

Focal Point Ireland: national report for 2017 - Treatment

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

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National Profile

A national drug strategy *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* was launched in July 2017. The strategy is structured around cross-cutting goals rather than the pillars of the previous national drug strategy. The main aim is to minimise the harms caused by the use and misuse of substances, and to promote rehabilitation and recovery. Therefore, there is a focus on the need for a range of treatment, rehabilitation and recovery services using the four-tier model. It also recognises the need for timely access to appropriate services for the client.

The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment. Drug treatment is therefore provided through a network of HSE services (public), but also non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment.

A range of treatment options is available for problem drug users, mainly in outpatient settings but also in residential settings. Almost all opiate substitution treatment (OST) provided is methadone. Buprenorphine in combination preparations is not yet routinely available in Ireland; however, there are measures in train which should address this. In 1998, the first formal methadone treatment protocol (MTP) was introduced to ensure that treatment for problem opiate use could be provided wherever the demand existed. Outpatient methadone treatment for problem opiate users is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics, or through specialised general practitioners (GPs) in the community. The first national comprehensive clinical guidelines for opioid substitution treatment were published in 2016.

Trends

There were no changes in trends between 2015 and 2016. Most of drug treatment (over 75%) is provided through publicly funded and voluntary outpatient services. Outpatient services include low-threshold and specialised OST GPs in the community. Inpatient treatment is mainly provided through residential centres run by voluntary agencies.

Opiates (mainly heroin) are the main problem illicit drug used by entrants to treatment, followed by cannabis and cocaine. The proportion of all entrants to treatment reporting an opiate as their main problem drug has decreased year-on-year since 2004, from a peak of 65% in 2004 to 47% in 2016. Over the period, cannabis has been consistently reported as the second most common main problem drug, with the proportion increasing from 21% in 2004 to 27% in 2016. The numbers presenting for treatment for problem cocaine use has increased again in 2016, rising to 12%, after a dropping to a low in 2012. For clients new to treatment, cannabis continues to be the main problem drug since 2010, replacing opiates (mainly heroin).

The majority of cases have been previously treated. The proportion of new entrants to treatment was unchanged in 2016 compared to 2015, when the reported figure was 39%. The proportion of new entrants has fluctuated from 39% in 2004 to a peak of 47% in 2009, and a drop to 39% in 2015. The majority of OST clients receive methadone in specialist outpatient clinics, with a smaller number receiving it from specialist GPs and a yet smaller proportion (less than 5%) in prison. The number of clients registered for OST on 31 December each year has increased, from 3,689 in 1998 to 10,087 in 2015.

The National Drug Treatment Reporting System, the surveillance database for treated problem drug users in Ireland, underwent a major transformation in 2017. It changed from being mainly hard copy returns to an on-line, web-based system. This change may have had some impact on returns, so therefore it is not possible to say if, for example, the overall decrease in cases for 2016 is a true decrease or a reflection of the changeover. It would not be unexpected, given the scale of the transition, that it could have impacted on returns. However, it is anticipated that the new system will improve quality and timeliness of the data in the future.

New developments

In July 2017 the national drug strategy - *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* was launched.

1. National profile

1.1 Policies and coordination

1.1.1 Main treatment priorities in the national drug strategy

Treatment and rehabilitation in the National Drugs Strategy

A national drug strategy Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025 was launched in July 2017 (Department of Health 2017). The strategy is structured around cross-cutting goals rather than the pillars of the previous national drug strategy (2009–2016) (Department of Community 2009). Treatment and rehabilitation are covered under the second goal of the new strategy. The main aim is to minimise the harms caused by the use and misuse of substances and to promote rehabilitation and recovery. The goal focuses on the range of treatment, rehabilitation and recovery services available to users. It recognises that ‘timely access to appropriate services relevant to the needs and circumstances of the person concerned is of fundamental importance’ (p. 33). There are two objectives to the goal; the first relates to treatment and rehabilitation and is described below; the second focuses specifically on people who inject drugs and the issues of overdose and drug-related deaths – this is considered in more detail in the Harm Reduction workbook (see Section 3.3).

The first objective under this goal is: ‘To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs’. It focuses on improving access to a range of services, for users generally and for some groups in particular. The approach taken to treatment and rehabilitation in this national drug strategy builds on that of the previous strategy. The Health Service Executive (HSE) follows a four-tiered person-centred model of rehabilitation which is based on the principle of ‘continuum of care’ (see Figure 1.1.1.1 below). This continues to be the national framework through which treatment and rehabilitation services are delivered, with all substances of misuse being dealt with and a focus on polydrug use.

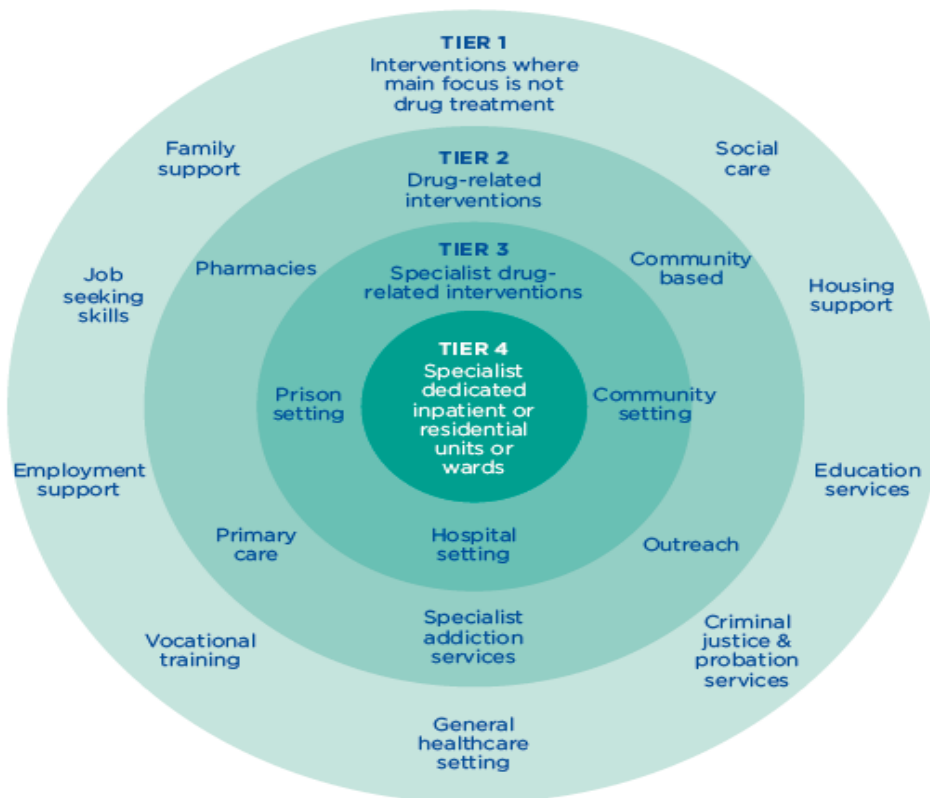


Figure 1.1.1 The four-tier model of care, National Drug Strategy, p. 34

Source of image: Doyle J, Ivanovic J 2010

The strategy also includes a number of actions under each objective. The timeframe for their delivery is 2017–2020. In terms of improving access to services actions include:

- To strengthen the implementation of the National Drugs Rehabilitation Framework (Doyle and Ivanovic 2010) by: developing a competency framework on key working, care planning and case management; and extending the training programme on the key processes of the Framework.

- To expand the availability and geographical spread of relevant quality drug and alcohol services and improve the range of services available, based on need. This will be done by: identifying and addressing gaps in provision in the four tiers; increasing the number of treatment episodes provided across the range of services; and, strengthening the capacity of services to address complex needs.
- To improve the availability of OST by examining potential mechanisms to increase access through expansion of GP prescribing, nurse-led prescribing and the provision of OST in community-based settings and homeless services.
- To enhance the quality and safety of care in the delivery of OST by implementing the HSE's National Clinical Guidelines on OST and reviewing them in line with National Clinical Effectiveness Committee processes (also see Section T1.5.1 below).

Also central to this objective is a range of actions set out to promote recovery by expanding and improving access to services for specific groups of people, including women, children and young people, groups with 'more complex needs' (p. 44), and prisoners.

For example:

- To expand addiction services for pregnant and postnatal women
- To respond to the needs of women who are using drugs and/or alcohol in a harmful manner by improving the range of 'wraparound' services available
- To expand the range, availability and geographical spread of services for those under 18 years
- To examine the need to develop specialist services to meet the needs of older people with long-term substance use issues
- To improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health Clinical Programme to address dual diagnosis; and develop joint protocols between mental health services and drug and alcohol services (also see Section 1.4.4 below).

1.1.2 Governance and coordination of drug treatment implementation

The Health Service Executive (HSE) is identified as the lead agency with responsibility for the delivery of most of the treatment and rehabilitation-related actions under the new strategy (Department of Health 2017). However, other agencies identified as having lead responsibility on specific actions include: the Department of Health, Tusla and the Irish Prison Service.

Established by the Health Act 2004, the HSE is responsible for the provision of all publicly funded health and personal social services for everyone living in Ireland. It provides an addiction service, including both drugs and alcohol, delivered through Social Inclusion Services, which is part of the HSE's Primary Care Division. This Division promotes and leads on integrated approaches to healthcare at different levels across the statutory and voluntary sectors, including the development of integrated care planning and case management approaches between all relevant agencies and service providers.

The HSE supports the non-statutory sector to provide a range of health and personal social services, including the drug projects supported by the local and regional drug and alcohol task forces, which receive annual funding of over €20 million annually. This funding is governed by way of Service Arrangements and Grant Aid Agreements. The HSE's Primary Care Division assists the drugs projects to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance Group, and seeks to ensure that funded organisations support and promote the aims and objectives of the national drug strategy.

Introduced in 2015, the HSE's Accountability Framework makes explicit the responsibilities of all HSE managers, including primary care managers, to deliver the targets set out in the HSE's National Service Plan (NSP) and the Primary Care Division Operational Plan (PCD OP). Addiction services are provided by Social Inclusion Services, the core objective of which is to improve health outcomes for the most vulnerable in society, including those with addiction issues, the homeless, refugees, asylum seekers, Traveller and Roma communities. As laid out in the National Service Plan for 2017, the priority actions for 2017 for the addiction services reflect those of the new strategy. They are to:

- Improve access to addiction treatment services for adults and children, with a particular focus on services for the under 18s
- Implement the recommendations of the National Drugs Rehabilitation Framework
- Establish a pilot supervised injecting facility in Dublin
- Expand access to naloxone to approximately 600 new clients
- Increase access to buprenorphine naloxone and buprenorphine products
- Provide 25 more addiction residential treatment beds and 142 additional treatment episodes.

1.1.3 Further aspects of drug treatment governance

In order to address problem opiate use and standardise treatment, in 1998 a more formalised methadone treatment protocol (MTP) was introduced, to ensure that treatment for problem opiate use could be provided wherever the demand exists (Methadone Prescribing Implementation Committee 2005, Methadone Treatment Services Review Group 1998). New regulations pertaining to the prescribing and dispensing of methadone were introduced. General practitioners (GPs) who wish to prescribe methadone in the community must undergo formalised training and the number of clients they can treat is capped, depending on experience. See also the new Clinical Guidelines in Section 1.5.1.

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

1.2 Organisation and provision of drug treatment

1.2.1 Outpatient drug treatment system – main providers

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also sections 1.1.2 and 1.4 in this workbook). Many of the non-statutory, voluntary agencies are partly funded by the HSE. An unknown number of private organisations also provide outpatient addiction treatment such as counselling. Very few of the private agencies contribute data to the TDI figures.

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

GPs are medical practitioners who treat acute and chronic illnesses and provide preventive care and health education for all ages and both sexes. They may treat drug users for their drug problems, in some cases in liaison with outpatient or inpatient drug services, and some of them may have a specific training in the treatment of drug users. Only those who have completed the specialist training can provide OST to clients who are stable; as such, these GPs represent an important part of drug treatment services in Ireland, particularly for stable clients on OST. For further information, see Section 1.4.7 below.

1.2.2 Further aspects of outpatient drug treatment provision

Over the past number of years, most addiction treatment has been provided by outpatient services. It is not possible to estimate the total number of clients in the national network as there is no information on the number of centres that do not report to TDI. Data from TDI have been used to populate Table 1.2.2. This shows that in 2015, 81.9% of all cases were treated in outpatient services. These figures can be considered the minimum number of cases treated.

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

Table I.2.2.1 Network of outpatient treatment facilities (total number of units and clients)

	Total number of units	National Definition (Characteristics/ Types of centre included within your country)	Total number of clients
Specialised drug treatment centres	312	Treatment facilities where the clients are treated during the day (and do not stay overnight). They may open in the evening but where the opening time excludes the night. Include OST clinics, counselling, therapeutic day care and socio-economic training units	5301
Low-threshold agencies	77	Aim to prevent and reduce health-related harm associated with drug dependence, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. May provide low dose OST, general medical assistance, brief interventions and needle exchange.	867
General primary healthcare (e.g. GPs)	349	Specially trained general practitioners (GPs) who provide OST in primary care	234
General/ Mental health care		Provided through the mental health directorate of the HSE or funded by the mental health directorate. Not included in the TDI data.	
Prisons (in-reach or transferred)	31	See inpatient facilities	720
Other outpatient units	361	Specially trained general practitioners who provide OST in primary care	
Other outpatient units			

Source: Standard table 24

1.2.3 Inpatient drug treatment system – Main providers and client utilisation

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

The mental health services also provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures. For further information, see ‘Drug admissions to psychiatric facilities’ in Section 1.2.4 of the Harms and Harm Reduction workbook.

1.2.4 Further aspects of inpatient drug treatment provision

Table II Network of inpatient treatment facilities (total number of units)

	Total number of units	National definition (characteristics/ types of centre included within your country)	Total number of clients
Hospital-based residential drug treatment	2	Wards or units in hospitals where the clients may stay overnight. This figure refers to the two hospital inpatient detoxification units. There are also 66 psychiatric hospitals for inpatients. These do not currently report to TDI.	201
Residential drug treatment (non-hospital based)			
Therapeutic communities			
Prisons			
Other inpatient units	52	Defined as centres where the clients may stay overnight. They include therapeutic communities, detoxification units, centres that offer residential facilities. It is not possible to differentiate between residential inpatient and therapeutic communities; therefore, both are reported together in this section.	1631
Other inpatient units			

Source: Standard table 24

1.3 Key data

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

Opiates (mainly heroin) and cannabis are the two main drugs for which cases sought treatment in 2016.

Just under half (46.9) (47.6%) of all cases entering treatment in 2016 reported opiates as their main problem drug (See Figure 1.3.1 and Table 1.3.1). Once again, the trends appear to show a slight decrease compared to 2015 (47.6%) and continue the overall downward trend in the representation of cases presenting with problem opiate use in treatment over the past number of years. Heroin continues to be the main drug in this category, representing 84.7% of all those reporting an opiate, similar to 2014 when 87.0% reported problem heroin use.

The next most common drug reported was cannabis, similar to previous years. Twenty-seven per cent of cases reported cannabis as their main problem drug, almost identical to the last two reporting years (see also Drug workbook). However the actual number of cases reported in 2016 (n = 2,381) is less than the number reported in 2015 (n = 2,645). The cause of this reduction is not known (see T1.3.3 for more information). The trend for problem cannabis use has stabilised over

the past number of years. The majority (60.9%) of those reporting cannabis as their main problem drug had never been treated before. This compares to 63.1% in 2015 and 64.1% in 2014. It may represent the start of a (gradual) decline in the proportion of cannabis cases who have never been treated, and may indicate a change in trends.

Cocaine remains the third most common drug reported. The upward trend is continuing, with 12.2% of cases reporting problem cocaine use in 2016 compared with 8.7% in 2014. It means the proportion of problem cocaine cases is higher than the last peak of 11.5% reported in 2009. This could be a reflection of the increased prevalence of use among the general population, recorded as 7.8 in 2014/2015, the highest since General Population Surveys studies were commenced (National Advisory Committee on Drugs and Alcohol 2016). Just over half of cases had never been previously treated (51.6%), which is the same figure as that recorded for 2015 (51.5%). Amphetamines (0.6%) and ecstasy (0.6%) continue to make up a very small proportion of the main problem drugs reported in 2016, with no change from the previous years.

Benzodiazepines continue to comprise the majority of the ‘other drugs’ category. Seventy-five per cent of cases who reported “other drugs” reported benzodiazepines as their main problem drug in 2016; the comparable figure for 2015 was 71%. Over half (54.6%) of these cases were previously treated in 2016, which is similar to the figure recorded for 2015 (56.2%).

1.3.2 Further methodological comments on the Key Treatment-related data

It is important to note that the NDTRS, the surveillance database for treated problem drug use in Ireland, underwent a major transformation in 2017. It changed from being mainly hard copy returns to an on-line, web-based system.

Given the scale of transformation, the changeover may have had some impact on returns, and therefore it is not possible to say if, for example, the overall decrease in cases for 2016 is a true decrease or a reflection of the changeover. It is expected that the new system will improve the quality and timeliness of the data in the future.

1.3.3 Characteristics of clients in treatment

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

Table 1.3.3.1: Summary table – Clients in treatment

	Number of clients
Total clients in treatment	8,954
Total OST clients	10,087
Total number of clients entering treatment	Data on OST and TDI are from different sources. These data are collected using different methodologies. Additionally, because there is some duplication, the data cannot be combined or compared meaningfully.

Source: ST24 and TDI

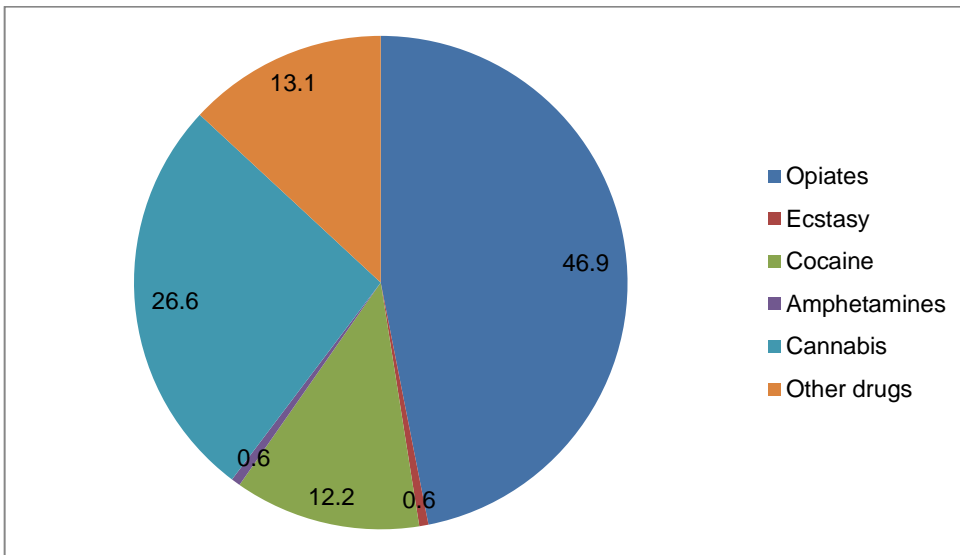


Figure 1.3.3.1 Proportion of treatment demands by primary drug
Source: TDI

1.4 Treatment modalities

1.4.1 Outpatient and inpatient services

The types of treatment and services offered vary depending on the service. The majority of OST is provided by designated HSE clinics, which often also offer other specialist services including psychiatry, counselling, social services and general medical activities, e.g. vaccinations (see also Section 1.4.7 below). Other services, which do not offer OST, may provide a wide variety of treatments including counselling, group therapy, socioeconomic training, complementary therapies, relapse prevention, etc.

Addiction treatment in prison is provided by the prison medical service or by in-reach services delivered by voluntary agencies. Treatments include 21-day pharmacy supervised detoxification (Cronin, et al. 2014), OST and psychiatric treatment, whereas counselling is mainly provided by in-reach services.

1.4.2 Inpatient drug treatment services

Residential drug treatment (non-hospital based) including therapeutic communities:

These services are provided mainly by non-statutory, voluntary agencies, and the ideology behind each varies according to the agency running the service. Some require clients to be drug-free and, depending on the service, may also require them to be off methadone. These types of service offer a wide range of treatments, including counselling, group therapy, social/occupational activities, family therapy, complementary therapies and aftercare.

Detoxification: There are two dedicated HSE hospital inpatient detoxification units (total of 18 beds). The average waiting time for these beds is between four and nine weeks (Byrne 2016, 16 September). In 2016, no client was waiting more than six months for a place in these centres. Ten other residential centres provided by voluntary/non-statutory services also offer detoxification as part of their suite of residential treatments. The average waiting time for these beds ranges from one day to 49 days (but mostly ranges between one and four weeks) (Byrne 2016, 16 September). One centre, which has four beds, provides adolescent residential detoxification. The average waiting time is within seven days of assessment for this service (Byrne 2016, 16 September).

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

1.4.3 Further aspect of available inpatient treatment services

It is noted that many residential centres (excluding psychiatric hospitals) do not have the ability or the expertise to provide psychiatric care to clients with a dual diagnosis (both a mental health issue and an addiction problem) (Byrne 2017, 17 January). See Section T3.1 below in relation to the establishment of the National Clinical Programme for assessing and managing patients who have both a mental health illness and addiction issues.

1.4.4 Main providers/organisations providing Opioid substitution treatment

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

In 2016, data from the Central Treatment List (CTL) (see also Section T2.1 below) 53.7% of patients were receiving treatment in specialist outpatient clinics, 41.5% from GPs, 4.6% in prison and less than 0.2% in an inpatient setting (personal communication, Caroline Comar, CTL). The proportion of clients receiving treatment from GPs has increased slowly but steadily over the years, from 31.7% in 2001 to 41.2% in 2015, stabilising in 2010 at 41.5%. The proportion of clients receiving treatment in specialist outpatient clinics has decreased, from 59.0% in 2008 to 53.8% in 2015. No change was seen in 2016 for this service type. The change seen between 2001 and 2015 likely reflects the policy to move stable OST clients back to primary care where they can receive all their care, including OST, from their own GP; in addition, the change between 2001 and 2015 also likely reflects the increase in the number of specialist GPs in the community.

In 2016 there were no studies or evaluations of coverage of treatment or barriers to OST treatment.

1.4.5 Number of clients in OST

The number of clients registered for methadone maintenance on 31 December each year is reported by the Central Treatment List (CTL) (see also Figure 2.1.3 in T2.1 below, Section T6.1 and Standard Table 24). On 31 December 2016, 10,087 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). This again represents a very slight increase (1.7%) on the previous year compared to the 1.8% increase between 2014 and 2015. The CTL is a national register of all clients on methadone maintenance.

Almost all clients receive methadone as their opiate substitute because, historically, this has been the drug of first choice for treating opiate dependency in Ireland. Again in 2011, an expert group once more concluded that methadone should remain the drug of first choice for treating opiate dependence (Expert Group on the Regulatory Framework 2011). Buprenorphine in combination preparations is not routinely available in Ireland. The drug Suboxone, a combination of buprenorphine and naloxone, was licensed for use in 2006 in Ireland as an alternative to methadone for opiate dependency although buprenorphine alone had been used in an extremely limited way in specialist addiction clinics before this time (Fitzgerald 2011). A feasibility study on the use of Suboxone was undertaken in 2009 (Fitzgerald 2011).

The expert group set up to consider the regulatory framework for products containing buprenorphine/naloxone and buprenorphine-only for the treatment of opioid dependence (Expert Group on the Regulatory Framework 2011) concluded that methadone was the drug of first choice for treating opiate dependency in Ireland, but that buprenorphine/naloxone may be appropriate for some patient cohorts in certain circumstances:

- Patients already receiving treatment with buprenorphine/naloxone
- Patients with a specific medical condition where methadone is contraindicated, for example, prolonged QT interval, an abnormal heart rhythm

- Patients who have never been prescribed methadone before, especially young patients, where detoxification is a primary goal of treatment
- Patients whose main problem drug is codeine or another pharmaceutical opioid; or
- Patients whom the prescriber believes to have been stable for at least six months, particularly with regard to employment or education, and committed to compliance with the treatment.

To date, Suboxone has not been prescribed any more widely in Ireland, and because these clients are currently not recorded in the CTL, no information is known about them. This is because resolution on legislative and financial arrangements is required. Suboxone must be given the same statutory basis as methadone and, as such, requires an amendment to the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations. This can only be amended by primary legislation (Chambers 2016, 12 June) which should be enacted in 2017. Also see Section 1.1.2 above.

1.4.6 Characteristics of clients in OST

Relationship between supervised methadone consumption and retention in treatment in primary care

A J-shaped relationship between supervised methadone consumption and retention in methadone maintenance treatment in primary care represents a ‘double-edged sword’, according to authors of an Irish study (Cousins, *et al.* 2017). This study was the first to examine the influence of supervised methadone consumption on retention in methadone treatment over multiple treatment episodes in primary care in Ireland.

Supervised methadone consumption entails the administration of methadone to patients by a pharmacist or clinician, thus ensuring that patients take methadone as prescribed. Ensuring patient compliance can prevent diversion of methadone to illicit drug markets and can reduce relapse to heroin use. Research has found supervised methadone consumption to be associated with a reduction in drug-related deaths, including those attributed to methadone. However, long-term supervision is resource intensive and may promote dropout from treatment due to the disruption to patients’ lives. Conflicting findings have emerged from the few studies that have compared supervised and unsupervised consumption.

At the time of the study, and consistent with World Health Organization recommendations, Irish guidelines for methadone maintenance treatment in primary care advised a minimum of one dose per week administered under pharmacy supervision. A dose of 60–120 mg daily, with prescriptions issued to dispense methadone for up to seven days, was further recommended.

The sample comprised 6,393 patients who experienced at least one methadone treatment episode between 2004 and 2010, and 19,715 treatment episodes. Patients were mostly male (68.5%) and aged under 30 years (58.6%).

The sample was identified by linking data from the Central Treatment List (the national register for methadone maintenance treatment); records from the HSE’s Methadone Treatment Scheme; the General Medical Services (GMS) pharmacy claims; and the HRB’s National Drug-Related Deaths Index (NDRDI). Included were persons aged 16–65 years who had at least three methadone prescriptions prescribed and dispensed in primary care during the study period. The GMS provided data on all other prescription medications dispensed to these patients, while data from the NDRDI enabled the identification of persons who had died during the timeframe.

Prescription refill data were used to assess the level of supervised methadone for each treatment episode, with those dispensing a single dose categorised as supervised. For each patient, the percentage of supervised prescriptions was calculated and classified as 20%, 20–39%, 40–59%,

60–79%, or 80% or more. Prescription data were also used to calculate the total number of prescriptions (comorbidity score) for other drugs issued to each patient across the timeframe.

Patients were deemed to be in continuous treatment if they had received a new prescription within seven days of the end of coverage of a prescription; they were deemed to have ceased treatment if they had not received a new prescription within that period. Retention in treatment was designated for treatment episodes that had no interruption in prescribed methadone lasting more than seven days. The length of treatment episodes was based on the date of the first prescription and coverage of the last. Only episodes that started within the timeframe of interest were included in the analyses.

Statistical analyses examined the relationship between supervised methadone consumption and time to discontinuation of treatment across multiple treatment episodes, accounting for recurrent methadone treatment episodes, and including age, gender, median daily methadone dose and comorbidities as potential confounders.

Results

- Thirty-six per cent of patients were supervised for less than 20% of prescriptions, 16% for 20–59%, and 48% for 60% or more during the initial treatment episode.
- Across episodes, treatment discontinuation was least among patients supervised for 20–59% of prescriptions, and was greatest among patients supervised for 60% or more (indicating a J-shaped relationship).
- Sixty-seven per cent of patients experienced more than one treatment episode; the median episode length for the initial treatment episode was 224 days; and the overall median episode length was 104 days.
- Daily methadone doses ranging from 60 to 120 mg per day were more effective at retaining patients in treatment than doses of less than 60 mg, or greater than 120 mg per day.
- The minimum recommended daily dose (60 mg) was not received by one-third of patients during the initial treatment episode.
- Many patients received co-prescriptions, most commonly for benzodiazepines (72%) and antidepressants (49%). Those with 11 or more were significantly more likely to have shorter treatment episodes than those with five or fewer.

Discussion

The J-shaped relationship identified suggests that with too little or too much supervision, patients may drop out of methadone treatment. This finding is consistent with trials in the US and Scotland, and is supported by qualitative research suggesting that supervision can be acceptable to patients in the short term, as they develop a routine and establish relationships with staff, but that patients prefer to be unsupervised in the longer term. The authors propose that other studies which found no differences in retention, based on whether consumption was supervised or unsupervised, failed to account for the relapsing nature of opioid addiction and the recurrence of treatment episodes. Consistent with research from Canada, many patients in the current study experienced multiple treatment episodes and were retained longer in later treatment episodes. Findings from a Scottish cohort study also suggest that cumulative exposure to opiate substitution improves patient survival. Although one-third of patients in the current study did not receive the recommended dosage, this proportion is lower than in the UK (57%) and Canada (51%). A further key finding is that many patients have comorbid conditions, and these patients tend to have shorter treatment episodes.

Conclusions

The findings highlight a challenge for clinicians: reducing supervision risks increasing the availability of street methadone and hence the population-level risk of methadone deaths, whereas increasing supervision risks dropout from treatment and greater patient mortality. The authors emphasise that further research is needed in order to profile patients suitable for unsupervised dosing, with the aim of retention in treatment and reduced diversion. The authors caution that the study methodology did not capture patients transferring from primary care to specialised settings; that it may have underestimated retention, and that did not consider the quality of treatment.

1.4.7 Further aspects on organisation, access and availability of OST

Brief intervention with methadone patients

The use of a brief intervention (BI) has been recommended by the World Health Organization (WHO) as an intervention to address problematic substance use. It recommends a two-step approach, whereby the most problematic substance is first identified using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Once identified, the clinician can deliver a BI tailored for the identified substance. WHO advises refining and tailoring the BI to meet the needs of the target population, to consider the context and culture of the service setting, thus ensuring it meets local needs and is both culturally and contextually suitable.

This paper outlines the development and process used to customise a BI for use with opioid-dependent methadone-maintained patients and to ensure its compatibility with the culture of an Irish drug-using population (Darker, *et al.* 2016). The authors sought to tailor all intervention materials for use in a subsequent cluster randomised controlled trial.

Methods

- WHO uses two manuals to describe the ASSIST and a BI; these were combined into a single BI manual and the style of the manual refined.
- A sample script of a screening and BI session was developed as well as an algorithm to facilitate clinicians during the BI session.
- A Substance Risk Card had been created for each individual substance assessed within the ASSIST screening tool. These cards outlined risks associated with the use of certain substances.
- The cards were modified: changes included weighting the severity of the risks, reordering associated risks with the more problematic risks at the top, and the inclusion of how particular substances might interact with methadone and exacerbate problems for users.
- Tickboxes were added to the risk cards. These boxes allow risks that are pertinent to a patient to be ticked by the clinician during a session, therefore tailoring the BI to the patient based on their own individual risk profile.
- To address literacy concerns for illiterate or semi-literate patients, photographs were added to illustrate key risk factors.
- The language on the card was simplified and written in the first person to personalise the feedback.
- Patients recognised the physical risks of taking drugs, such as dental damage and the physical damage that long-term drug use can have on appearance.
- The 'Pros and Cons of Substance Use' section of a BI was used by the clinician to help patients explore why they use a substance and to consider reasons to reduce use or quit. Issues such as addiction, financial reasons to quit or cut down, risk of criminal activity and court conviction were important to patients and included as categories. More detail was added to examples.
- The value of proposed patient take-home material from the BI session, comprising the Feedback Report Card with results from the ASSIST screening tool and a personalised Substance Risk Card, was discussed. Patient opinion was divided on its usefulness. Concerns for patient confidentiality led to the adoption of a generic folder with a neutral title and cover.

Conclusion

The authors adhered to the WHO recommendations to tailor BI programmes to be culturally and contextually appropriate to the treatment cohort and clinical environment. Qualitative methods were used to identify and implement modifications to the BI and material for use in a later trial. The BI

manual was used to standardise training of clinicians for the later trial. Outcome data published elsewhere demonstrated that the tailored intervention was effective.

1.5 Quality assurance of drug treatment services

1.5.1 Quality assurance in drug treatment

New clinical guidelines for opioid substitution treatment (OST)

New clinical guidelines for opioid substitution treatment (OST) in Ireland have been published (Health Service Executive 2016). They were developed by a working group comprising the Health Service Executive (HSE), the College of Psychiatrists of Ireland, the Irish College of General Practitioners, the Pharmaceutical Society of Ireland and HSE addiction services. The group reviewed all relevant national and international guidelines and consulted stakeholders in the addiction services. Professor Michael Farrell, Director of the National Drug and Alcohol Research Centre at the University of New South Wales provided expert opinion throughout the process. This comprehensive document is divided into seven sections, each covering all different aspects of OST treatment: the guiding principles; rehabilitation and psychosocial components of OST; principles and key operational stages of pharmacological interventions of OST; assessment of dependence and management of OST; drug testing; OST and associated health considerations; and specific treatment situations and populations.

The guidelines emphasise the importance of clinical governance and standards in OST treatment. Governance looks to put the service user first, working towards delivering a quality service and maintaining patient safety (see Appendix 1, p. 70). The need for properly qualified and accredited staff to deliver the right interventions is also spelled out.

There is an acknowledgment of the importance of family/carers in the treatment process. The guidelines recommend that services should proactively engage with family/carers to enable them to be active partners in the treatment, with the service user's consent. This is particularly important for teenagers. The guidelines also note that this group can have their own issues, distinct from the service user, which may need to be addressed.

The document includes in-depth information for prescribing buprenorphine/buprenorphine-naloxone. The guidelines state that due to the safer profile of these formulations, induction and stabilisation can be quicker. They can be commenced by Level 2 general practitioners (GPs) and HSE addiction clinic prescribers. Other recommendations include:

- The first dose must not start until the service user experiences withdrawal symptoms (usually eight hours after last taking heroin or 24 hours after the last dose of methadone), as there is a risk of precipitated withdrawal.
- Precipitated withdrawal occurs when buprenorphine displaces other opiates from the opioid receptors and, as it is only a partial opiate agonist, this results in a rapid reduction of the effects of opiates, which in turn results in severe withdrawal symptoms.
- The recommended starting dose is between 4 mg and 8 mg daily, which can be increased by between 2 mg to 8 mg daily (usually 4 mg).
- The dose can be increased up to a maximum of 24 mg for buprenorphine/naloxone or 32 mg for buprenorphine alone.
- The stabilisation phase for these drugs is usually between four and six weeks, shorter than methadone, usually between 16 mg and 24 mg.
- Maintenance on buprenorphine/buprenorphine-naloxone can be overseen by Level 1 GPs.
- While it may vary by individual service user, a suitable maintenance dose will reduce or eliminate withdrawal symptoms and cravings over a 24-hour period.

Once the service user is stable, the frequency of supervision and/or dispensing can be reduced; for example, buprenorphine-naloxone can be taken on alternate days (e.g. 8 mg daily dose can be taken as 16 mg on alternate days). However, the dose given on any one day cannot exceed 24 mg. All service users on long-term prescriptions should have regular care plan reviews (three monthly) within a wider treatment plan of social and psychological support.

For detoxification, buprenorphine/buprenorphine-naloxone can be reduced by 2 mg every two weeks. Detoxification from this formulation is often quicker than with methadone.

The guide states that evidence shows that contingency management (CM), for example using incentives such as take-home OST, is proven to improve outcomes in this patient group. However, it does have some disadvantages and it is therefore recommended that it be provided as part of a structured care plan in combination with other evidence-based interventions. The guidelines directly address the issue of diversion. They state that take-home OST as an incentive for CM should be balanced against the known positive benefits to the service user and any potential risks, such as unsafe storage in homes or diversion. The criteria for deciding whether or not a client is suitable for take-home OST is based on known risk factors, and an assessment of the individual service user and community safety, but also clinical stability. In the guidelines, clinical stability is defined as:

- Adherence with treatment directives
- No recent problematic drug or alcohol use
- Stable housing
- Stable dose of methadone (with allowances for occasional dose increases)
- Emotional stability and good insight into safety issues

Contraindications to receiving take-home OST are:

- Repeated intoxication on presentation at the clinic/pharmacy
- Children living in the patient's household, with concerns that they may be at risk of harm
- Current chaotic and unpredictable behaviour
- Assessed as at risk of self-harm
- Current hazardous use of drugs (including benzodiazepines or alcohol), as this can increase risks of fatal overdose

A brief summary of the entire guide contents and all key points are reproduced below.

1. Guiding principles

Contents: good governance; therapeutic alliance; and information sharing (p. 11). The key points are:

- OST plays an intrinsic role in supporting patients to recover from opioid dependence.
- OST should be provided at the lowest level of complexity, matching the patient's needs, and as close to home as possible.
- Service users should be fully involved in the development of their care plans, setting goals and reviewing progress.
- It is good practice to involve service users in the design, planning, development, and evaluation of services.
- One of the strengths of drug treatment and rehabilitation in Ireland is the valuable partnership between statutory drug treatment services and the community/voluntary sectors.
- Services should be proactive in their engagement with family members, with the recognition that they have distinct needs from service users.
- A good therapeutic alliance is crucial to the delivery of any treatment intervention.

2. Rehabilitation and psychosocial components of OST

Contents: OST as a component of rehabilitation; integrated care plans; psychosocial interventions; key steps involved in the integrated care pathway; (p. 13). The key points are:

- All drug users entering treatment:
- Should have a care plan based on assessed need, which is regularly reviewed
- Should have full risk assessments to evaluate immediate health concerns, mental health issues, and risks to children
- Should have their needs assessed across the domains of drug and alcohol use, health, offending, and social functioning.
- Key working is a basic delivery mechanism for interventions in addiction services.
- Psychosocial interventions:
- Are a fundamental part of drug and alcohol treatment
- Are the mainstay of treatment for the use of cocaine and other stimulants
- Can also address common associated or co-occurring mental disorders, such as depression or anxiety.
- Self-help and mutual aid approaches have been found to be highly effective for some individuals.
- Contingency management (CM), Community Reinforcement Approach (CRA), Community Reinforcement Approach and Family Training (CRAFT) and Adolescent Community

Reinforcement Approach (ACRA), and family and couples interventions should be offered, where appropriate.

3. Principles and key operational stages of pharmacological interventions for OST

Contents: aims and objectives of OST; legislative requirements for prescriptions and initiation of OST (including buprenorphine/naloxone); provision of information to the patient; communication between prescriber; dispensing pharmacist and multidisciplinary team; contingency management; diversion of opioid substitution medication; supervised consumption; ongoing assessment of OST; and referral procedure for change of OST location (p. 17). The key points are:

- Good communication between the patient, the prescriber, the pharmacist, and other members of the interdisciplinary team is crucial in providing optimal treatment
- Carers should be active partners in drug treatment, where consent is given.
- Patients should be made fully aware of the risks of their medication and of the importance of protecting children from accidental ingestion.
- Prescribing, supervision, and dispensing arrangements should also aim to minimise risks to children.
- Supervision of methadone has been proven to reduce deaths related to overdose of methadone.
- Supervised consumption needs to be available for all patients for a length of time appropriate to their needs and risks.
- Ongoing assessment and care planning is central to the treatment process.

4. Assessment of dependence and management of OST

Contents: Phase 1 assessing dependence; Phase 2 induction phase; Phase 3 stabilisation; Phase 4 maintenance; and Phase 5 detoxification (p. 26). The key points are:

- Methadone or buprenorphine, used at the optimal dose range, are both effective medicines for OST.
- Dose induction with methadone should aim to achieve an effective dose, while also exercising caution about the inherent risks of too rapid an increase.
- Dose induction with buprenorphine may be carried out more rapidly, with less risk of overdose.
- Clinicians should aim to optimise treatment interventions for patients who are not benefiting from treatment, usually by providing additional and more intensive interventions (pharmacological and psychosocial) that may increase retention and improve outcomes.
- Once stable on OST, at least one dose per week should be supervised.
- Methadone and buprenorphine are both effective in detoxification regimens.
- OST is a medical treatment and should not be used punitively, i.e. there should be no dose reduction as a sanction for ongoing illicit drug use.
- Opioid detoxification should be offered as part of a care plan to patients who are ready for and committed to abstinence.
- Health professionals working in isolation must ensure they maintain up-to-date good practice.

5. Drug testing

Contents: objectives of drug testing; rationale; procedures for testing; usefulness of drug testing; urine sample adulteration; supervision of urine samples; testing for alcohol and Z-drugs (p. 38). The key points are:

- Drug testing may be used as an ongoing tool for monitoring illicit drug use and adherence with prescribed medications.
- Most drug testing processes consist of two separate types of analysis: a screening test and a confirmation test.
- The clinical situation will dictate the type of testing (screening or confirmatory) and frequency of testing.
- Once a patient reaches a stable point with OST, a reduction in frequency of drug testing is recommended.
- Drug testing should be randomised where possible.
- Direct observation of urine specimen collection is not required in routine clinical practice.
- The use of oral fluid drug testing is an acceptable alternative to urine drug testing.
- Drug testing results should be shared between treatment locations and agencies, with appropriate consent, to prevent the duplication of testing.

- Addiction services, including Level 1 and Level 2 GPs, nationally should have access to an appropriately accredited laboratory for drug testing/confirmatory analysis.
- Biological fluids should be handled with appropriate standard and transmission-based precautions.
- The recommendations for frequency of testing are to be viewed as a minimum standard for all patients receiving OST. In certain clinical situations, some patients may find that more regular testing may help them reach and maintain stability.
- Stability and safer prescribing of OST is assessed on a range of criteria, drug screening being one of those. There are limitations to the value of drug testing, and clinicians need to assess stability across a range of parameters.

6. OST and associated health considerations

Contents: responses to continued drug and alcohol misuse for patients; mental health; viral infections; vaccinations; health implications for continued drug and alcohol use; pain management for drug misusers; ECG monitoring; and drug-related deaths (overdose, reducing drug-related deaths, dealing with overdose emergency) (p. 43).

The key points are:

- OST should be provided with a range of other medical interventions.
- Psychosocial interventions can also address common associated or co-occurring mental disorders.
- Common mental health problems are frequent in people accessing addiction services. Interventions may need to be provided in addiction services, in conjunction with Community Mental Health Teams (CMHTs). Those with severe mental health problems should have care integrated with acute community-based secondary mental health services.
- Reducing potential harm due to overdose, blood-borne viruses, and other infections should be part of patient care.
- All drug users should be offered testing and vaccination against hepatitis A and B, where indicated. This discussion should be documented in the patient's record.
- All drug users should be offered testing and appropriate treatment for hepatitis C and HIV infections.
- Retaining patients in high-quality treatment is protective against overdose. This protection may be enhanced by other interventions, including training drug users and their families and carers in the risks of overdose, its prevention, and how to respond in an emergency.
- Drug users who are also using alcohol in a problematic way should be offered alcohol treatments.
- Drug users who smoke tobacco should be offered smoking cessation interventions.

7. Specific treatment situations and populations

Contents: hidden harm; criminal justice system (Garda custody, Drug Treatment Court, probation, prison); opiate-dependent patients in hospital; pregnancy and neonatal care; young people; older current and ex-drug users; and palliative care and life-limiting conditions (p. 57).

The key points are:

- Effective, safe and responsive services for service users involve working together and with others in teams in primary care and/or secondary care.
- Interventions must be carried out by trained and competent people with a clear understanding of the impact of problematic drug use.
- Appropriate communication and transfer of information between professionals is vital to ensure seamless care in line with the HSE consent policy.
- Assessment and evidence-based care provided by a liaison or multidisciplinary team is appropriate in many cases.
- Quality of treatment should be consistent across the criminal justice system, including prisons.
- Drug users in hospitals will require interventions that facilitate their medical treatment and, if possible, improve their engagement with drug misuse treatment.
- Clinicians working with pregnant women should aim to support the woman in achieving drug stability in order to reduce the risk of neonatal abstinence syndrome (NAS).
- Young people are likely to require different interventions compared to adults, and healthcare professionals will require specific competencies to deliver these interventions.
- Information sharing, governance, policies and practice should include guidance for clinicians working with the parents of under 18-year-old service users.

- Older drug users are likely to have increased drug-related and non-drug-related health needs. Drug users in pain will have needs for pharmacological and other interventions similar to non-drug users.

Updated community detoxification protocols for methadone and benzodiazepines

The Ana Liffey Drug Project has produced updated community detoxification protocols for both methadone and benzodiazepines (Ana Liffey Drug Project 2016a, Ana Liffey Drug Project 2016b). One of the main changes is the removal of the need for the mandatory broker role in the community detoxification structure. Key to the detoxification process is a named key worker or healthcare professional to provide psychosocial support and a GP to provide the necessary initial assessment and medical support throughout the process. There is an emphasis on psychosocial support and the key work process in the updated documents. The issues of dual diagnosis and mental health in community detoxification are discussed. Other updates relate to suggested detoxification schedules for methadone.

Methadone detoxification schedule 1

After stabilisation, dosage should be reduced every 1–2 weeks, which will bring the person down to zero in approximately 12 weeks, typically a reduction of 5 mg. While some people may prefer to detox more quickly at the beginning, there is currently no evidence to support whether this is more effective than that of a slowly tapered dose.

Methadone detoxification schedule 2

Reduction of dosage by 10 mg per week down to 40 mg per day, after which the dosage should be reduced by 5 mg per week. The reduction in dosage should be decided upon with the person, and there should not be more than one dosage change per week.

Timeframe for detoxification from methadone

The rate and pace of dosage reduction for detoxification should be decided on a case-by-case basis, depending on the needs and wishes of the person. For people with dual addiction with a hypnotic (e.g. benzodiazepines or Z-drugs) and methadone, the protocols recommend that they should be detoxified off the hypnotic first, then methadone. There are no updates to the suggested detoxification schedules for benzodiazepines.

The aim of the protocols is to improve service delivery and ensure best possible practice for each person seeking a detoxification. This in no way precludes healthcare professionals providing additional supports to meet the needs of person based on their particular circumstances: 'The Steering Committee fully recognises, and wishes to emphasise, the importance of local knowledge and expertise in ensuring successful delivery of services. There is nothing to prevent services mandating an individual or agency locally to promote and/or coordinate the new guidelines' (p. 11).

2. Trends

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

New treatment entrants (Figure 2.1.1)

In 2015, there were 3,742 new entrants recorded in the NDTRS (see also TDI table and Figure 2.1.1), almost identical to 2014 when there were 3,774 new entrants recorded. New treatment entrants represented 39.4% of all cases in 2015. The proportion of new entrants in treatment has fluctuated slightly over the 10-year reporting period, from 39.3% in 2004 to a peak of 47.2% in 2009 and down to 39.6% in 2014 before stabilising at 39.4% in 2015.

Between 2006 and 2010 opiates (mainly heroin) were the main problem drug reported by new entrants, but this was superseded by cannabis in 2011, and this trend continues. Cocaine peaked among new entrants in 2009 at 19.0%, dropping steadily thereafter until 2012 and then increasing again to 51.5% in 2015. Both amphetamines and ecstasy are reported only very rarely by new entrants to treatment.

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

All treatment entrants (Figure 2.1.2)

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

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

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

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

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

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

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

Opioid substitution treatment (OST) clients (Figure 2.1.3)

The number of clients registered for OST on 31 December each year reported by the Central Treatment List (CTL) has increased from 3,689 in 1998 to 9,917 in 2015 (personal communication, Caroline Comar, CTL) (see also Standard table 24). The increase is due to improvements in and expansion of services, with more clients availing of treatment and more facilities becoming available each year (Farrell and Barry 2010). Since 2008 the rate of increase has been less than 4% annually. The stabilisation in the number of clients registered on the CTL may in part be due to the decreasing number of younger clients (i.e. age 25 years or younger). The proportion of this group increased from 0.1% in 2000 (none were registered before that) to a peak of 6.7% in 2010. Since then the proportion has decreased year-on-year to 2.1% in 2015.

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

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

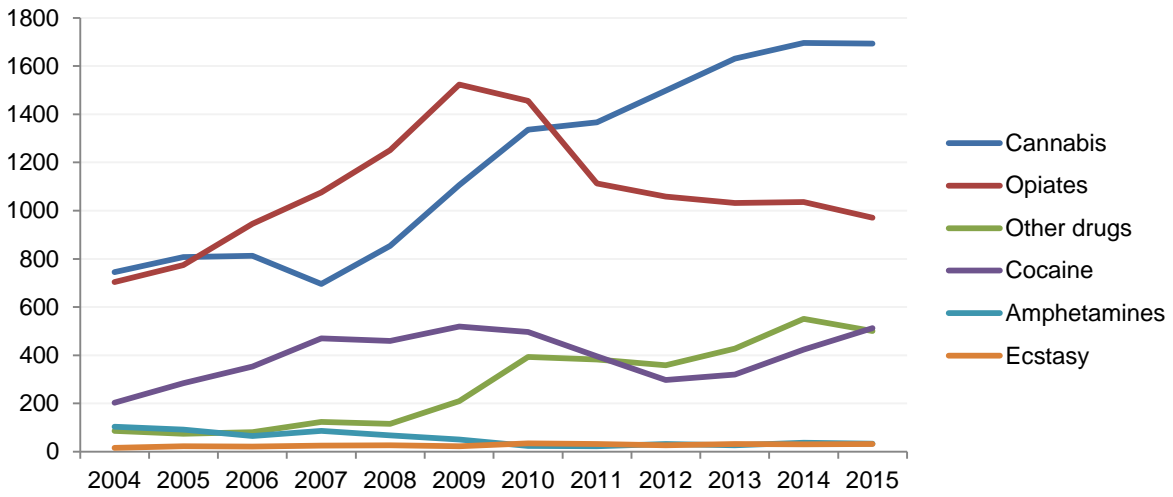


Figure 2.1.1 Trends in numbers of first-time clients entering treatment, by primary drug, 2004–2015
Source: TDI

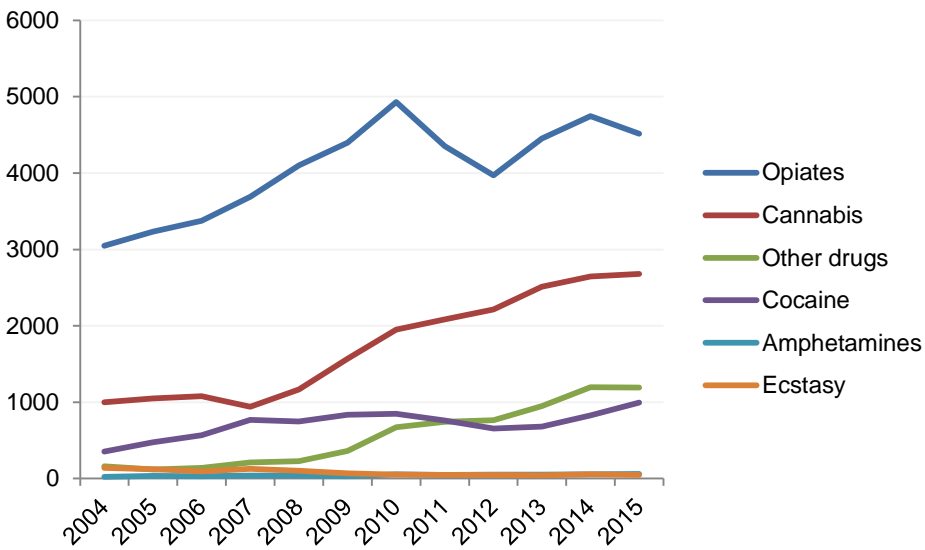


Figure 2.1.2. Trends in numbers of all clients entering treatment, by primary drug, 2004–2015
Source: TDI

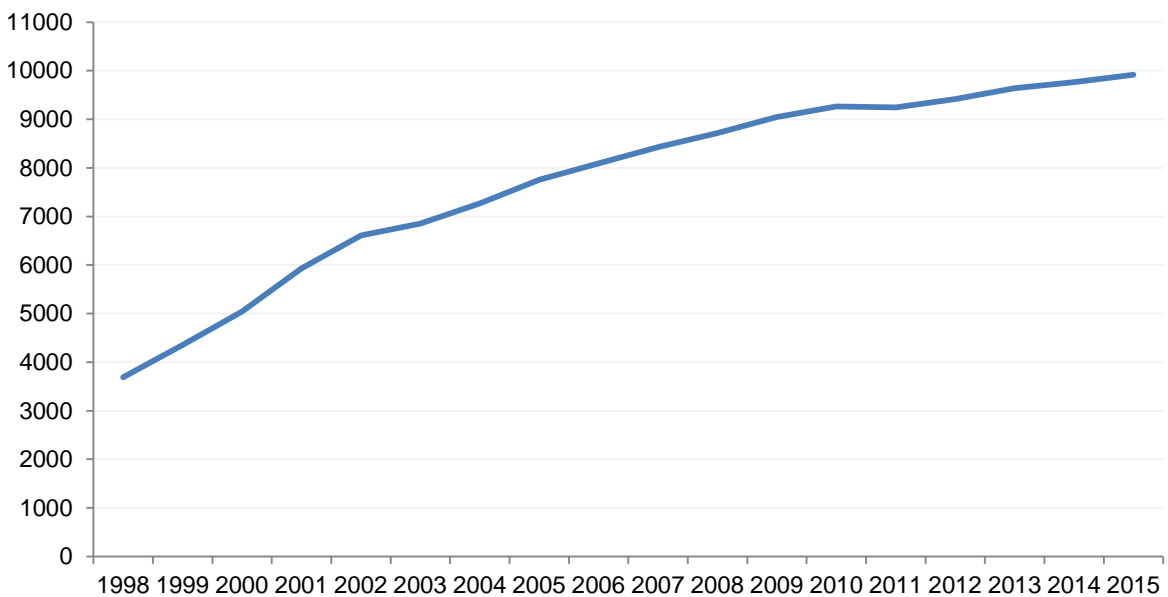


Figure 2.1.3 Trends in numbers of clients in opioid substitution treatment, 1998–2015
Source: CTL – Number of clients registered as of 31 December each year and ST 24

3. Sources, methodology and references

3.1 Sources

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

The **CTL** is an administrative database to regulate the dispensing of methadone treatment. Established under Statutory Instrument No 225 (Minister for Health and Children 1998), it is a complete register of all patients receiving methadone (as treatment for problem with opiate use) in Ireland. When a person is considered suitable for methadone detoxification, stabilisation or maintenance, the prescribing doctor notifies the CTL by completing an entry form, a unique number is allocated to the client and a treatment card is issued for clients when dispensed in community pharmacies. Numbers on the CTL are published annually by the Health Service Executive and Health Research Board.

The **NDTRS** is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems’. The NDTRS is a case-based, anonymised database. It is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

3.2 Methodology

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

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

Self-concept

Depression

Anxiety

Anger, and

Disruptive behaviour

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

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

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

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

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances

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