age	34	30	31	34	-
Newly diagnosed NAS	2	8	8	4	15 ^{##}

Source: The Rotunda Hospital Annual Report, 2016

* Including one set of twins.

** Including two sets of twins.

[#] Including one baby of a set of twins.

^{##} Neonatal intensive care unit admission for NAS.

NAS = Neonatal abstinence syndrome

DLM = Drug Liaison Midwife.

Coombe Women and Infants University Hospital annual report, 2014

In 2015, the Coombe Women and Infants University Hospital published its annual report for 2014 and reported that 278 women had attended the Addiction and Communicable/Infectious Diseases Service for antenatal care and postnatal follow-up (Coombe Women and Infants University Hospital 2016).

Of those attending antenatal care:

- 36 were positive for HBV, of whom 10 were newly diagnosed;
- 52 were positive for HCV, of whom eight were newly diagnosed;
- 24 were positive for HIV, of whom none were newly diagnosed; and
- four were co-infected with HCV, but none were co-infected with either HBV or syphilis.

In terms of addiction, 64 women were linked with the DLM. Of these 64 women, 41 delivered 41 live babies. Of the 41 babies, 20 were admitted to special care. Of these 20 babies, 15 required pharmacological treatment for NAS. The report states that heroin continues to be the primary substance used, but cocaine and benzodiazepine use was also evident.

1.4 Other drug-related health harms

1.4.1 Other drug-related health harms

National Registry of Deliberate Self-Harm annual report, 2015

The 14th annual report from the National Registry of Deliberate Self-Harm was published in 2016 (Griffin, *et al.* 2016). The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2015, and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol were not included.

Rates of self-harm

There were 11,189 recorded presentations of deliberate self-harm in 2015, involving 8,791 individuals. This implies that more than one in five (21%) presentations was a repeat episode. Taking the population into account, the age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 204 per 100,000 population. This is similar to the rate recorded in 2014 (200 per 100,000). There were successive decreases in the self-harm rate between 2011 and 2013; nevertheless, the rate in 2015 was still 9% higher than in 2007, the year before the economic recession (Figure 1.4.1.1).

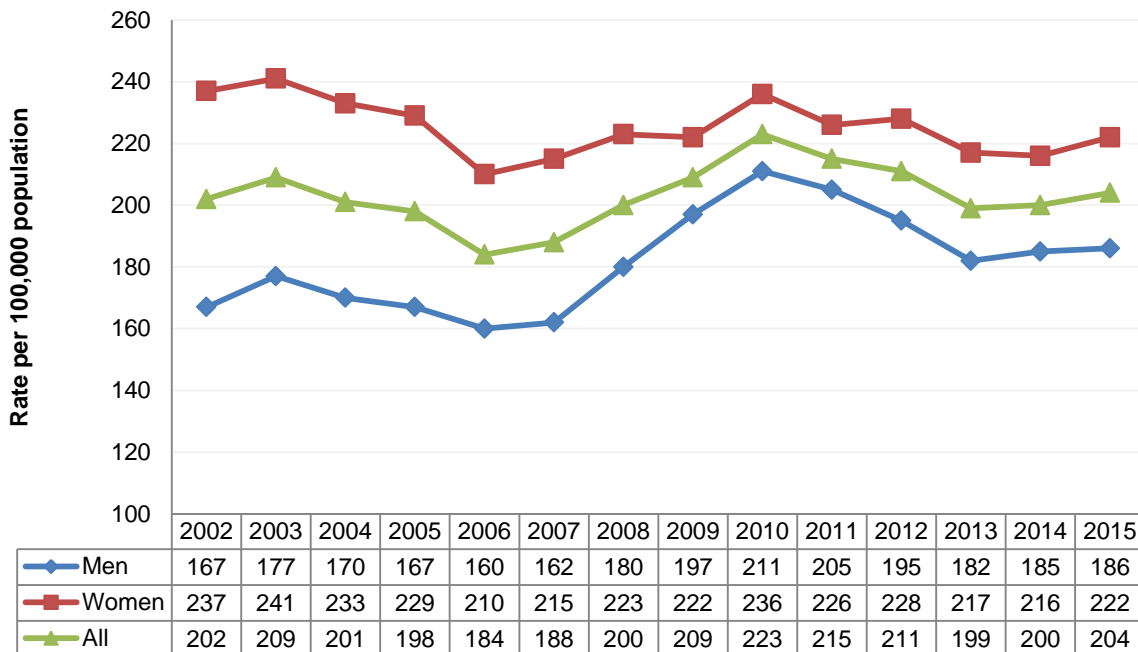


Figure 1.4.1.1 Person-based rate of deliberate self-harm from 2002 to 2015 by gender

Source: National Suicide Research Foundation, 2016

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

In 2015, the national rate of self-harm among males was 186 per 100,000, 1% higher than in 2014. The rate among females was 222 per 100,000, which was 3% higher than in 2014. Since 2007, male and female rates of self-harm have increased by 15% and 3%, respectively. With regard to age, when compared to 2014, the only significant change in the rate of hospital-treated self-harm was among men aged 35-39 years, where the rate increased by 15% from 220 per 100,000 to 253 per 100,000. The authors noted that increasing rates observed in males is particularly worrying considering the higher lethality of self-harm methods among men.

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2015, occurring in 7,319 episodes (65%). As observed in 2014, overdose rates were higher among women (71%) than among men (59%). Minor tranquilisers, paracetamol-containing medicines and

antidepressants/mood stabilisers were involved in 38%, 29% and 20% of drug overdose acts, respectively. In 69% of cases, the total number of tablets taken was known, with an average of 28 tablets taken in episodes of self-harm that involved a drug overdose.

There was an 18% increase in the number of presentations involving street drugs (cannabis, ecstasy and cocaine), which rose from 465 in 2014 to 547 in 2015, following annual decreases from 2010 to 2013. The 2015 level is the highest recorded since 2008 and the second highest ever recorded by the registry. Alcohol was involved in 31% of all self-harm presentations, and was involved significantly more often in male episodes of self-harm than in female episodes.

The authors concluded that these findings underlined the need for on-going efforts to:

- reduce access to minor tranquilisers and other frequently used drugs;
- further research to examine the sources of illicit drugs used in intentional overdoses;
- intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol; and
- further strategies to reduce access to alcohol.

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

Self-harm, alcohol consumption and public holidays

Research that has recently been published in the *Journal of Affective Disorders* (Griffin, *et al.* 2017), highlights the effect of alcohol consumption on self-harm presentations to Irish hospital emergency departments during public holidays.

The National Self-Harm Registry Ireland has consistently shown peaks in self-harm presentations out of hours at weekends and during public holidays. Presentations involving self-harm peak around midnight, and approximately one-third of presentations are recorded on Sundays and Mondays. In recent years, peak attendances have been observed on public holidays. During the period from 2007 to 2015, the mean number of self-harm presentations was 27 daily and 32 on public holidays. Across all years, St Patrick's Day and New Year's Day showed higher numbers of presentations compared to other public holidays, with a yearly average of 44 and 41, respectively.

It was found that alcohol was involved in 43% of self-harm presentations on public holidays compared to 38% on all other days. Self-harm presentations had a 24% increased likelihood of involving alcohol on public holidays compared to all other days (relative risk: 1.24, 95% CI: 1.17–1.32). In addition, self-harm presentations to hospital on Christmas Eve, Christmas Day and New Year's Eve had an 80%, 77% and 62% increased probability of involving alcohol, respectively (Figure 1.4.1.2).

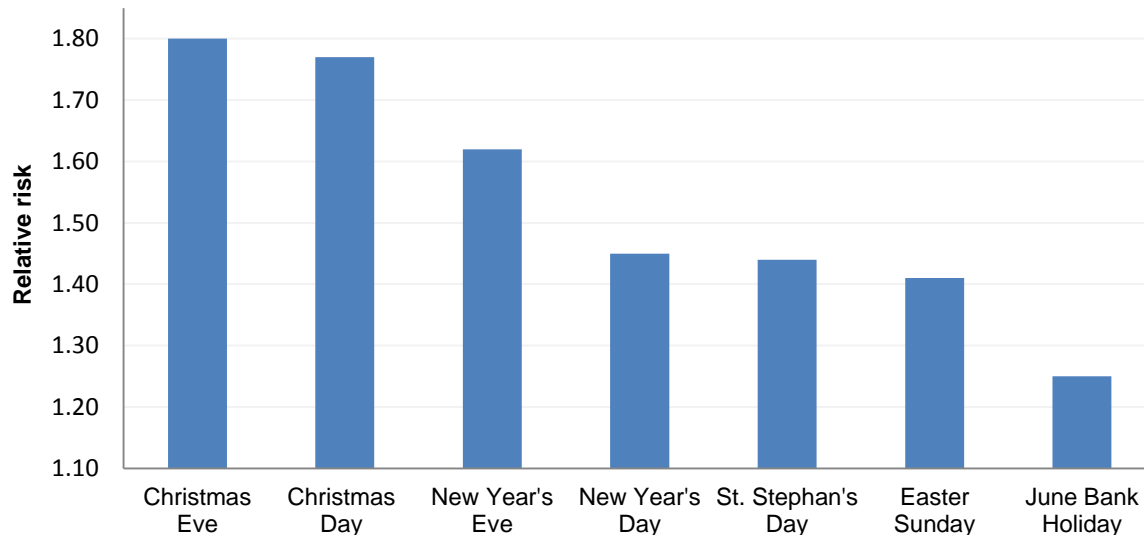


Figure 1.4.1.2 Association between alcohol consumption and self-harm presentations during public holidays

Source: Griffin E, Dillon CB, O'Regan G, Corcoran P, Perry IJ, *et al.*, 2017

The authors concluded that the findings support the hypothesis that self-harm presentations are elevated on public holidays and that alcohol consumption is more strongly associated with self-harm presentations on public holidays.

These findings highlight the need for continuing efforts to:

- enhance health service capacity at specific times;
- increase awareness of the negative effects of alcohol misuse and abuse;
- educate self-harm patients and their families about the importance of reduced use of, and access to, alcohol;
- arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse); and
- ensure the assessment of alcohol and other substance misuse and abuse is a structural part of the assessment to determine the risk of repeated self-harm and suicide.

1.5 Harm reduction interventions

1.5.1 Drug policy and main harm reduction objectives

The strategic aims and objectives of the current drugs strategy (Department of Community 2009) with regard to harm reduction interventions include the following:

- To enable people with drug misuse problems to access treatment and other supports and to reintegrate into society.
- To reduce the risk behaviour associated with drug misuse.
- To reduce the harm caused by drug misuse to individuals, families and communities.
- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social wellbeing, with the ultimate aim of leading a drug-free lifestyle.
- To minimise the harm to those who continue to engage in drug taking activities that put them at risk.

For further details on the drugs strategy, see Section 1.1 of the Policy workbook.

1.5.2 Organisation of harm reduction services

Regional Drug and Alcohol Task Force (RDTF) areas in Ireland offer harm reduction programmes including needle exchange from fixed sites, mobile units and outreach work. Outreach workers frequently practise ‘backpacking’ – a process whereby staff, in the absence of a local clinic or mobile unit – carry supplies of drug-taking paraphernalia for distribution to known drug misusers (Moore, *et al.* 2004).

Additional support services operate from sites in the greater Dublin in addition to a number of Dublin-based or national community-based organisations (CBOs) such as Merchants Quay Ireland (MQI) and the Ana Liffey Drug Project (ALDP). Some of these services are seasonal or simply on a fixed-time, once-per-week basis. Harm reduction services report initiatives including free needle exchange; providing alcohol wipes, sterile water, citric acid filters, spoons and condoms; the provision of methadone and naloxone therapy; and rehabilitation, education and community/family support. In addition, there are pharmacies providing needle exchange in each RDTF area in Ireland apart from those covering counties Dublin, Kildare and Wicklow.

1.5.3 Harm reduction services

Harm reduction services: Community-Based Organisations (CBOs)

Merchants Quay Ireland (MQI) annual review, 2015

MQI is a national voluntary agency providing services for homeless people and for drug users. In 2015, there were 19 MQI locations in 11 counties in the Republic of Ireland (Figure 1.5.3.1). In September 2016, MQI published its annual review for 2015 (Merchants Quay Ireland 2016).



Figure 1.5.3.1 MQI locations in Ireland

Source: MQI, 2016

1. Dublin; 2. Shelton Abbey, Co. Wicklow; 3. St Francis Farm, Co. Carlow; 4. Cork city; 5. Limerick city; 6. Co. Offaly; 7. Co. Westmeath; 8. Portlaoise town, Co. Laois; 9. Co. Longford; 10. Castlerea town, Co. Roscommon; 11. Loughran House, Co. Cavan.

MQI: Open access drug services

Assertive Outreach Service (AOS)

In line with the MQI mission statement to reach out to the most vulnerable in society, this service aims to make contact with drug users not engaged with other services and to provide them with accessible support options. In 2015, the AOS contacted vulnerable drug users on the street, collected used needles and syringes and liaised with local community groups, including police, Dublin City Council and other drug and homeless service providers. The geographical zone covered by the AOS is predominantly around each MQI location (Figure 1.5.3.1).

AOS workers also liaised with a variety of other businesses, residents, individual tourists, and services. Clients were assisted with accommodation, drug treatment options, clothing, food, showers and basic services. The AOS visited a number of clients in hospitals and nursing homes throughout the year. This involved working with medical staff and social workers to progress care plans. MQI workers also accompanied service users to doctors, court, post offices and case conference meetings. The service engaged with 55 homeless individuals in specific casework, and with over 1,000 individuals on an informal support basis, throughout 2015.

Intensive Engagement Service (IES)

Many of the drug users who avail of MQI's Open Access Homeless and Drug Services are homeless and have financial and legal problems. The MQI morning service (10.00 to 1pm) has transitioned from a drop-in service to a one-to-one support function called the Intensive Engagement Service (IES). This service operated throughout 2015, resulting in a smaller number of visits but an increased depth of work on individual needs, providing support with accommodation, treatment and training, as well as with medical, welfare and legal issues. This service also provides continuity of care, as it may sometimes take weeks or months of working with multiple support agencies in order to attain outcomes for clients. In maintaining contact with clients, MQI is able to assist both clients and partner agencies by filling out paperwork or getting signatures on medical card applications, homeless registrations or treatment referral forms. In 2015, 1,008 individuals availed of the IES, visiting the service 2,761 times. Each of the 1,008 individuals accessing the IES was provided with options to see specialist in-house supports, such as the Young Persons Support Worker, medical staff or drug treatment specialists.

MQI: Harm reduction services

These services may be accessed by drug users simply by walking in from the street. For this reason, MQI is often the first place people with drug problems turn to for help in the Republic of Ireland.

Health Promotion Unit

This unit provides drug users with information about the risks associated with drug use and the means to minimise such risks. MQI offers drug users a pathway into treatment and the possibility of living a life without drugs. In the needle exchange and health promotion service, the main focus is on reducing the harms associated with injecting drug use, fostering the motivation to make positive change, giving advice on HIV, HBV and HCV prevention, and providing information on overdose and other risks. MQI also offers early referral to drug treatment services.

In 2015, there were 27,388 visits to drug services, an increase of 4% on the number of visits in 2014. As part of the MQI health promotion remit, a total of 1,643 safer injecting workshops were undertaken with PWID in 2015. Many of these interventions were with new injecting drug users, and are an important part of early intervention where people are given treatment options and advice on the dangers of injecting drugs.

The Naloxone Demonstration Model (NDM)

Along with partners in the HSE, the Family Support Network and the ALDP, MQI was front and centre in the national roll-out of the Naloxone Demonstration Model (NDM) in 2015. To date, more than 100 drug users have been prescribed naloxone, and an external evaluation concluded that the scheme was a success. Since the NDM began, there have been five recorded 'overdose reversals' which may have contributed to lives being saved. In 2015, 600 individuals were trained in how to

use naloxone. Future developments include providing accredited training in order to supply the mechanisms to support the statutory changes required to make this product more widely available in Ireland.

MQI: Support services

Methadone prescribing – Treatment and support

In 2015, MQI collaborated with the GPs from Safetynet, an accessible health service for people experiencing homelessness, in providing methadone substitution therapy to 20 service users.

Into Education and Employment: Stabilisation Programme (IEE)

As part of MQI support services, Into Education and Employment (IEE) offers therapeutic groups, life skills training, personal development work and pre-employment training to help drug users reintegrate into society. Links with the City of Dublin Education and Training Board allow MQI to include a strong educational component within this programme, with clients gaining Quality and Qualifications Ireland (QQI) accreditation on some courses. This is of considerable importance in addressing the educational disadvantage experienced by many drug users. The MQI's IEE programme had 66 participants during 2015, an increase of 43% from the number of participants in 2014, with course content consisting of art therapy, cooking, drama, yoga, gardening, therapeutic group work, history, maths, and educational and social outings. Clients using this service were predominantly younger people, with 79% of participants aged between 25 and 39 years.

The IEE group seeks to establish a regular pattern of discipline and attendance in order to prepare people for mainstream training and employment. Although not all clients stayed with the programme in 2015, and some relapsed into chaotic drug use, MQI noted that many people did progress to training, work experience and a more structured, abstinence-based treatment. This programme operates with a low threshold ethos, seeking to keep clients engaged.

Family Support Group (FSG)

MQI offers one-to-one advice and support to family members on the realities of drug use and how they can best cope and provide optimum support to drug users. MQI also runs a Family Support Group (FSG), which meets every week and provides a forum where parents, as well as other close relatives and friends of drug users, are offered support and advice on a range of issues. Participants provide support for each other, and the group is continually open to new members. The weekly FSG is linked to the National Family Support Network, which offers an opportunity to raise issues at a national level. MQI's FSG in Dublin worked with 30 individuals throughout 2015.

MQI: Midlands Services

With support and funding from the Midlands Regional Drug and Alcohol Task Force (MRDTF) and the HSE, MQI provides services in the four Midlands counties of Laois, Longford, Offaly and Westmeath. The MQI Family Support and Community Harm Reduction Team was established in late 2008 and provides dedicated outreach services for individuals actively using drugs. It also provides Family Support Services focused on the needs of the families of active drug users. The Midlands team consists of MQI staff, Department of Social Protection participants, those on work placement and volunteers working across these four Midlands counties.

Rehabilitation and Aftercare Service

MQI, with the support of the MRDTF and the HSE, established the Rehabilitation and Aftercare Service in September 2010. The purpose of this service is to provide a range of rehabilitation and aftercare supports targeting clients from the region, including those exiting drug treatment and prison. This involves assisting clients in the process of regaining their capacity for a daily life free from the impact of problem drug use and enabling their reintegration into the community. MQI workers provide case management for clients with a view to ensuring that all clients have their needs assessed and that they have the opportunity to participate in developing a care plan offering a pathway towards rehabilitation.

Workers also provide psychosocial support for persons leaving drug treatment or prison via one-to-one support and aftercare group work. This service worked with 75 individuals in 2015. The team liaised closely with interagency partners in order to address the underlying issues of addiction: accommodation, healthcare and abuse. Service users were both supported and challenged in terms of meeting their care plan goals and received one-to-one interventions and group support where required. There were 359 one-to-one sessions and 103 groups facilitated in 2015.

Athlone Open Door Centre (ODC)

The Athlone Open Door Centre (ODC) provides a range of services for drug users in Athlone. These include a drop-in centre offering crisis support, food service, washing and laundry facilities, vocational training initiatives and support towards rehabilitation and reintegration. The service is focused on providing crisis support and offering progression pathways for clients. It operates in partnership with the Department of Social Protection, HSE, Educational and Training Board, GPs and other interagency partners in the Midlands region. As part of the harm reduction and rehabilitation process, the Athlone ODC team worked closely with a group of 114 individuals in 2015, many of whom attended on a regular basis.

Clients make use of facilities within the centre as well as one-to-one counselling sessions with project workers. The ODC team develops therapeutic relationships with clients through a focused, non-judgemental approach to their work. In 2015, there were 114 individuals (91 male and 23 female) using the service, and there were 3,395 visits to the centre, which included the provision of 3,014 meals, 204 showers, 211 laundry services, and 2,850 advice and support sessions.

Midlands Family Support Services

These services involve the provision of interventions that support families in coping with addiction-related issues. Such services often include counselling, guidance and advice. Under the drugs strategy, family support is seen as increasingly important in the areas of drug treatment and prevention.

The MQI Midlands Family Support Services assist families to:

- deal with the trauma associated with a family member or loved one using drugs;
- work with vulnerable families in the area of drugs prevention;
- act as a reliable source of information on drug use and related issues;
- deal with the reaction of neighbours and others;
- overcome self-blaming responses;
- create positive coping strategies that will help the family and drug user make positive decisions;
- build their capacity to respond;
- set rules of behaviour for those living in their house; and
- challenge views that the family caused the drug use problem, can control it, or can cure it.

These services also provide one-to-one sessions by appointment for parents and other close relatives of drug users seeking advice and support. MQI works to proactively link people with other support or treatment services that may be relevant to their needs. In 2015, the project engaged with 87 individuals, provided 1,011 support phone calls and facilitated 203 family support groups, including one-to-one support sessions where required.

Midlands Community Harm Reduction Services

MQI is aware that local people and organisations are often very concerned about the level of public and community harm associated with drug use in their communities, as well as the risks that drug users may expose themselves to. Therefore, the aims of these services are to:

- act as a resource for community groups in their efforts to minimise the impact of problem drug use on their communities;

- reduce the level of individual and community harm experienced in local communities as a result of drug use;
- reduce the associated level of public health risk experienced in designated areas;
- provide harm reduction and crisis support services to local drug users in places, and at times, where such services are unavailable;
- ensure that problems associated with drug use are minimised; and
- promote a partnership model between Residents Associations, Estate Management Committees, Community Policing Services and Midlands services in tackling drug issues at a local level.

Midland Day Programme

MQI launched a Department of Social Protection Community Employment Scheme based in the Athlone ODC at the end of 2014. This day programme continued to operate successfully in 2015 and provided 15 individuals with employment and training tailored to their specific goals in life. Securing employment is a significant step for those seeking to permanently exit lifestyles involving drugs and homelessness. Rehabilitation and aftercare were incorporated into the scope of harm reduction outreach workers in the Midlands area. This is in line with international research indicating what works in drug treatment, thus ensuring that people who have achieved abstinence are given the vital support they need to maintain drug-free lifestyles as a part of their individual care plan.

Midlands Resettlement Service

Post-treatment settlement is an ongoing issue, and in 2015 the Midlands Resettlement Service continued working relationships with county councils, accommodation providers and property owners in order to secure or maintain housing for those at the margins of homelessness. The Midlands team works on individual cases in order to ensure that recovery pathways out of homelessness and addiction are consolidated through maintaining accommodation with support. Further treatment and progression options are a central part of the work of MQI in order to progress pathways for drug users back into mainstream society.

MQI: Drug-free treatment services

St. Francis Farm (SFF) Residential Rehabilitation and Detox Services

The Rehabilitation Service at St. Francis Farm (SFF) offers a 13-bed therapeutic facility with a 14-week rehabilitation programme set on a working farm in Co. Carlow. At SFF, MQI provides a safe environment where service users can explore the reasons for their drug use, adjust to life without drugs, learn effective coping mechanisms and make positive choices about their future.

There were 377 clients referred to the SFF Residential Rehabilitation Service during 2015, a 6% increase compared to the number of referrals in 2014. In addition, there were 272 assessment appointments offered to clients referred. Of these, 178 attended their assessment appointment. In 2015, a total of 51 individuals were admitted to the programme – 37 men and 14 women. This represents an 11% increase in admissions compared to 2014. In addition to clients' addiction needs, 49% of clients were homeless and 50% were the subject of criminal justice orders on admission.

The Residential Detoxification Service at SFF delivers both methadone and combined methadone/benzodiazepine detoxes. This unit has a 10-bed capacity for men and women, and the detox activity programme includes individual care planning, therapeutic group work, psycho-educational workshops, fitness/gym training and farm work activities.

A total of 347 assessment appointments were offered to referred clients during 2015 – 250 males and 97 females. This was a 29% increase compared to the 269 assessment appointments offered in 2014. There were 63 clients admitted for detox services during 2015 – 47 men and 16 women. All of the 63 clients admitted to SFF detox services in 2015 were on prescription methadone. The length of time individual clients were on methadone prior to admission ranged from one to 28 years. Of the 63 clients who departed the service during 2015, 83% completed their detox, a 14% increase compared to 2014.

SFF has a national catchment area, and in 2015 accepted admissions from 20 counties, with Dublin and Cork being the largest sources of clients.

Ana Liffey Drug Project (ALDP)

The ALDP is a 'low-threshold harm reduction' project working with people who are actively using drugs and experiencing associated problems. The ALDP has been offering harm reduction services to people in the North Inner City area of Dublin since 1982, from two premises at 48 and 51 Middle Abbey Street. Across these two buildings they offer a wide variety of low threshold, harm reduction services that offer drug users pathways out of their current circumstance, including addiction and homelessness.

The ALDP is committed to impacting positively on the neighbourhood and the wider community. Subsequently, they are active in managing antisocial behaviour in the area and, in return, receive ongoing support from the local business community.

The services offered in Dublin are:

- Open Access
- Assertive Outreach
- Needle and Syringe Programme
- Medical Services
- Stabilisation Group
- Detox Group
- Harm Reduction Group
- Treatment Options Group
- Assessment for Residential Treatment
- Key Working and Case Management
- Prison Inreach

The ALDP Mid-West region provides harm reduction services in Limerick city and three counties to people affected by problem substance use, their families and the wider community. The counties served are:

- Limerick
- Clare
- North Tipperary

The services offered in the Mid-West region are:

- Open Access
- Assertive Outreach
- Needle and Syringe Programme
- Medical Services
- Harm Reduction Group
- Assessment Group for Residential Treatment
- Pre-entry to the Helping Women Recover Group
- Key Working and Case Management
- Prison Inreach

The ALDP Online and Digital Services team also offers support and information to the general public, to drug users, and to other agencies that work with problem drug users.

Harm reduction services: Needle exchange

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

- Static – 24 sites, mainly in Dublin city

- Outreach – 14 sites mainly in counties Dublin, Kildare, Laois, Offaly, Waterford and Wicklow
- Pharmacy – 111 sites in regions outside Dublin, Kildare and Wicklow

Data on the number of syringes exchanged from static and outreach sites were unavailable for this report. Information on pharmacy-based needle exchange in Ireland is discussed in the following sections.

Pharmacy-based needle exchange: Overview, assessment and needles exchanged

Pharmacy-based needle exchange: Overview

The current drugs strategy aims to reduce harms arising from substance misuse and to reduce the prevalence of blood-borne viruses among PWID through the expansion of needle exchange provision to include community pharmacy-based programmes (Department of Community 2009).

In October 2011, the HSE rolled out the national Pharmacy Needle Exchange Programme, which is a partnership initiative between the Elton John AIDS Foundation, the Irish Pharmacy Union and the HSE. Once pharmacies have signed a service level agreement with the HSE, their contact details are passed on to the relevant HSE services so that they can promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment. There are pharmacies providing needle exchange in each RDTF area, apart from those covering counties Dublin, Kildare and Wicklow, which are served by a mix of static and outreach needle exchange programmes. At the end of 2016, there were 111 pharmacies providing needle exchange (Table 1.5.3.1).

Table 1.5.3.1 Number of pharmacies providing needle exchange in Ireland by RDTF area, 2011–2016

RDTF area	2011	2012	2013	2014	2015	2016
Midland (Longford, Laois, Offaly, Westmeath)	5	13	15	16	17	18
North Eastern (Meath, Louth, Cavan, Monaghan)	3	9	16	21	22	21
North West (Sligo, Leitrim, West Cavan, Donegal)	3	4	7	6	6	6
Southern (Cork and Kerry)	8	10	16	21	19	21
South East (Carlow, Kilkenny, Waterford, Wexford, South Tipperary)	13	21	22	24	17	17
Western (Galway, Mayo, Roscommon)	5	2	10	13	11	12
Mid-West (Clare, Limerick, North Tipperary)	5	8	13	14	15	16
Total	42	67	99	115	107	111

Source: Unpublished data from HSE, 2017

Pharmacy-based needle exchange: Assessment

In line with best practice, the Steering Group of the HSE Pharmacy Needle Exchange Programme commissioned Liverpool John Moores University – in partnership with Waterford Institute of Technology – to carry out an external evaluation (Bates, *et al.* 2015). This study was undertaken to evaluate the three-year pilot stage of the programme and the progress in delivering needle exchange services to PWID. It aimed specifically to:

- understand client and stakeholder satisfaction with needle exchange and attitudes towards, and experiences of, these services;
- provide information relating to safer injecting, safer sexual behaviour, and the prevalence of blood-borne viruses that can be compared to international literature and to data collected during future evaluations; and
- provide recommendations regarding the development and delivery of services and policy.

This section presents the methodology and main findings from this study.

Methodology

All pharmacies participating in the programme in April 2014 were eligible to take part in the study, and staff were asked to complete an online survey. Pharmacy staff were also requested to opt in to additional parts of the research, including participating in an interview with a member of the research team.

Pharmacies were provided with questionnaires that staff were requested to ask any client using the needle exchange to complete. Visits were made to five of the 10 pharmacies participating in the programme that had the greatest number of monthly transactions, where needle exchange clients were approached and asked if they would like to participate in the study through an interview. A brief online consultation with stakeholders was also undertaken, examining their perceptions of the programme effectiveness and identifying strengths, weaknesses, and areas for further development.

Main findings

Pharmacy staff results

Experience of service provision

Pharmacy staff reported a variety of successes. The service was described in interviews as quick and efficient, with minimal impact on the running of other pharmacy activities. However, uptake was viewed as sporadic in some sites, with comments around levels of heroin availability impacting on injecting rates. Increasing uptake was reported in some sites, but with no change in gender profiles. Although a majority of staff reported positively about the needle exchange and clients, negative impacts of the service identified by small numbers of staff included the risk of crime and undesirable behaviour in the pharmacy and surrounding area. In addition, where pharmacies were located within shopping areas, it was apparent that some local businesses and security objected to the needle exchange.

Engagement and trust in needle exchange

The majority of staff surveyed believed they had engaged well with clients, although difficulties identified included a lack of interest in engagement from some clients. The exchange itself was described by the majority of interviewed staff as a quick process, with service users appearing anxious to leave the site. Lack of interaction was generally due to service users' reluctance to engage and pharmacists' lack of time. While it was noted that clients may like the speedy transaction, it was also recognised that this limits the opportunity to offer further intervention. First contact characterised by friendliness on the part of the pharmacist and frontline staff was viewed by many as being vital when initially developing positive and trusting relationships with service users.

Needle and equipment provision

Pack size options were described by the majority of interviewees as optimising efficiency and discretion for the user. However, some staff observed that service users reported that the needles and syringes provided were not the right size or the right volume, and identified that needles for groin injecting would be a useful addition. Further potential additions to packs that were suggested by pharmacy staff included tourniquets and condoms. The needle exchange transaction itself was viewed as efficient, but in some instances was hampered by poor dialogue between pharmacists and service users, as well as low return rates.

Training and information needs

The most frequent response when staff were asked to identify methods to improve the service was the provision of more information through training about local services and helplines, as well as refresher courses in response to emergent drug issues and service needs. In particular, training regarding performance- and image-enhancing drugs, such as steroids and melanotans, was commonly requested. The majority of pharmacies engaged with local community drug services and methadone clinics, but observed the need for greater visibility of services and referral routes.

Client-reported outcomes

Client satisfaction with services

The survey sample (n=74) included 23 females and 46 males with a mean age of 32 years (five clients did not report their gender). The majority (88%) reported using heroin, with less than 15%

reporting use of any other drug. Generally, PWID reported high satisfaction with service provision, including the injecting kits provided, pharmacy location, opening hours, staff knowledge and information provision. A minority of clients reported dissatisfaction with the attitudes of staff (24%) and privacy within the needle exchange (30%), with lower satisfaction on both criteria among females. Experiences of accessing the pharmacies were generally positive, with few comments around stigma associated with injecting drug use or uncomfortable feelings on accessing the pharmacy. Additionally, participants were satisfied with the confidential nature of the exchange. Pharmacy staff were viewed as friendly and polite, with the primary reasons stated for using specific pharmacies being related to location of the pharmacy and staff attitude.

Client behavioural outcomes

Self-reported rates of HBV, HCV and HIV diagnosis were 7%, 22% and 5%, respectively. Approximately one-third of clients reported never having been tested for each of these blood-borne viruses. Almost half (49%) of the survey sample reporting having used a needle with which someone else had already injected, with 28% having done so in the past month. Females were more likely than males to have shared a needle ever, or in the past month. Approximately half (47%) of clients reported having multiple sexual partners in the past month, including a small proportion with five or more partners (7%). A minority (39%) of clients reported always using a condom during sexual intercourse.

Stakeholder survey

Six stakeholders completed the survey, including representatives from drug services, the Irish Pharmacy Union, and outreach services. Overall, the programme was rated as being 'very effective' (n=3) or 'somewhat effective' (n=3). Key strengths identified included the increase in availability and accessibility of needle exchange services, and the impact of this on access to equipment and health professionals. Perceived weaknesses included difficulties encouraging returns, the need for a 'pick and mix' service as opposed to premade, pre-prepared packs (which are not suitable for all clients), a lack of signposting to other services, and the identification of some stigma affecting needle exchange relations with local businesses and customers.

Conclusions and recommendations

Overall, the evidence from the study suggests that the Pharmacy Needle Exchange Programme is acceptable and accessible to PWID in Ireland, and that it is largely supported by pharmacy staff. Nevertheless, despite these successes, a number of recommendations were suggested that might help improve service provision and further meet client needs. These included the following:

- Provide a wider range of equipment or packs suitable for all clients. Additionally, the possibility of providing 'pick and mix' services, in addition to pre-prepared packs, may better meet client needs.
- Develop integrated care pathways to link the exchange programme with other services for PWID, such as drug agencies and sexual health services. As more health interventions become embedded within the pharmacy, this is likely to become increasingly important to prevent pharmacies from becoming isolated from other related organisations providing services for injecting drug users.
- Consider offering in-pharmacy testing for blood-borne viruses. Where this is not possible, ensure that pharmacy staff are provided with sufficient information on local services to enable efficient referral processes and signposting.
- Increase the frequency of training provision for pharmacy staff and include information about anabolic steroids, melanotans, and associated performance- and image-enhancing drugs to help staff provide services to clients who inject these drugs. Training should be constantly reviewed to ensure that it is meeting the needs of pharmacy staff. The profile of PWID is likely to change, and therefore the knowledge and skill requirements of staff will change too, leading to the need for top-up training.
- Ensure that staff have sufficient training and knowledge about drug use and health-related issues to confidently provide harm reduction advice and support.
- Encourage (through training and information for staff) a consistent approach to increase returns and improve engagement with clients. Additionally, build on current work being undertaken regarding appropriate community responses to drug-related litter.

- Oversee the transition from a paper-based monitoring system to an electronic data monitoring system to be used by all participating pharmacies.

As well as these recommendations, the authors suggest that future evaluations should use the same survey procedures to allow comparison of outcomes as an indication of programme development. In addition, the possibility of collecting biological samples from clients was also mentioned.

Pharmacy-based needle exchange: Number of needles exchanged

Figure 1.5.3.2 shows the number of individual needles exchanged from pharmacy-based sites for the years 2015 and 2016, by month. There were a total of 277,305 individual syringes exchanged in 2015 and 279,154 exchanged in 2016.



Figure 1.5.3.2 Number of individual needles exchanged from pharmacy-based sites by month, 2015 and 2016

Source: Unpublished data from HSE, 2017

Figures 1.5.3.3 and 1.5.3.4 show the number of persons who attended pharmacy-based needle exchanges in 2015 and 2016. It should be noted that the sex breakdown is based on unique male and female individuals attending each month, and not on how many persons attended, or how many needles were exchanged by each person. An average of 1,604 persons attended pharmacy-based needle exchanges each month in 2015 (compared to an average of 1,330 per month in 2014), and an average of 1,614 persons attended each month in 2016. In both years and each month, the majority of individual attendees were male.

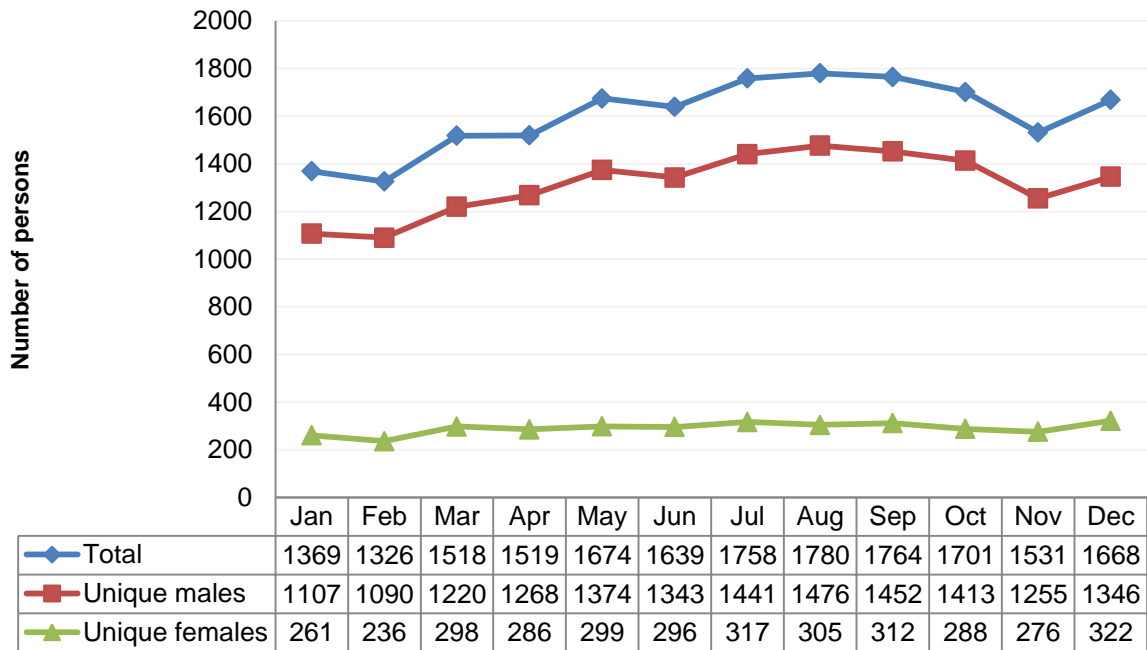


Figure 1.5.3.3 Number of persons attending needle exchange, by month and gender, 2015

Source: Unpublished data from HSE, 2017

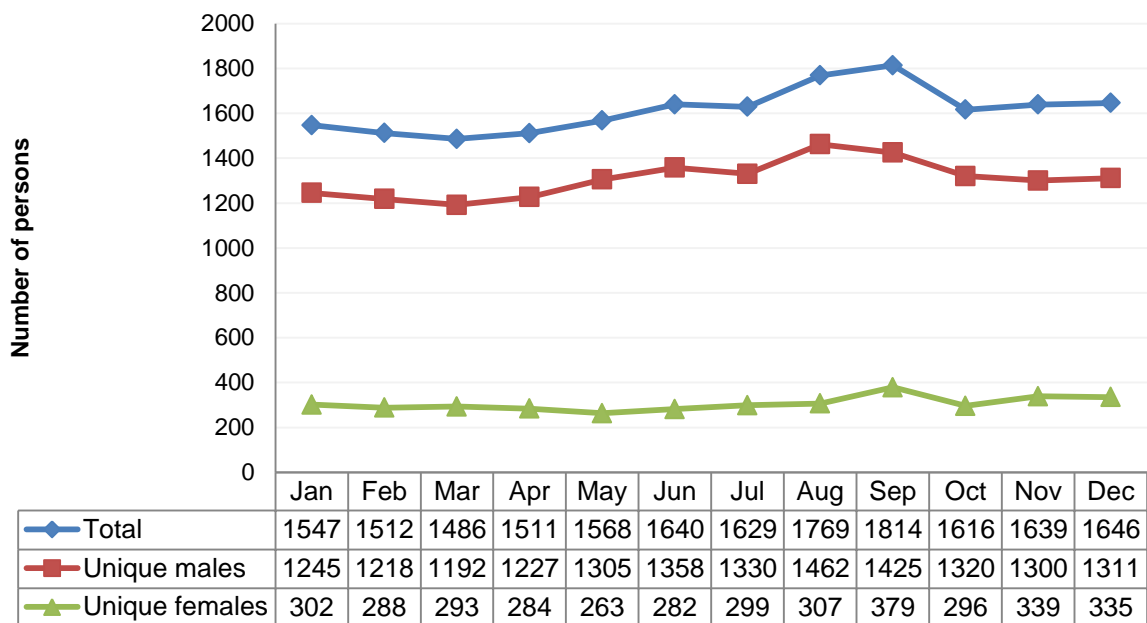


Figure 1.5.3.4 Number of persons attending needle exchange, by month and gender, 2016

Source: Unpublished data from HSE, 2017

MQI needle exchange

As previously discussed, MQI is a national voluntary agency providing services for homeless people and for drug users. Its needle exchange and health promotion service provides drug users with information about the risks associated with drug use and the means to minimise such risks. It also provides drug users with a pathway into treatment and the possibility of living life without drugs (Merchants Quay Ireland 2016). The number of needle exchange interventions provided by the unit between 2011 and 2015 is shown in Figure 1.5.3.5.

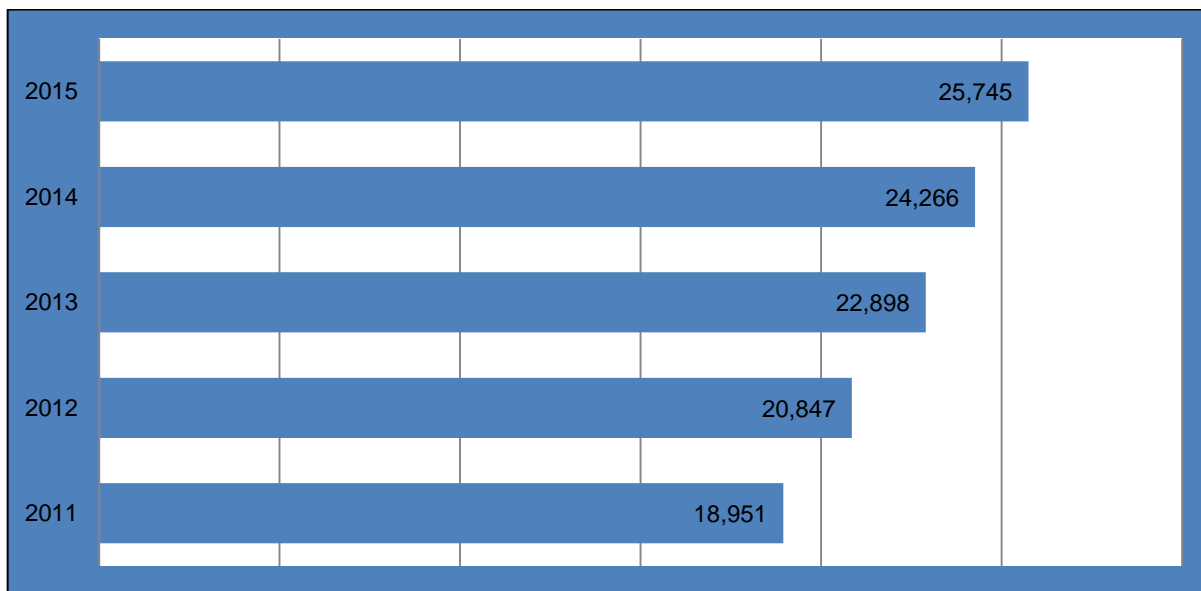


Figure 1.5.3.5 Number of needle exchange interventions, MQI Health Promotion Unit, 2011–2015

Source: MQI, 2016

In 2015, there were 27,388 visits to MQI's Drug Services, and increase of 4% on the number of visits in 2014, and there were 25,745 needle exchange interventions, an increase of 6% on the number of interventions in 2014. A total of 2,676 individuals used the service, of which 461 were new clients.

MQI, in association with the MRDTF and the HSE, administers the Midlands Family Support and the Community Harm Reduction services, providing outreach and working with families of those actively using drugs in this task force region. The services facilitated an average of 164 needle exchanges each month and operated in close partnership with local pharmacy-based needle exchange schemes.

1.5.4 Harm reduction services: availability and access

Alcohol treatment services in Ireland: How the public views them

The HSE has recently published findings from a study that examined the level of public support in Ireland for alcohol screening in healthcare settings, and that assessed if alcohol treatment services are deemed available and adequate (Hope and Barry 2016). The study was based on two cross-sectional national drinking surveys conducted in 2006 and 2010. For the purpose of this research, the two survey data sets were combined (n=2011) to allow for detailed analysis.

A similar methodology was used across the two surveys: that of a national quota sample of adults aged 18 years and over using face-to-face interviews. The response rate was 62%. Several main findings from the study are discussed below.

Alcohol screening in healthcare settings

A majority of survey respondents agreed that intervention by health professionals regarding patients' drinking habits in different healthcare settings should take place. The highest level of support for asking patients about their drinking behaviours as standard practice was in maternity services (91%), followed by general hospitals (84%) and primary care (80%).

Demographics

A higher percentage of married people (82%) in comparison to single people (77%) agreed that GPs should ask all patients about their drinking habits as standard practice. Across the regions of Ireland, those living in Dublin were less supportive of GP intervention in comparison to the rest of Leinster (79% vs 87%). More women than men (86% vs 82%) were supportive of alcohol screening; respondents who were younger were less supportive. Support was higher among those from lower socioeconomic classes (87%) in comparison to other classes.

Drinking patterns and alcohol harms

Participants who abstained from alcohol were more supportive of health professionals asking patients about their drinking behaviours as standard practice. Respondents who were heavy drinkers were less supportive of alcohol screening in primary care, general hospitals and maternity services. Those who reported one or more of seven negative consequences due to their own drinking were also less supportive of alcohol screening by health professionals in general hospitals and in maternity services. Nevertheless, even among heavy drinkers, the majority (70%–86%) were in favour of health practitioners asking about drinking habits.

Availability and adequacy of alcohol treatment services

Just 4 in 10 respondents agreed that alcohol treatment services were available in their local health service area, whereas a similar number (43%) were unaware (don't know) if alcohol treatment services were available. In addition, only one in five agreed that alcohol treatment services were adequate, whereas one in four believed that treatment services were not adequate and over half were unsure (Figure 1.5.4.1). Subjects who lived in Dublin were significantly ($p < 0.01$) less aware of the availability of alcohol treatment services in their local health service area when compared to respondents from other regions, with two-thirds saying they did not know if treatment services were available.

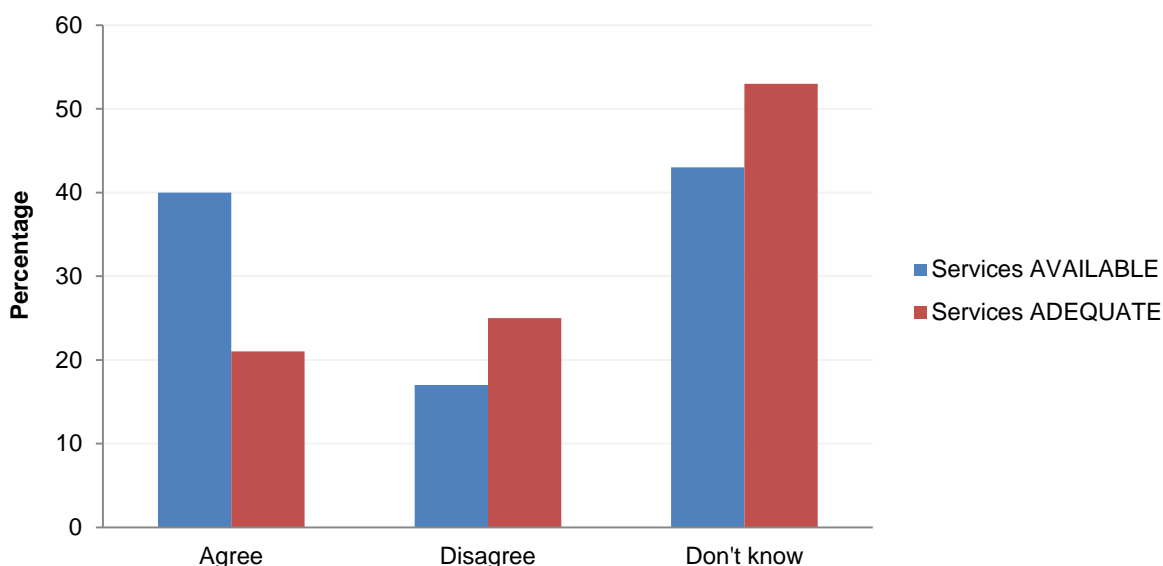


Figure 1.5.4.1 Alcohol treatment in Ireland – perceived availability and adequacy of services

Source: HSE, 2016

Conclusions

The results from these surveys suggest that most Irish adults are supportive of alcohol screening in healthcare settings. However, the findings also indicate that a high percentage of survey respondents were unaware of the availability of alcohol treatment services in local health areas. The authors suggest that these findings will be relevant in the planning of future services in relation to alcohol and other substance use. Effective delivery of alcohol screening, as well as early intervention, may help reduce the burden and associated cost of alcohol-related problems in Ireland.

Availability of and access to harm reduction services for drug users

See section 1.5.3 for information on the availability of and access to harm reduction services for drug users in Ireland. For information on the availability of and access to harm reduction services within Irish prisons, see Prison workbook Section 1.3.3.

2. New developments

2.1 New developments in drug-related infectious diseases

No effect of recent or former injecting drug use on HCV treatment adherence or therapeutic response – results from a large HCV treatment programme in Ireland

Background

PWID represent the majority of the HCV epidemic in the developed world (Nelson, *et al.* 2011). The majority of new infections develop in active PWID, with this group accounting for more than 80% of new infections in high-income countries (Cornberg, *et al.* 2011). Furthermore, an additional large reservoir of infection exists amongst former PWID who remain undiagnosed.

Historically, HCV treatment guidelines have excluded PWID from consideration for treatment. Drug injectors are viewed as having 'difficult to treat' HCV, with perceived inferior treatment adherence and outcomes, as well as concerns regarding re-infection risk. Important factors that have limited treatment uptake in PWID are the contraindications and adverse effects of Interferon-based (IFN-based) therapy. The development and availability of IFN-free direct-acting antiviral (DAA) regimes with high efficacy, improved tolerability and a limited side effect profile will significantly increase the proportion of patients who can be offered HCV therapy. However, adherence to therapy in 'real-world' population groups will remain paramount in the DAA era. A recent study conducted in Ireland investigated differences in HCV treatment adherence and outcomes between former PWID, recent PWID and non-drug users treated with IFN and ribavirin therapy (Elsherif, *et al.* 2017). In this study, which has been published in the journal *PLOS ONE*, differences between PWID and non-drug users were analysed for adherence to treatment and outcomes in all patients treated for chronic HCV infection in a university teaching hospital in Ireland from 2002 to 2012. The PWID group also included former and recent drug users who were treated in a community-based drug treatment centre.

Results

Treatment completion/compliance

There were 608 former PWID, 85 recent PWID and 307 non-PWID who commenced HCV therapy. There was no significant difference in treatment non-completion (for reasons other than virologic non-response) between PWID and non-PWID (8.4% vs 6.8%; relative risk: 1.23, 95% CI: 0.76–1.99). Additionally, there was no significant difference in treatment non-completion between former and recent PWID (8.7% vs 5.9%; relative risk: 0.84, 95% CI: 0.33–2.10). Fifteen patients (17.6%) in the recent PWID group tested positive for opiates at least once during treatment, 11 (12.9%) tested positive for benzodiazepines and five (5.9%) tested positive for cocaine. Seven patients tested positive for two of the drug classes, while five tested positive for all three classes. No patients reported injecting illicit drugs during treatment or in the six-month post-treatment follow-up period.

Response to treatment

As shown in Figure 3.2.1, the overall sustained virologic response (SVR) rate in PWID (64.1%) was not significantly different from non-PWID (60.9%) (relative risk: 1.05, 95% CI: 0.95–1.17). In addition, there was no significant difference in SVR rates between the groups when comparing genotype 1 and genotype 3 infections.

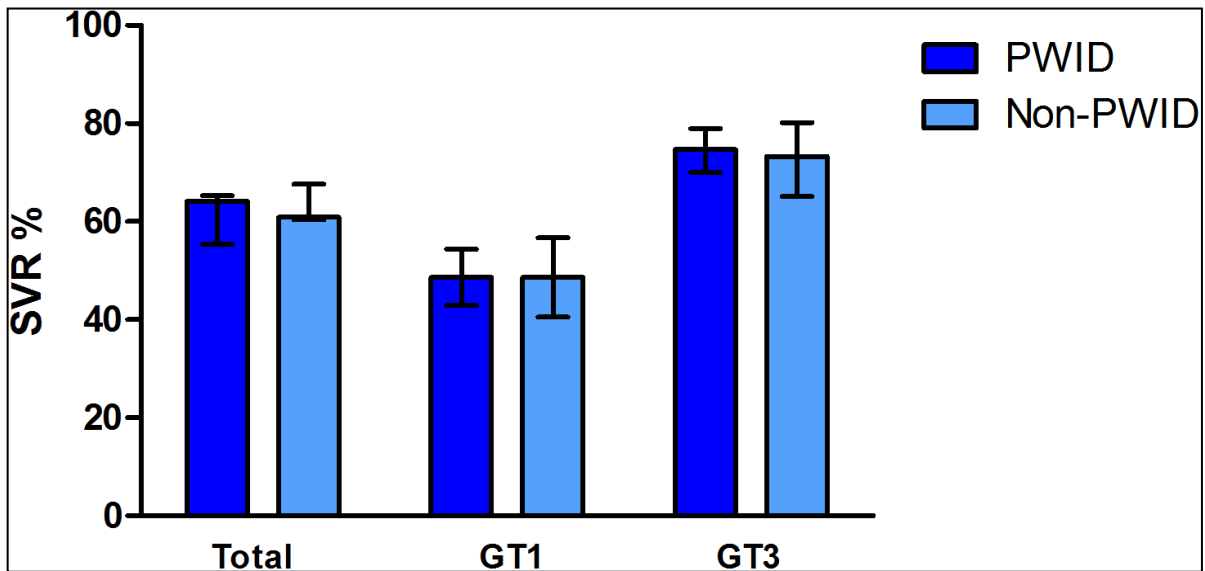


Figure 2.1.1. Treatment response: Rates of sustained virologic response (95% CI bars) with dual therapy in PWID (people who inject drugs) and non-PWID (a) for all genotypes: 64.1% vs 60.9% (b) genotype 1: 48.6% vs 48.6% and (c) genotype 3: 74.7% vs 73.3%

Source: Elsherif O, Bannan C, Keating S, McKiernan S, Bergin C, *et al.*, 2017

Follow-up data on 219 former PWID who achieved SVR between 2002 and 2007 for a median of 57 months (ranging from six to 168 months) indicated that 13 patients were re-infected with HCV, a re-infection rate of 10.5 per 1,000 person years of follow-up. All 13 of the re-infected patients had a relapse in injecting drug use. There was no significant difference in re-infection rates between former PWID with and without HIV co-infection.

Conclusions

The results from this large retrospective study of a decade of HCV treatment outcomes in Ireland indicate that PWID have similar treatment adherence to IFN and DAA HCV therapy as non-PWID patients with chronic HCV infection. In addition, PWID patients have a comparable response to treatment. The authors conclude that prioritising PWID for HCV treatment may be a cost-effective initiative for reducing long-term health costs, and that HCV elimination is an ambitious target that cannot be achieved by excluding PWID from treatment.

2.2 New developments in harm reduction interventions

On 17 July 2017, the Irish Taoiseach, Leo Varadkar, joined the Minister for Health Simon Harris and Minister of State Catherine Byrne to launch *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025* (Department of Health 2017). *Reducing Harm, Supporting Recovery* lays out the direction of Government policy on drug and alcohol use until 2025. The new strategy aims to provide an integrated public health approach to drug and alcohol use, focused on promoting healthier lifestyles within society.

The strategy contains an ambitious 50-point action plan from 2017 to 2020, and provides the scope to develop further actions between 2021 and 2025 to ensure the continued relevance of the strategy to emerging needs in the future. The vision of the strategy is to create a healthier and safer Ireland, and its actions will contribute to improving the health, well-being and safety of the population of Ireland in the coming years. Launching the strategy, the Taoiseach said, “For the ideal of a Republic of Opportunity to be meaningful, it must apply to all. Treating substance abuse and drug addiction as a public health issue, rather than a criminal justice issue, helps individuals, helps families, and helps communities. It reduces crime because it rebuilds lives. So it helps all of us.”

Key actions of *Reducing Harm, Supporting Recovery* include the following:

- Introduction of a pilot supervised injecting facility in Dublin’s city centre.

- Establishment of a Working Group to examine alternative approaches to the possession for personal use of small quantities of illegal drugs.
- Funding for a programme to promote community awareness of alcohol-related harm.
- A new targeted youth services scheme for young people at risk of substance misuse in socially and economically disadvantaged communities.
- Expansion of drug and alcohol addiction services, including residential services.
- Recruitment of four Clinical Nurse Specialists and two Young Persons Counsellors to complement HSE multidisciplinary teams for under-18s.
- Recruitment of seven additional drug-liaison midwives to support pregnant women with alcohol dependency.
- Establishment of a Working Group to explore ways of improving progression options for people exiting treatment, prison or community employment schemes, with a view to developing a new programme of supported care and employment.

For further information on the *Reducing Harm, Supporting Recovery* drugs strategy see Policy workbook Section 1.1.1.

3. Additional information

3.1 Additional sources of information

A typology of alcohol consumption among university students in Ireland

Elevated levels of alcohol consumption among university students are well documented, with research indicating a rise in alcohol use among students in Ireland and increasing levels of high-risk drinking, which is often associated with illicit substances use (Davoren, *et al.* 2015). Policy-makers have attempted to combat this problem, as tailoring effective public health policy is crucial to tackling this burgeoning issue. Recently, typologies have been hypothesised as a pertinent public health tool. While traditional analysis methods tend to categorise individuals based on consumption profile alone, a typology approach may enhance an understanding of a societal phenomenon while making it possible to note patterns.

Recent research conducted by University College Cork aimed to develop a typology of alcohol consumption among the Irish university student population (Davoren, *et al.* 2016). In this study, published in the journal *BMJ Open*, hundreds of possible statements on types of alcohol consumption were generated from a systematic review and a set of one-on-one interviews. These were then reduced to 36 statements. Forty-three students were advised to scan through the 36 statements and fill the statements into a 'forced choice, standardised distribution'. Following this, a 45–90-minute interview was conducted with each student to illuminate subjectivity surrounding alcohol consumption.

A typology describing four distinct groupings of alcohol consumer was uncovered. These were:

- **'Guarded drinker, careful spender, controlled enjoyment'**: Characterised by students who enjoy socialising but only within the remit of social, family or cultural rules, which are self-regulated, and who described their alcohol consumption as cautious and light.
- **'Calculated hedonists'**: Students who indicated a hedonistic style of drinking. These students drank alcohol to feel pleasure, to enjoy themselves, to have fun and to become drunk.
- **'Peer influenced with an ulterior motive'**: Students who focused on consuming alcohol as part of a group or at a party. These individuals were motivated by the sense of belonging they gain from alcohol consumption, indicating that drinking helps them to feel a part of the group and adds a sense of social confidence.
- **'Inevitable bingers'**: Students who described how they drink until all the alcohol they have is gone. These individuals noted self-inflicted dangerous situations arising from their own behaviours and drinking habits.

As this was the first study to propose types of alcohol consumption based on a student's own subjectivity, the authors acknowledge that future research will be required to investigate the degree

to which each of these types is subscribed. Nevertheless, these profiles may provide a framework for public policy-makers and health promotion practitioners when tackling substance use at both a micro and macro level.

4. Sources and methodology

4.1 Sources

Data for this workbook were provided using five sources:

- National Drug-Related Deaths Index (NDRDI)
- Health Protection Surveillance Centre (HPSC)
- Hospital In-Patient Enquiry (HIPE) scheme
- National Psychiatric In-patient Reporting System (NPIRS)
- National Self-Harm Registry Ireland

4.2 Methodology

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

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

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

The **National Psychiatric In-patient Reporting System (NPIRS)**, administered by the HRB, is a national psychiatric database that provides detailed information on all admissions to, and discharges from, 56 inpatient psychiatric services in Ireland. It records data on cases receiving inpatient treatment for problem drug and alcohol use. NPIRS does not collect data on the prevalence of psychiatric co-morbidity in Ireland. The HRB publishes an annual report on the data collected by the NPIRS, entitled *Activities of Irish Psychiatric Units and Hospitals*.

The **National Self-Harm Registry** Ireland is a national system of population monitoring for the occurrence of deliberate self-harm, established by the National Suicide Research Foundation at the request of the Department of Health and Children. Since 2006–2007, the Registry has achieved complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with a non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are

included. Not considered deliberate self-harm are accidental overdoses – e.g., an individual who takes additional medication in the case of illness, without any intention to self-harm; alcohol overdoses alone, where the intention was not to self-harm; or accidental overdoses of street drugs (drugs used for recreational purposes), without the intention to self-harm – and individuals who are dead on arrival at hospital as a result of suicide.

4.2 References

- Attewill, F. (2011, 31 January). Fears for addicts as heroin drought hits. Metro. Retrieved from <http://www.drugsandalcohol.ie/15367/>
- Bates, G., Van Hout, M. C., Hearne, E., Mackridge, A. and McVeigh, J. (2015). Evaluation of the pilot stage of the pharmacy needle exchange programme in Ireland. Health Service Executive, Dublin. Available at <http://www.drugsandalcohol.ie/26905/>
- Carew, A. M., Murphy, N., Long, J., Hunter, K., Lyons, S., Walsh, C. , *et al.* (2017). Incidence of hepatitis C among people who inject drugs in Ireland. Hepatology, Medicine and Policy, **2**, (1). Available at <http://www.drugsandalcohol.ie/26726/>
- Coombe Women and Infants University Hospital (2016). Coombe Women and Infants University Hospital annual clinical report 2014. Coombe Women and Infants University Hospital, Dublin. Available at <http://www.drugsandalcohol.ie/26734/>
- Cornberg, M., Razavi, H. A., Alberti, A., Bernasconi, E., Buti, M., Cooper, C. , *et al.* (2011). A systematic review of hepatitis C virus epidemiology in Europe, Canada and Israel. Liver International, **31**, (Suppl 2), 30-60. Available at <http://www.drugsandalcohol.ie/27691/>
- Cousins, G., Boland, F., Courtney, B., Barry, J., Lyons, S. and Fahey, T. (2016). Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction, **111**, (1), 73-82. Available at <http://www.drugsandalcohol.ie/24374/>
- Cousins, G., Boland, F., Barry, J., Lyons, S., Keenan, E., O'Driscoll, D. , *et al.* (2017). J-shaped relationship between supervised methadone consumption and retention in methadone maintenance treatment (MMT) in primary care: national cohort study. Drug and Alcohol Dependence, **173**, 126-131. Available at <http://www.drugsandalcohol.ie/26891/>
- Daly, A. and Craig, S. (2016). Activities of Irish psychiatric units and hospitals 2015. Main findings. Health Research Board, Dublin. Available at <http://www.drugsandalcohol.ie/25844/>
- Davoren, M. P., Shiely, F., Byrne, M. and Perry, I. J. (2015). Hazardous alcohol consumption among university students in Ireland: a cross-sectional study. BMJ Open, **5**, (e006045). Available at <http://www.drugsandalcohol.ie/23350/>
- Davoren, M. P., Cronin, M., Perry, I. J. and O'Connor, K. (2016). Alcohol consumption among university students: a typology of consumption to aid the tailoring of effective public health policy. BMJ Open, **6**, (11), e011815. Available at <http://www.drugsandalcohol.ie/26485/>
- Department of Community, Rural and Gaeltacht Affairs, (2009). National Drugs Strategy (interim) 2009–2016. Department of Community, Rural and Gaeltacht Affairs, Dublin. Available at <http://www.drugsandalcohol.ie/12388/>
- Department of Health (2017). Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017 - 2025. Department of Health, Dublin. Available at <http://www.drugsandalcohol.ie/27603/>
- Elsherif, O., Bannan, C., Keating, S., McKiernan, S., Bergin, C. and Norris, S. (2017). Outcomes from a large 10 year hepatitis C treatment programme in people who inject drugs: No effect of recent or former injecting drug use on treatment adherence or therapeutic response. PLoS ONE, **12**, (6), e0178398. Available at <http://www.drugsandalcohol.ie/27486/>
- European Monitoring Centre for Drugs and Drug Addiction (2011) Statistical bulletin 2011. Available at <http://www.drugsandalcohol.ie/15525/>
- Griffin, E., Arensman, E., Dillon, C. B., Corcoran, P., Williamson, E. and Perry, I. J. (2016). National Self-Harm Registry Ireland annual report 2015. National Suicide Research Foundation, Cork. Available at <http://www.drugsandalcohol.ie/26297/>
- Griffin, E., Dillon, C. B., O'Regan, G., Corcoran, P., Perry, I. J. and Arensman, E. (2017). The paradox of public holidays: Hospital-treated self-harm and associated factors. Journal of Affective Disorders, **218**, 30-34. Available at <http://www.drugsandalcohol.ie/27285/>

- Hay, G., Jaddoa, A., Oysten, J., Webster, J., Van Hout, M. C. and Rael dos Santos, A. (2017). Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods. Dublin. Available at www.drugsandalcohol.ie/27233
- Health Research Board (2016). National Drug-Related Deaths Index 2004 to 2014 data. Health Research Board, Dublin. Available at <http://www.drugsandalcohol.ie/26299/>
- Hope, A. and Barry, J. (2016). Alcohol treatment services in Ireland: how the public view them. Health Service Executive, Dublin. Available at <http://www.drugsandalcohol.ie/26577/>
- HSE National Hepatitis C Strategy Working Group (2012). National hepatitis C strategy 2011–2014. Health Service Executive, Dublin. Available at <http://www.drugsandalcohol.ie/18325>
- Merchants Quay Ireland (2016). Merchants Quay Ireland. Annual review 2015. Merchants Quay Ireland, Dublin. Available at <http://www.drugsandalcohol.ie/26106/>
- Moore, G., McCarthy, P., MacNeela, P., MacGabhann, L., Philbin, M. and Proudfoot, D. (2004). A review of harm reduction approaches in Ireland and evidence from the international literature. Stationery Office, Dublin.
- Nelson, P. K., Mathers, B. M., Cowie, B., Hagan, H., Des Jarlais, D. C., Horyniak, D. , *et al.* (2011). Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. The Lancet, **378**, (9791), 571-583. Available at <http://www.drugsandalcohol.ie/15845/>
- O'Keefe, C. (2010, December 16). Heroin drought can lead to death. Irish Examiner. Retrieved from <http://www.drugsandalcohol.ie/14424/>
- Thanki, D. and Vicente, J. (2013). PDU (Problem drug use) revision summary. European Monitoring Centre for Drugs and Drug Addiction, Lisbon. Available at <http://www.drugsandalcohol.ie/27693/>
- The Rotunda Hospital (2016). Rotunda Hospital. Clinical report 2015. The Rotunda Hospital, Dublin. Available at <http://www.drugsandalcohol.ie/27551/>

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.

Acknowledgements

Completion of the national focal point's reports to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) depends on the support and cooperation of a number of government departments and statutory bodies. Among those to whom we would like to express our thanks are the staff of the following:

Customs Drugs Law Enforcement, Revenue
Department of Children and Youth Affairs
Department of Education and Skills
Drugs and Organised Crime Unit, An Garda Síochána
Drugs Policy Division, Department of Justice and Equality
Drugs Policy Unit, Department of Health
Forensic Science Ireland
Health Protection Surveillance Centre, Health Service Executive
Hospital In-Patient Enquiry Scheme, Health Service Executive
Irish Prison Service
National Advisory Committee on Drugs and Alcohol, Department of Health
National Social Inclusion Office, Primary Care Division, Health Service Executive

We also wish to acknowledge the assistance of the coordinators and staff of local and regional Drug and Alcohol Task Forces, voluntary, community-based and other non-governmental organisations.

We wish to thank our HRB colleagues in the Evidence Centre, National Drug Treatment Reporting System, the National Drug-related Deaths Index and the HRB National Drugs Library, all of whom make significant contributions to the preparation of the national report.