Focal Point Ireland: national report for 2018 - harms and harm reduction

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

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(2019) *Focal Point Ireland: national report for 2018 – prevention*.
(2019) *Focal Point Ireland: national report for 2018 – legal framework*.
(2019) *Focal Point Ireland: national report for 2018 – prison.*
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T0. Summary

Ireland maintains a special register, which is a complete census of all drug-induced deaths. 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 drug poisoning, and 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.

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

The number of overdose cases admitted to Irish hospital 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 notified in the Republic of Ireland is stabilising, rather than continuing to decline. There has been an overall increase in the number of notifications of HIV. The increased number of people who inject drugs (PWID) among HIV notifications in 2014 was due to an outbreak of HIV among homeless drug users in Dublin.

Harm reduction services available in Ireland include needle exchange from fixed sites and mobile units, and outreach work provided by regional authorities and community-based organisations. In addition, there are pharmacies providing needle exchange in each regional drug and alcohol task force (RDATF) area in Ireland. At the end of 2017, there were 111 pharmacies providing needle exchange. A total of 519,578 individual syringes were exchanged in the Republic of Ireland in 2017.

T1. National profile and trends

T1.1 Drug-related deaths

T1.1.1 Overdose deaths

At time of publication there was no new data for 2016 poisoning deaths in Ireland (the most recent data collection year).

[2016 data available March 2019 https://www.drugsandalcohol.ie/deaths-data/]

T1.1.2 Toxicology of overdose deaths

At time of publication there was no new data for 2016 on toxicology for poisoning deaths in Ireland. [2016 data available March 2019 https://www.drugsandalcohol.ie/deaths-data/]

T1.1.3 Mortality cohort studies

There are no mortality cohort studies to report for 2017.

T1.1.4 Trends

T1.1.5 Overview of all drug-related deaths (including alcohol) in Ireland, 2014

The annual overview of all drug-related deaths in Ireland for 2015 showed that alcohol continued to be the drug most commonly implicated in poisoning deaths. This overview includes both illicit drugs (covered by Section D and reported through ST5 and 6) and also other substances such as alcohol and prescription medication not reported in ST5 and 6**.** It also includes data on non-poisoning deaths among drug users (Health Research Board 2017).

In the twelve-year period 2004–2015 there were a total of 7,422 drug-related deaths: 4,222 (57%) were due to poisoning and 3,200 (43%) were non-poisoning.

In 2015, there were 695 deaths (poisoning and non-poisoning combined), marginally lower than the number reported in 2014 (n=719). The median age for all deaths in 2015 was 41 years and 72% (n=503) of all deaths were male. There were approximately 20,000 of potential life years lost because of drug-related deaths in 2015.

People who were injecting at the time of the incident that lead to their death represented 8% of all drug-related deaths in 2015. Of these deaths:

- 93% were male
- 89% were poisoning deaths
- 52% died in Dublin City
- 94% of the poisoning deaths involved opiates.

Poisoning deaths in 2015

The annual number of poisoning deaths decreased by 4%, from 364 in 2014 to 348 in 2015. Almost two thirds of poisoning deaths involved polydrugs, with an average of four different drugs involved. Benzodiazepines were the most common drug group implicated in polydrug deaths.

Prescription drugs were implicated in two out of three poisoning deaths:

- Diazepam (a benzodiazepine) was the most common single prescription drug, implicated in almost one third (101, 29%) of all poisonings
- Methadone was implicated in a quarter of poisonings (86, 25%)
- Pregabalin-related deaths (an anti-epileptic drug which is also prescribed for chronic pain and for some anxiety conditions) increased by 69%, from 26 deaths in 2014 to 44 in 2015.

Cocaine-related deaths have been increasing since 2010 with 44 deaths reported in 2015 compared to 21 in 2010. Alcohol was implicated in 107 deaths (31% of all poisonings) and alcohol alone was responsible for 14% (n=47) of all poisoning deaths in 2015.

Of those injectors who died in 2015 of a poisoning death which involved opiates:

- 40% were not alone at the time of the incident that led to their death
- 20% injected in a public place
- 27% involved a single opiate type drug.

Non-poisoning deaths in 2015

The number of non-poisoning deaths deceased by 2%, from 355 in 2014 to 347 in 2015. The main causes of non-poisoning deaths were hanging (83, 24%) and cardiac events (55, 16%). Of those who died as a result of hanging, over a half (59%) had a history of mental health problems.

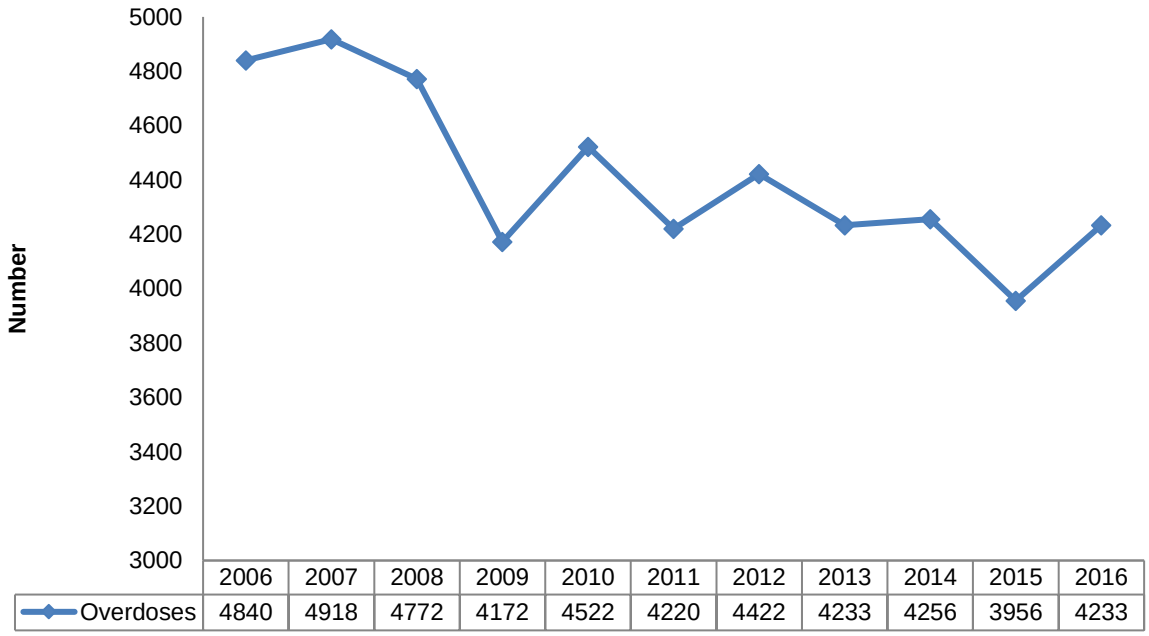
T1.2 Drug related acute emergencies

T1.2.1 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 HIPE scheme were analysed to determine trends in non-fatal overdoses in patients discharged from Irish hospitals in 2016. There were 4,311 overdose cases in that year; of these cases, 78 died in hospital. Only discharged cases are included in this analysis. The number of overdose cases was up from the 3,956 recorded in 2015. However, trends over time indicate a general decrease in overdose cases admitted to Irish hospitals (Figure T1.2.1.1).

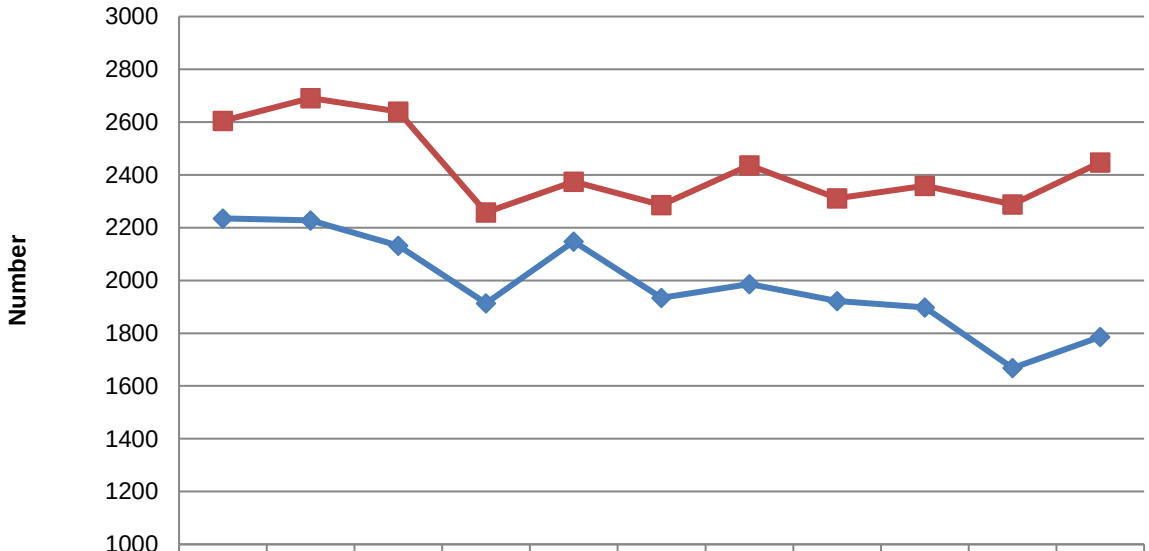


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Overdoses	4840	4918	4772	4172	4522	4220	4422	4233	4256	3956	4233

Figure T1.2.1.1 Number of overdose cases admitted to Irish hospitals, by year, 2006–2016
Source: HIPE, Healthcare Pricing Office, 2018

Gender

Between 2006 and 2016, there were more overdose cases among women than men, with women accounting for 2,447 (58%) of all non-fatal overdose cases in 2016 (Figure T1.2.1.2).

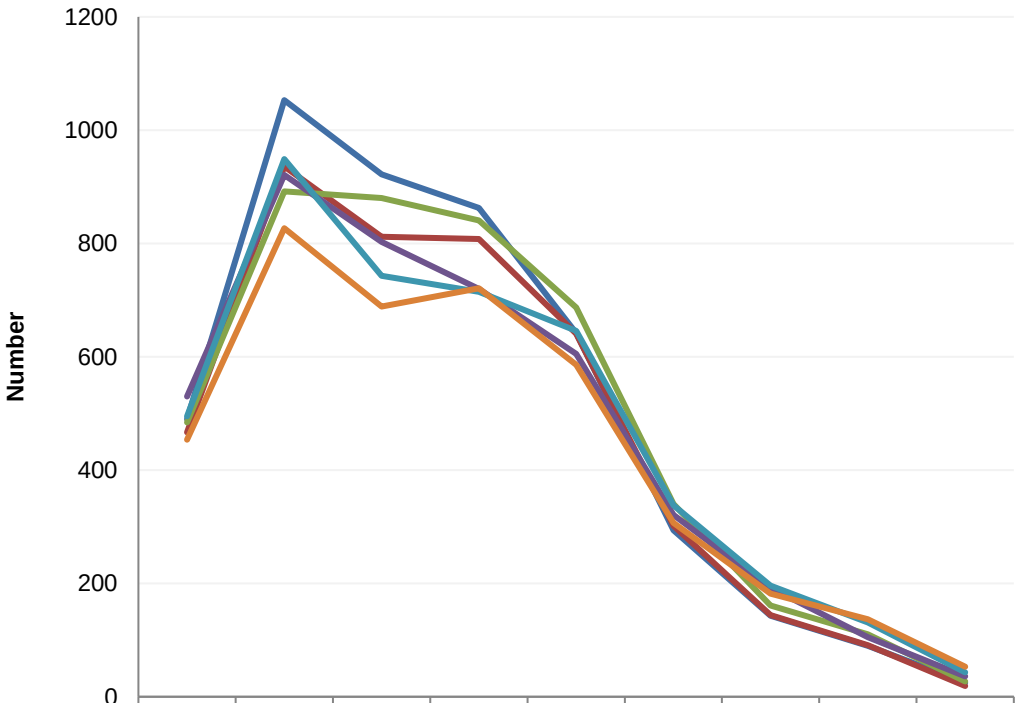


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Males	2235	2227	2132	1914	2148	1934	1986	1922	1898	1668	1786
Females	2605	2691	2640	2258	2374	2286	2436	2311	2358	2288	2447

Figure T1.2.1.2 Number of overdose cases admitted to Irish hospitals, by year and gender, 2006–2016
Source: HIPE, Healthcare Pricing Office, 2018

Age group

Between 2015 and 2016, there was an increase in the number of non-fatal overdose cases among those aged 24 years or under, and in adults aged between 55 and 74 years. As noted in previous national reports, the incidence of overdose cases peaked in the 15–24 age group, and thereafter decreased with age (Figure T1.2.1.3). In 2016, 36% of cases were aged under 25 years.



	0-14 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
2010	490	1053	922	863	642	294	143	90	25
2011	467	936	812	808	641	302	144	91	19
2012	484	892	880	841	687	340	161	110	27
2013	530	921	803	720	605	321	192	105	36
2014	495	949	743	715	646	338	196	131	43
2015	454	827	689	721	586	307	182	137	53

Figure T1.2.1.3 Non-fatal overdose cases admitted to Irish hospitals, by year and age group, 2010–2015
Source: HIPE, Healthcare Pricing Office, 2017

T1.2.2 Toxicology of drug-related acute emergencies

Drugs involved

Table T1.2.2.1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2016.

Non-opioid analgesics were present in 1,566 of these cases. Paracetamol is included in this drug category and was present in 1,275 cases. Psychotropic agents and benzodiazepines were taken in 1,041 and 778 cases, respectively. There was evidence of alcohol consumption in 325 cases. Cases involving alcohol are included in this analysis only when alcohol was used in conjunction with another substance.

Table T1.2.2.1 Categories of drugs involved in non-fatal overdose cases admitted to Irish hospitals, 2016*

Drug category	Number
Non-opioid analgesics	1566
Paracetamol (4-Aminophenol derivatives)	*1275*
Benzodiazepines	778
Psychotropic agents	1041
Anti-epileptic/sedative/anti-Parkinson agents	1910

Drug category	Number
Narcotics and hallucinogens	692
Alcohol**	325
Systemic and haematological agents	172
Cardiovascular agents	159
Autonomic nervous system	123
Anaesthetics	16
Hormones	129
Systemic antibiotics	60
Gastrointestinal agents	107
Other chemicals and noxious substances	268
Diuretics	51
Muscle and respiratory agents	33
Topical agents	36
Anti-infectives/anti-parasitics	25
Other gases and vapours	48
Other and unspecified drugs	886

Source: HIPE, Healthcare Pricing Office, 2018

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

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

Overdoses involving narcotics or hallucinogens

Figure T1.2.2.1 shows positive findings of illicit substances among overdose cases in 2016. Opiates were used in 13% (554) of these cases, cocaine in 2.7% (116) and cannabis in 1.3% (53) of cases. There were no overdose cases involving hallucinogenic substances.

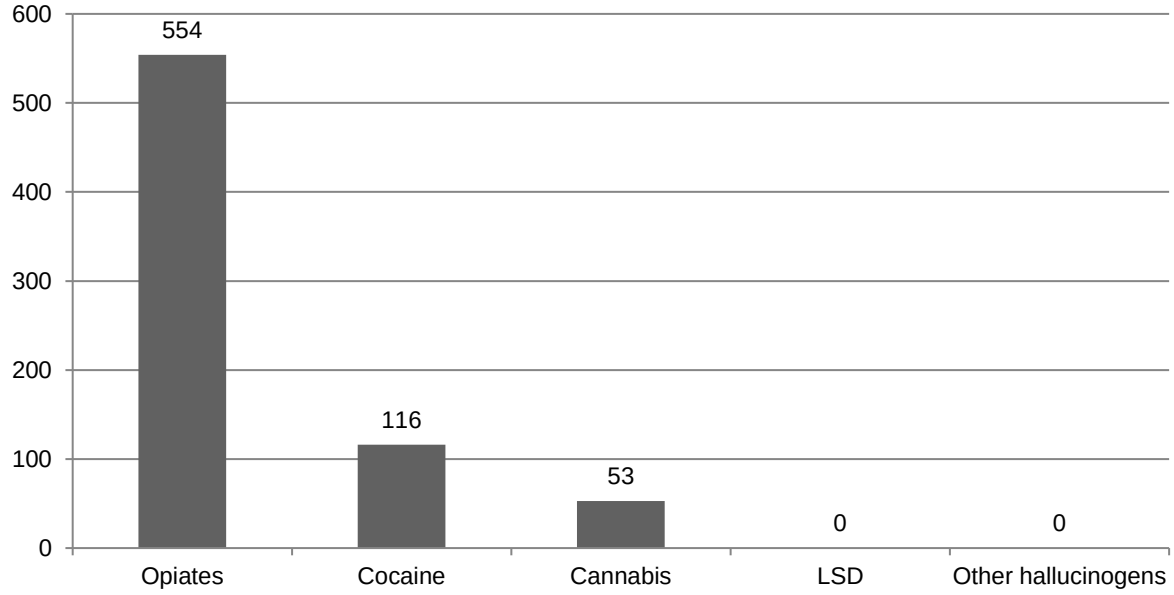


Figure T1.2.2.1 Narcotics and hallucinogens involved in overdose cases admitted to Irish hospitals, 2016
Source: HIPE, Healthcare Pricing Office, 2018

Overdoses classified by intent

In 2016, for 63% (2,671) of cases, the overdose was classified as intentional (Figure T1.2.2.2). For 439 cases, classification of intent was not clear.

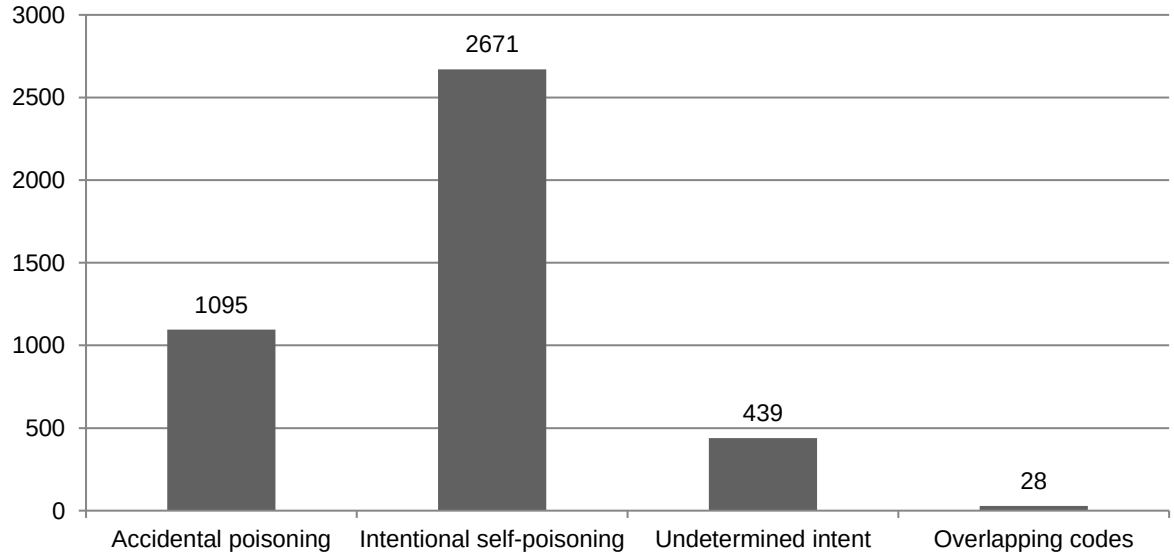


Figure T1.2.2.2 Overdose cases admitted to Irish hospitals, classified by intent, 2016
Source: HIPE, Healthcare Pricing Office, 2018

Table T1.2.2.2 presents the positive findings per category of drugs and other substances involved in cases of intentional self-poisoning (n=2,671) in 2016. Non-opioid analgesics were involved in 1,277 cases; benzodiazepines were involved in 583 cases, and psychotropic agents in 788 cases.

Table T1.2.2.2 Categories of drugs involved in intentional self-poisoning cases admitted to Irish hospitals, 2016*

Drug category	Number
Non-opioid analgesics	1277
Benzodiazepines	583
Psychotropic agents	788

Drug category	Number
Anti-epileptic/sedative/anti-Parkinson agents	1384
Narcotics and hallucinogens	375
Alcohol**	252
Systemic and haematological agents	98
Cardiovascular agents	88
Autonomic nervous system	81
Anaesthetics	7
Hormones	83
Systemic antibiotics	38
Gastrointestinal agents	85
Other chemicals and noxious substances	91
Diuretics	26
Muscle and respiratory agents	12
Topical agents	6
Anti-infectives/anti-parasitics	14
Other gases and vapours	~
Other and unspecified drugs	476

Source: HIPE, Healthcare Pricing Office, 2018
*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.

T1.2.3 Explanations of short term (5 years) and long term trends in the number and nature of drug-induced emergencies

No information

T1.2.4 Additional information on drug-related acute emergencies

Frequently used drug types and intentional drug overdoses in Ireland

Intentional drug overdose (IDO) is the most common form of hospital-treated self-harm, involved in between 65% and 85% of presentations in Ireland, as reported by National Self-Harm Registry Ireland (Perry*, et al.* 2012). However, no national study has systematically classified the range of drugs involved using a validated system in Ireland. The Anatomical Therapeutic Chemical (ATC) system is a World Health Organization-recommended classification system designed to measure drug utilisation at an internationally comparable level (WHO Collaborating Centre for Drug Statistics Methodology 2017). Recently conducted research aimed to examine drugs taken in IDO according to the ATC classification (Daly, Caroline*, et al.* 2018).

In this study, published in the *European Journal of Public Health,* presentations of IDO in the Republic of Ireland for the period 1 January 2012 to 31 December 2014 were examined, and information on demographic and overdose characteristics obtained. Drugs were classified according to their use at the time of ATC system application (December 2016). Illegal drugs were identified using the Misuse of Drugs Acts, 1984.[1]

Results

During the study period, there were 18,329 self-harm presentations involving IDO, representing 67.6% of all self-harm presentations. The majority (58.7%) of presentations were made by females. The majority of IDO presentations involved overdose only (89.5%), with self-cutting identified as the most common combined method, involved in 6.5% of IDOs. Alcohol was present in 40.6% of IDOs and was more common in male presentations (44.7% vs 37.8%, p<0.01). The median number of total tablets taken per IDO case was 23 for males and 20 for females, with over one-third of presentations involving the ingestion of between 20 and 49 tablets.

The drugs that were most frequently used in IDO are shown in Figure T1.2.4.1. The most frequently used drug was paracetamol, which was involved in 27.8% of IDOs. Anti-inflammatory drugs (ibuprofen and diclofenac) and antidepressant drugs (escitalopram and venlafaxine) were also frequently taken in IDO (6.6%, 2.4%, 5.1% and 3.4%, respectively). Illegal drugs were involved in 6% of IDOs.

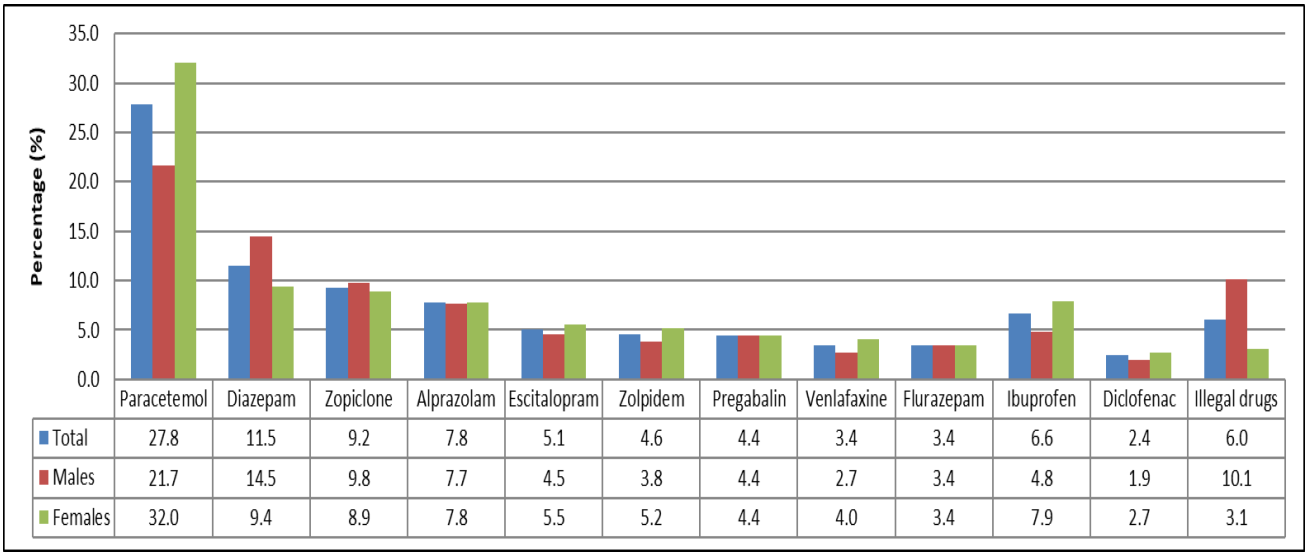
Other key findings from the study included the following:

- Significant gender differences were found in relation to drugs involved in IDO. Musculoskeletal system drugs were significantly more common in female, as compared with male, IDOs (14% vs 9.2%, p<0.01). Similarly, IDOs involving analgesics and antidepressants were significantly more common in female presentations (36.4% vs 26.7%, p<0.01 and 23.9% vs 19.1%, p<0.01). In particular, paracetamol was involved significantly more often in female IDOs (32% vs 21.7%, p<0.01).
- Illegal drugs were three times more common in male, as compared with female, presentations (10.1% vs 3.1%, p<0.01).
- Alcohol involvement in IDO was significantly higher in male, as compared with female, presentations (44.7% vs 37.8%, p<0.01).
- Alcohol was most frequently consumed in presentations involving illegal drugs (47.8%), followed by anxiolytics (49.3%, p<0.01).

[1] Further information on all legislation, statutory instruments and regulations referred to in this workbook can be retrieved from the Electronic Irish Statute Book (http://www.irishstatutebook.ie/)

Conclusions

The results from this research suggest that people who engage in IDO frequently take prescription-only or sales-restricted drugs, and that IDOs often involve alcohol and/or polydrug use. The authors concluded that the findings highlight the importance of addressing drug and alcohol misuse, potential inappropriate prescribing, and the enforcement of legislation restricting specific drug sales.



	Paracetemol	Diazepam	Zopiclone	Alprazolam	Escitalopram	Zolpidem	Pregabalin	Venlafaxine	Flurazepam	Ibuprofen	Diclofenac	Illegal drugs
Total	27.8	11.5	9.2	7.8	5.1	4.6	4.4	3.4	3.4	6.6	2.4	6.0
Males	21.7	14.5	9.8	7.7	4.5	3.8	4.4	2.7	3.4	4.8	1.9	10.1
Females	32.0	9.4	8.9	7.8	5.5	5.2	4.4	4.0	3.4	7.9	2.7	3.1

Figure T1.2.4.1 Drugs frequently involved in IDO in Ireland, total and by gender, 2012–2014
Source: Daly *et al*., 2018

Hospital presentations and preceding factors of drug overdose among adolescents

Background

Suicide is one of the major causes of death in many populations, particularly among adolescents, and poisoning or drug overdose (OD) is the leading method of attempted suicide. Public health interventions aim to reduce the morbidity and mortality of self-poisoning by limiting the availability of potentially toxic medications to at-risk populations. An understanding of the preceding factors and potential triggers of self-poisoning/drug overdose may aid in the development of specific intervention strategies.

Recent Irish research aimed to highlight the pattern of presentations and preceding factors of OD in an adolescent population (Maduemem*, et al.* 2018). In this study, which was published in the *Irish Medical Journal,* the authors retrospectively evaluated the data of 85 adolescents (81.2% female) presenting with OD to a large regional hospital in Ireland over a three-year period. Data were retrieved from the Hospital Inpatient Enquiry (HIPE) system, and included information on patients' demographics, preceding factors and drugs used in OD.

Results

The median age at presentation was 15.83. The median time from event to hospital presentation was 2.6 hours, with the mean length of hospital stay being 2.24 days. Thirty-eight (44.7%) adolescents had a history of deliberate non-drug-related self-harm while 14.1% (n=12) were

previously seen for deliberate self-poisoning/OD. Among factors associated with OD, the following were noted:

- Depression was the most common mental health problem associated with OD.
- Other preceding factors included unstable family dynamics, family history of mental illness, social problems and romantic break-ups.
- Certain factors had gender predilection; substance abuse and conduct disorder were more common among males.

The drugs implicated in adolescent OD presentations are shown in Figure T1.2.4.2. The most common agents of overdose were analgesics (n=83), with acetaminophen being the most commonly used analgesic. Other drugs used in OD cases included antidepressants, antipsychotics, antibiotics and antihistamines. Forty-six (54.1%) cases presented with polypharmacy overdose. Three patients (3.5%) inhaled aerosol of kitchen spray, while concomitant alcohol (vodka) and drug overdose was documented in 17.6% (15/85) of cases.

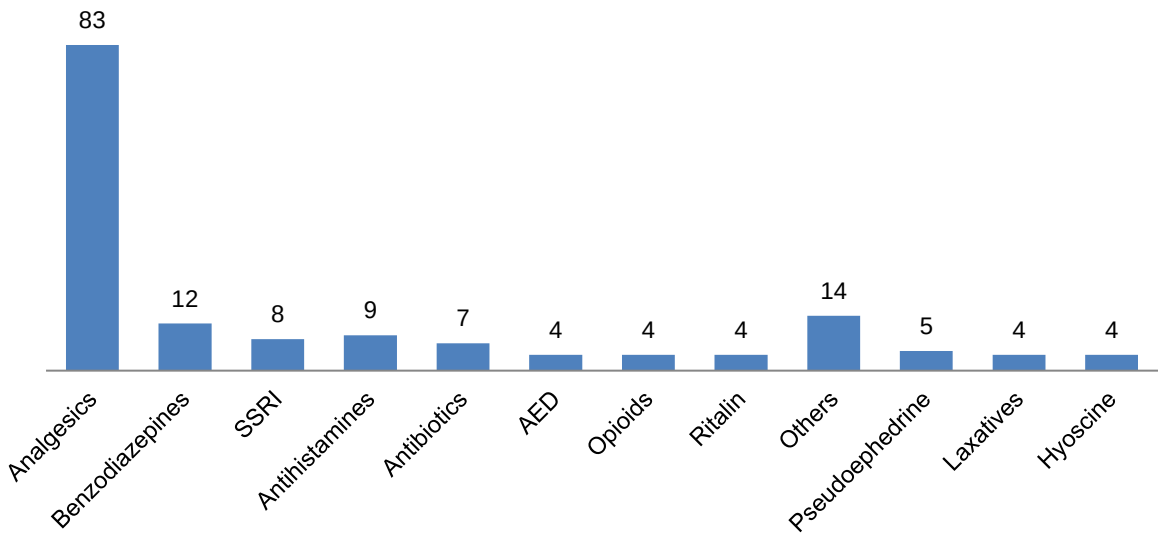


Figure T1.2.4.2 Number of drugs implicated in OD among adolescents
Source: Maduemem K, Adedokun C, Umana E, 2018
SSRI: Selective serotonin reuptake inhibitor
AED: Anti-epilepsy drug
Others: multivitamins; iron; lyrica; eltroxin; oral contraceptive pills; valeriana; pantoprazole; furosemide; statin; ecstasy; bleach; kitchen spray

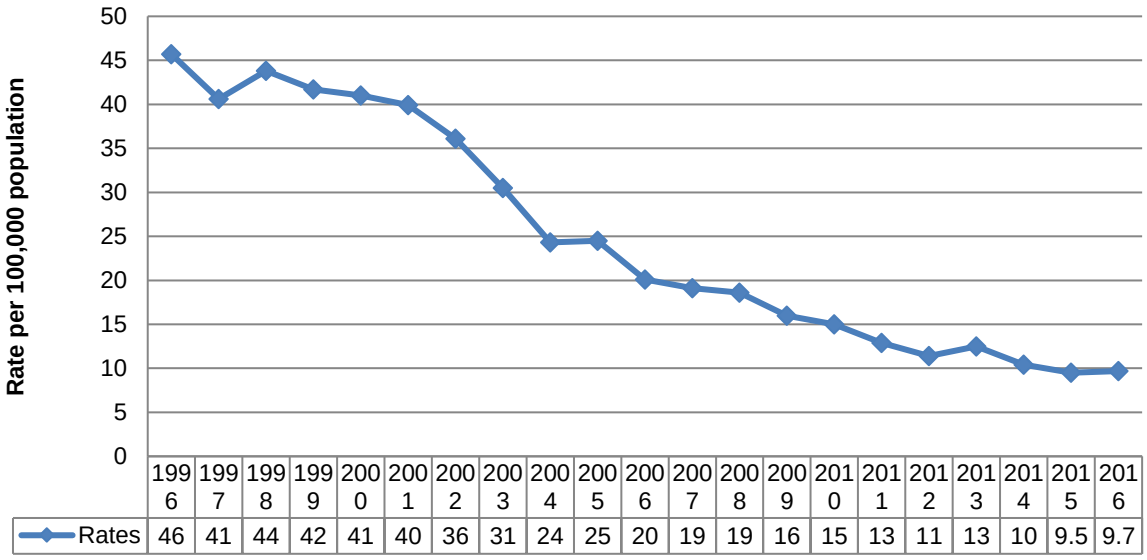
Conclusions

The authors suggest that the number of OD patients in this study probably represent only a small proportion of OD cases among adolescents and that it is likely that substantial numbers of self-poisoning occur in the community. Gender differences should be considered in the assessment, prevention, and management of future self-harm or suicides by community policy-makers and clinicians.

Trends in alcohol and drug admission to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2016 (Daly, Antoinette and Craig 2018), the annual report published by the Health Research Board Mental Health Information Systems Unit, shows that the number of new admissions to inpatient care for alcohol disorders has stabilised.

In 2016, some 1,260 cases were admitted to psychiatric facilities with an alcohol disorder; of these 445 were treated for the first time. Figure T1.2.4.3 presents the rates of first admission between 1996 and 2016 for cases with a diagnosis of an alcohol disorder. The admission rate in 2016 was similar to the previous year, while trends over time indicate an overall decline in first admissions. Slightly less than one-third of cases hospitalised for an alcohol disorder in 2016 stayed just under one week, while 28% of cases were hospitalised for between one and three months, a rate similar to previous years.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Rates	46	41	44	42	41	40	36	31	24	25	20	19	19	16	15	13	11	13	10	9.5	9.7

Figure T1.2.4.3 Rates of psychiatric first admission of cases with a diagnosis of an alcohol disorder per 100,000 of the population in Ireland, 1996–2016
Source: Daly and Craig, 2018

In 2016, some 943 cases with a diagnosis of a drug disorder were admitted to psychiatric facilities. Of these cases, 415 were treated for the first time. Figure T1.2.4.4 presents the rates of first admission between 1996 and 2016 of cases with a diagnosis of a drug disorder. Although the rate decreased slightly in 2016, there has been an overall increase in the rate of first admission of cases with a diagnosis of a drug disorder since 2011. It should be noted that the report does not present data on drug use and psychiatric comorbidity, so it is not possible to determine whether or not these admissions were appropriate.

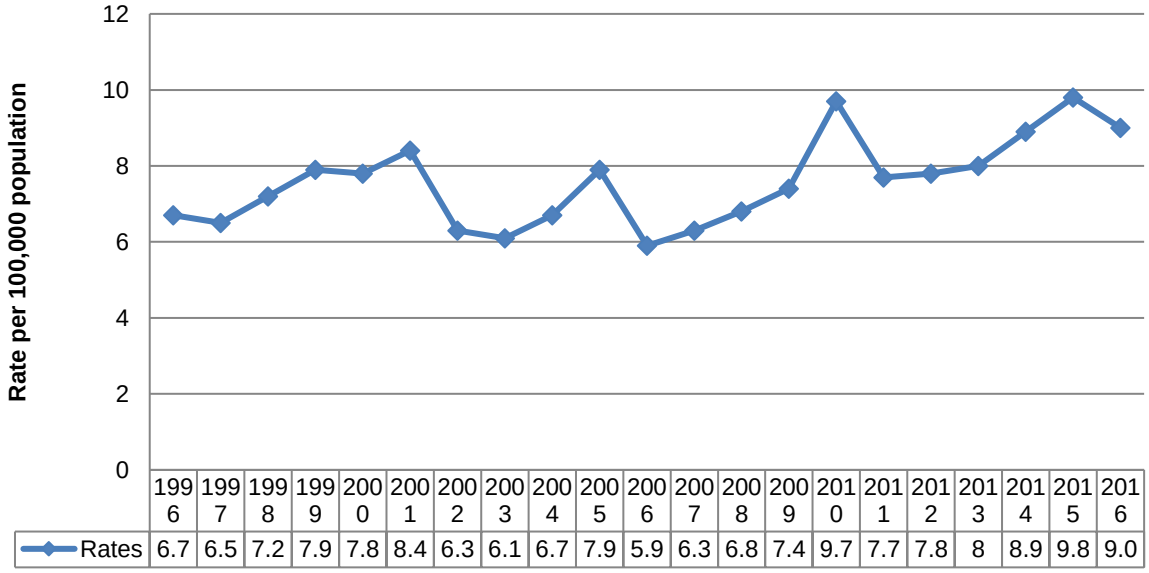


Figure T1.2.4.4 Rates of psychiatric first admission of cases with a diagnosis of a drug disorder per 100,000 of the population in Ireland, 1996–2016
Source: Daly and Craig, 2018

Other notable statistics on admissions for a drug disorder in 2016 include the following:

- Just over half of cases hospitalised for a drug disorder stayed under one week (52.6%), while 99% were discharged within three months. It should be noted that admissions and discharges represent episodes or events and not persons.
- 14% of first-time admissions were involuntary.
- Similar to previous years, the rate of first-time admissions was higher for men (12.2 per 100,000) than for women (4.9 per 100,000).

Alcohol-related presentations to emergency departments in Ireland

A recent report from the World Health Organization demonstrated that almost half of Irish drinkers engage in heavy drinking on a regular basis, placing Ireland's binge drinking rates at the second highest of 174 countries studied (World Health Organization 2014). A national survey found that 75% of the alcohol consumed in Ireland was part of a binge drinking session (Long and Mongan 2014). Emergency departments (EDs) respond to many of the consequences of alcohol-related harm associated with binge drinking. However, knowledge of the prevalence of alcohol-related presentations to EDs in Ireland is limited to localised or single-site studies. Consequently, there has been no nationally agreed systematic way of counting alcohol-related presentations.

Recent research aimed to investigate the scale of alcohol-related presentations to EDs in Ireland (McNicholl*, et al.* 2018). In this study, which has been published in the journal *BMJ Open*, the authors developed a pragmatic method of investigating alcohol-related presentations in a nationally representative sample by reviewing all records in the same four 6-hour periods in every 24-hour ED in Ireland. The dates and times were chosen to broadly represent times that are busy and quiet, as alcohol-related presentations are likely to vary by time of day, week and season. The main outcome

measure was the prevalence of alcohol-related presentations, and this was compared with presentations that were not alcohol related.

It was found that during the four 6-hour periods, there was a total of 3,194 presentations to EDs, of which 189 (5.9%) were alcohol related. This varied from 29% in the early hours of Sunday morning to 1.2% on Monday morning. Alcohol-related presentations to EDs were more likely to be men, attend on early hours of Sunday morning, arrive by ambulance, leave before being seen by a doctor or leave against medical advice. They were also less likely to be admitted to hospital.

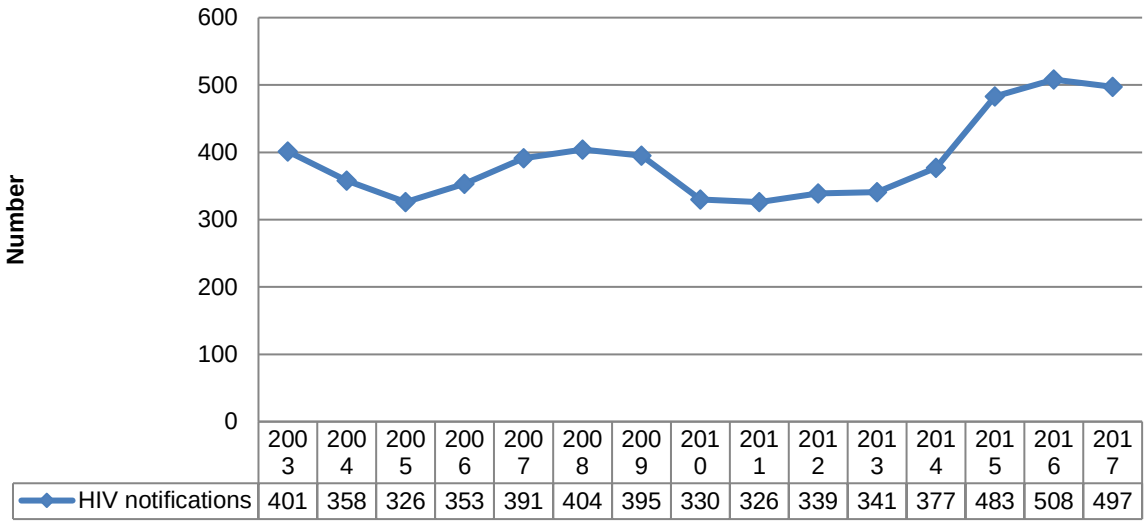
The authors concluded that alcohol is a significant burden on EDs, especially on Saturday nights and Sunday mornings, and that the impact of alcohol-related presentations on ED staff and other patients is likely to add to the stress on patients and staff. This in turn may challenge the quality of care provided. They suggest that addressing the alcohol-related burden on EDs requires improvements in data collection and information systems, the development of appropriate interventions and related referral services in addition to better preventive actions for alcohol-related harm.

T1.3 Drug related infectious diseases

T1.3.1 Main drug-related infectious diseases among drug users – HIV, HBV, HCV

HIV notifications, 2017

According to data compiled by the HPSC, at the end of 2017, 497 people were newly diagnosed with HIV in Ireland, a notification rate of 10.4 per 100,000 population. This marks a decrease of 2% compared with 2016 (n=508) (Figure T1.3.1.1).



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HIV notifications	401	358	326	353	391	404	395	330	326	339	341	377	483	508	497

Figure T1.3.1.1 Number of new HIV notifications reported in Ireland, by year of notification, 2003–2017
Source: Health Service Executive (HSE) and HPSC, 2018

Of HIV notifications in 2017:

- 321 were male and 82 were female.

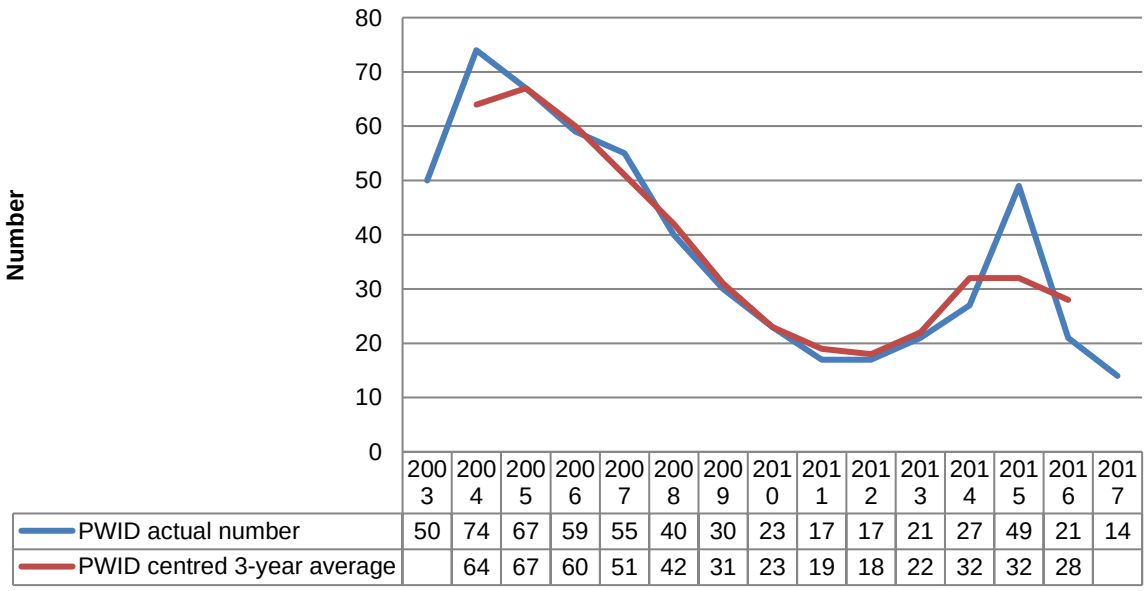
- 252 were men who have sex with men.
- For 18.9% (94) of HIV notifications in 2017, there was no reported risk factor, although this is likely to change as more data become available.

In 2017, 14 HIV notifications were PWID (Table T1.3.1.1). This compares with 21 notifications in 2016 and 49 notifications in 2015. The figure for 2017 is the lowest number of PWID among HIV notifications since data have been routinely collected (Figure T1.3.1.2).

Table T1.3.1.1 New HIV notifications reported to the HPSC by risk factor status, 2016

Risk factor status	n (%)
Total	497
Cases *with* reported risk factor data	403 (81.1)
Of which:	
Male	321 (79.7)
Female	82 (20.3)
Gender unknown	0 (0)
Injecting drug users	14 (3.5)
Men who have sex with men	252 (62.5)
Recipient blood/blood products	0 (0)
Other risk factors	137 (27.5)
Cases *without* reported risk factor data	94 (18.9)

Source: HSE and HPSC, 2018



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
PWID actual number	50	74	67	59	55	40	30	23	17	17	21	27	49	21	14
PWID centred 3-year average		64	67	60	51	42	31	23	19	18	22	32	32	28	

Figure T1.3.1.2 Number and rolling average number of PWID among HIV notifications reported in Ireland, by year of notification, 2003–2017
Source: HSE and HPSC, 2018

Of the PWID among HIV notifications in 2017, 12 were male and 2 were female, with a median age of 35. No subjects were under 25 years of age. The majority (57%) lived in Dublin, Kildare or Wicklow (Table T1.3.1.2).

Table T1.3.1.2 Characteristics of new HIV notifications who reported injecting drug use as a risk factor, 2017

Known injector cases	n (%)
Total	14
Gender	
Male	12 (85.7)
Female	2 (14.3)
Gender unknown	0 (0)
Age	
Mean age	37
Median age	35
Under 25 years	0 (0)
25–34 years	3 (21.4)
Age unknown	0 (0)
Place of residence	
Dublin, Kildare or Wicklow	8 (57.1)
Elsewhere in Ireland	6 (42.8)

Source: HSE and HPSC, 2017

The increased number of PWID among HIV notifications in 2014/15 was due to an outbreak of HIV among homeless drug users in Dublin (See 2016 Harms and Harm Reduction workbook, Section T1.3.6).

HBV notifications, 2016

There were 534 notifications of HBV in 2017, an increase of 9% on 2016, when there were 489 notifications. The notification rate for 2017 was 11.2 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 T1.3.1.3).

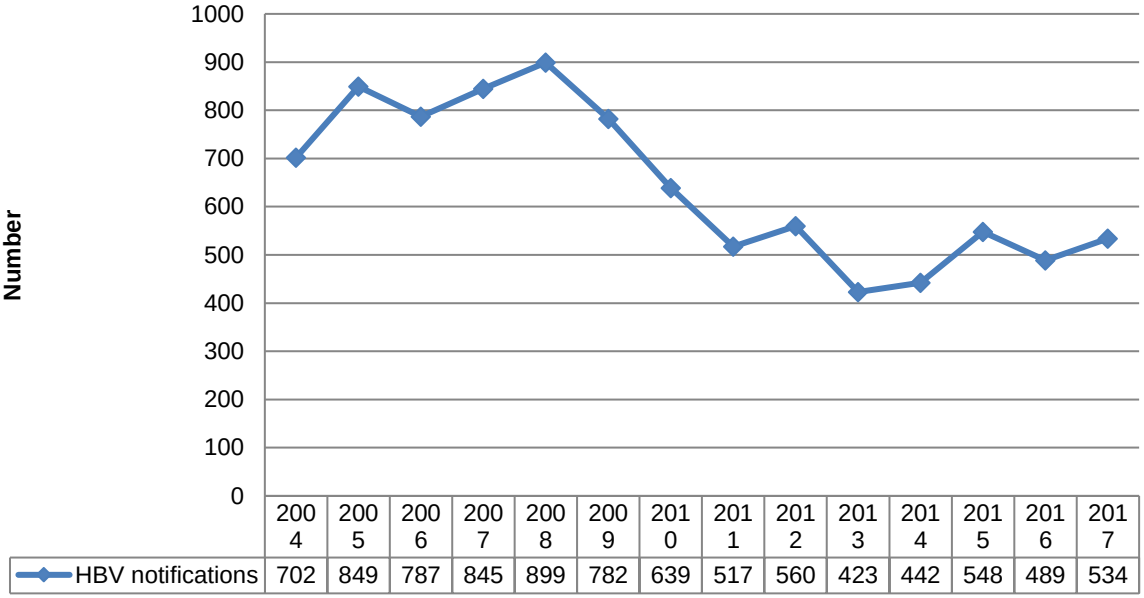


Figure T1.3.1.3 Number of HBV notifications reported in Ireland, by year of notification, 2004–2017
Source: HSE and HPSC, 2018

Eighty-six per cent (n=457) of the 534 HBV notifications in 2017 contained information on acute/chronic status. Of these, 93% (n=426) were chronically infected (long-term infection) and 7% (n=31) were acutely infected (recent infection).

Risk factor data were available for 71% (n=22) of the acute cases notified in 2017. Of these acute cases, only one notification was an injecting drug user (Table T1.3.1.3).

Table T1.3.1.3 Acute and chronic new HBV cases reported to the HPSC, 2017

HBV status	Acute	Chronic	Unknown
	n (%)	n (%)	n (%)
Total	31	426	77
% of cases by status	(5.8)	(79.8)	(14.4)
Cases with reported risk factor	22	71	6
% of cases with risk factor data	(71)	(17)	(19)
Of which:			
Injecting drug users	1	3	0
Cases without reported risk factor data	9	354	71
% of cases without risk factor data	(29)	(83)	(81)

Source: HSE and HPSC, 2018
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.

HCV notifications, 2017

There were 621 HCV notifications in the Republic of Ireland in 2017, a decrease of 4% on 2016, when there were 650 notifications. The notification rate for 2017 was 13.0 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 T1.3.1.4). While notifications continued to decline slightly in 2017, 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 well.

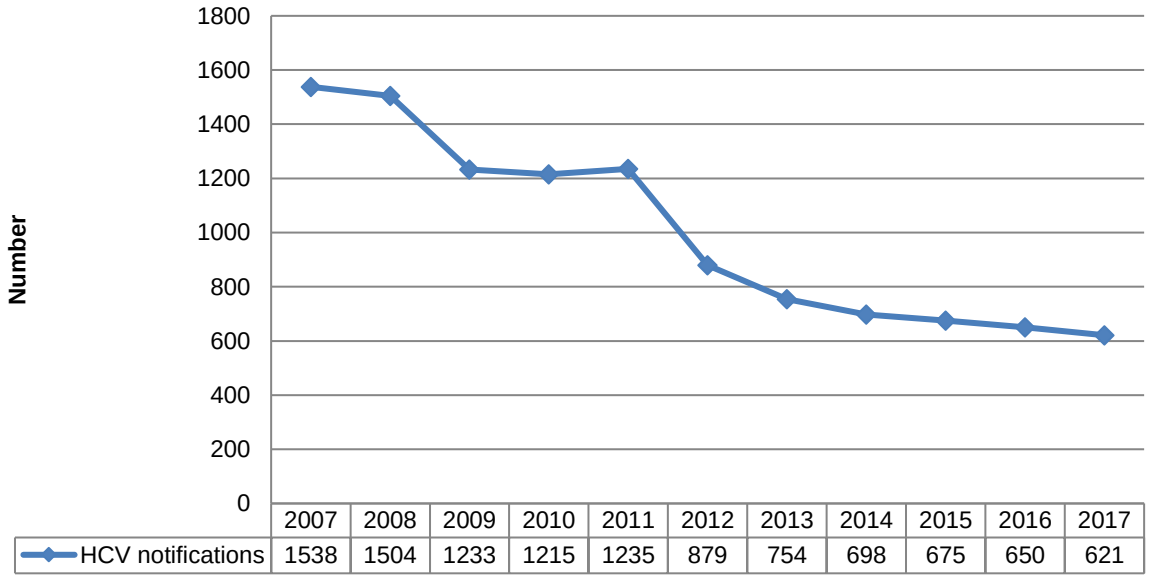


Figure T1.3.1.4 Number of HCV notifications reported in Ireland, by year of notification, 2007–2017
Source: HSE and HPSC, 2018

Information on the most likely risk factor was available for 48% (n=299) of cases in 2017 (Table T1.3.1.4). Two hundred and nine cases with risk factor data were PWID and 12 were infected through contaminated blood products. For 18 cases, no known risk factors were identified; this was despite follow-up by public health officials. Sixty-six cases who did not have primary risk factor data reported were born in an endemic country or were asylum seekers.

Table T1.3.1.4 New HCV cases reported to the HPSC, by risk factor status, 2017

Risk factor status	n (%)
Total	621
Cases *with* reported risk factor data	299 (48)
Of which:	
Injecting drug users	209 (70)

Risk factor status	n (%)
Recipient blood/blood products	12 (4)
Other risk factors	60 (20)
No known risk factor identified	18 (6)
Cases *without* reported risk factor data	322 (52)

Source: HSE and HPSC, 2018

The proportion of cases attributed to injecting drug use has decreased from 88% in 2011 to 70% in 2017; however, risk factor data were not available for a significant number of cases and therefore this finding is difficult to interpret. Data for 2017 will improve as further validation work is carried out in the coming months.

Of the PWID among HCV notifications in 2017, 157 were male and 52 were female, with a median age of 39. Ten subjects were under 25 years of age. The majority (66%) lived in Dublin, Kildare or Wicklow (Table T1.3.1.5).

Table T1.3.1.5 Characteristics of new HCV notifications who reported injecting drug use as a risk factor, 2017

Known injector cases	n (%)
Total	209 (70)
Gender	
Male	157 (75)
Female	52 (25)
Gender not known	0
Age	
Mean age	40
Median age	39
Under 25 years	10 (5)
25–34 years	49 (23)
Over 34 years	150 (72)
Age not known	0
Place of residence	
Dublin, Kildare or Wicklow	138 (66)
Elsewhere in Ireland	71 (34)

Source: HSE and HPSC, 2018

T1.3.2 Notifications of drug-related infectious diseases

No new information

T1.3.3 Prevalence data of drug-related infectious diseases outside the routine monitoring

Chemsex, risk behaviours and infection among men who have sex with men in Dublin

Evidence suggests that among men who have sex with men (MSM) and who use drugs, there is a preference for 'sex drugs', including alkyl nitrites ('poppers'), crystal methamphetamine ('crystal meth'), club drugs (including ketamine and ecstasy) and new psychoactive substances (McCarthy-Caplan*, et al.* 2014). Drug use for or during sex ('chemsex') among MSM has caused concern due to the direct effects of the drugs themselves in addition to an increased risk of transmission of sexually transmitted infections (STIs).

Recent Irish research aimed to assess the prevalence of chemsex, associated behaviours and STIs among attendees at Ireland's only MSM-specific sexual health clinic in Dublin, over a six-week period in 2016 (Glynn*, et al.* 2017). In this study, published in the *International Journal of Drugs Policy*, a questionnaire was used to collect demographic data, information on sexuality and sexual practice, self-reported history of treatment for STIs, and chemsex use. Key variables independently associated with treatment for STIs over the previous 12 months were identified using multivariable logistic regression. Ninety-four per cent of attendees who were asked to take part in the study completed the questionnaire.

Among the findings, the study authors highlighted the following:

- One in four (27%) reported engaging in chemsex within the previous 12 months.
- Half had taken two drugs on their last chemsex occasion.
- One in five (23%) reported that they or their partners had lost consciousness as a result of chemsex.
- One in four (25%) reported that chemsex was impacting negatively on their lives and almost one-third (31%) reported that they would like help or advice about chemsex.

It was also found that those engaging in chemsex were more likely to have had more sexual partners ($p<0.001$), more partners for anal intercourse ($p<0.001$) and to have had anal intercourse without a condom ($p=0.041$). They were also more likely to report having been treated for gonorrhoea over the previous 12 months (adjusted OR: 2.03, 95% CI 1.19–3.46, $p=0.009$). Overall, 6% of participants reported that they had ever been diagnosed with HIV, although no significant difference was seen in the proportion of respondents who reported having been diagnosed with HIV according to whether they reported that they had (8%) or had not (5%) engaged in chemsex ($p=0.097$).

The authors concluded that the results from this survey of MSM clinic attendees in Dublin agree with international evidence suggesting a chemsex culture among a subset of MSM. They hope that these findings will be used to develop an effective response that addresses addiction and sexual ill-health among MSM who experience harm, and seek help as a consequence of engagement in chemsex.

T1.3.4 Drug-related infectious diseases – behavioural data

HIV in Ireland: knowledge, attitudes and stigma

Recent research published by HIV Ireland examined national HIV knowledge and attitudes and the stigma associated with HIV (HIV Ireland 2017). HIV Ireland is a registered charity operating at local, national and European levels. The principal aim of the organisation is to contribute towards a significant reduction in the incidence and prevalence of HIV in Ireland and towards the realisation of an AIDS-free generation. The present study involved the development of two surveys. The first survey aimed to measure knowledge and attitudes among the general Irish population. The second survey measured stigma and the experiences of those living with HIV. Subjects were required to be 18 years of age or older and the surveys were completed by 1,013 and 168 respondents, respectively.

HIV knowledge and attitudes among the general public

Almost all adults (98%) correctly thought that HIV can be transmitted by sharing needles and syringes. A similar proportion correctly thought that HIV can be transmitted by a man and a woman, or a man and a man, having sex without a condom. However, the study found that myths in relation to HIV transmission remain and that young people had less correct knowledge than older people in relation to most methods of HIV transmission.

Misperceptions regarding HIV transmission among the general public included the following:

- 70% of respondents believed HIV can be transmitted through a bite.
- 24% believed HIV can be transmitted through kissing.
- 10% believed HIV can be transmitted through sharing a glass.
- 9% believed HIV can be transmitted through using a public toilet.

The authors also noted that more than 50% of respondents believed that HIV can be transmitted through a blood transfusion. While theoretically possible, this is not a reality given the safeguards and screening used in Ireland. HIV Ireland suggested that this assumption may negatively affect experiences of health services.

Stigma and experiences of those living with HIV

The second survey found that stigma and the fear of stigma affect how people living with HIV experience their lives. Almost two-thirds (61%) of respondents feared being rejected in a relationship and almost half of this cohort (32%) had actually been rejected. Fifty-four per cent of

respondents were single; the comparable figure in the general population is 38%. The majority (61%) of people living with HIV had not disclosed their HIV status at some point, as they were afraid they would be judged or treated differently if they did. The stress that stigma can cause may explain why in the past year almost one in five (17%) respondents living with HIV had felt suicidal. More than one-third also reported having suffered from low self-esteem, and having felt anger, guilt or shame, and they blamed themselves for their HIV status.
Other key findings among respondents living with HIV included the following:

- 88% thought that some members of the general public believe that living with HIV is shameful.
- 35% agreed that some people do not want to associate with them, and 38% believed that some people think they deserve to have HIV.
- A majority believed that it was more stigmatising to have contracted HIV through sex (76%) and through injecting drug use (67%).
- 18% of respondents living with HIV have had their HIV status disclosed accidentally in a hospital setting.

Conclusions
The authors suggest that knowledge in the general population regarding HIV transmission is relatively good, potentially highlighting the work done in relation to HIV awareness raising in Ireland. Nevertheless, the study indicates that there is some room for improvement, in particular with regard to knowledge gaps and misperceptions among younger adults. Stigma still persists and affects the everyday lives of people living with HIV. While stigma is most sorely felt by the person immediately impacted upon, society at large is not immune from the effects resulting from HIV-related stigma, as it may reduce the likelihood of people getting tested. HIV Ireland hopes that this research will highlight these issues and provide data to support informed education, awareness raising, and effective policy development.

T1.3.5 Other drug-related infectious diseases

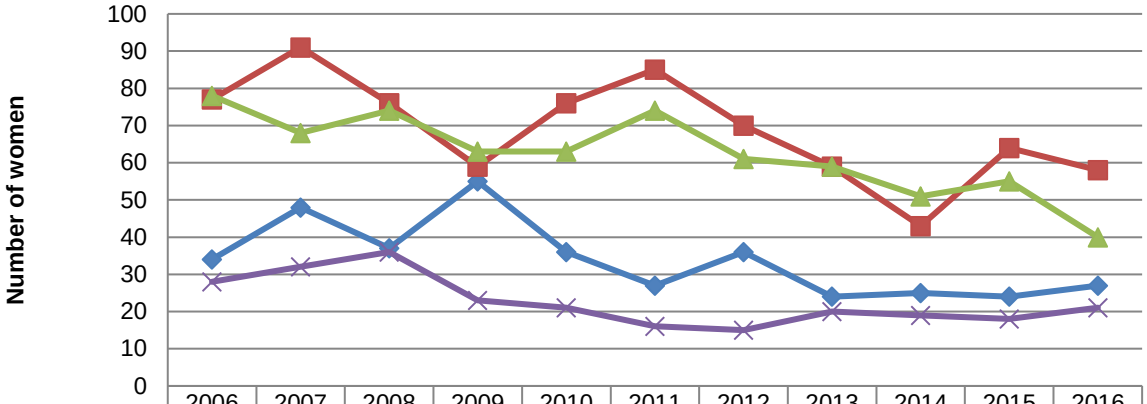
No information

T1.3.6 Additional information on drug-related infectious diseases

DOVE Clinic, The Rotunda Hospital Annual Report, 2016

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 in pregnancy. Exposure may also occur through illicit drug use. Figures from the clinic for 2016 were published in the hospital's Annual Report in 2017 (The Rotunda Hospital 2017).

Figure T1.3.6.1 shows the number of women who booked into the DOVE Clinic for antenatal care each year during the period 2006–2016. It also shows these women's diagnosis.



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
HIV	34	48	37	55	36	27	36	24	25	24	27
HBV	77	91	76	59	76	85	70	59	43	64	58
HCV	78	68	74	63	63	74	61	59	51	55	40
Syphilis	28	32	36	23	21	16	15	20	19	18	21

FigureT1.3.6.1 DOVE Clinic bookings, by year, 2006–2016
Source: The Rotunda Hospital, 2017

During 2016, some 201 women booked into the DOVE Clinic for antenatal care. Of these:

- 27 (13%) were positive for HIV, an increase of 13% compared with 2015.
- 58 (29%) were positive for hepatitis B (HBV) surface antigen, representing a decrease of 11% compared with 2015.
- 40 (20%) were positive for hepatitis C (HCV) antibody, a decrease of 27% compared with 2015.
- 21 (11%) had positive treponemal serology (syphilis), an increase of 17% compared with 2015.
- 59 (29%) attended for addiction support services; of these women, 38 were participating in a prescription methadone maintenance programme, representing an increase of 14% compared with 2015.

It should be noted that these numbers refer to patients who booked for care during 2016. Table T1.3.6.1 summarises the outcome of patients who actually delivered during 2016. Of these patients, 27 were HIV-positive, 66 were HBV-positive, and 40 were HCV-positive. A total of 60 deliveries were to mothers attending the drug liaison midwife.

Table T1.3.6.1 Deliveries to mothers attending the DOVE Clinic who were positive for HIV, HBV, HCV or syphilis, or who were attending the drug liaison midwife, 2016

Mother's status	HIV positive	HBV positive	HCV positive	Syphilis positive	DLM
Total mothers delivered	27	66	40	16	60
Total mothers delivered <500 g (including miscarriage)	0	0	2	1	1

Mother's status	HIV positive	HBV positive	HCV positive	Syphilis positive	DLM
Total mothers delivered ≥500 g	27	66	38	15	59
Live infants	27	66	40/41*	16/18**	59/60**
Miscarriage	0	0	2**	0	0
Stillbirth	0	0	1	1	1
Infants <37 weeks gestation	3	4	6	3	10
Infants ≥37 weeks gestation	24	62	34	13	50
Caesarean section	12	14	14	6	21
HIV, HBV, HCV or syphilis-positive infants	1	0	1	0	–
Maternal mean age	31	30	33	33.5	–

Source: The Rotunda Hospital, 2017
*Including three sets of twins.
**Including one set of twins.
DLM = drug liaison midwife.

T1.4 Other drug-related health harms

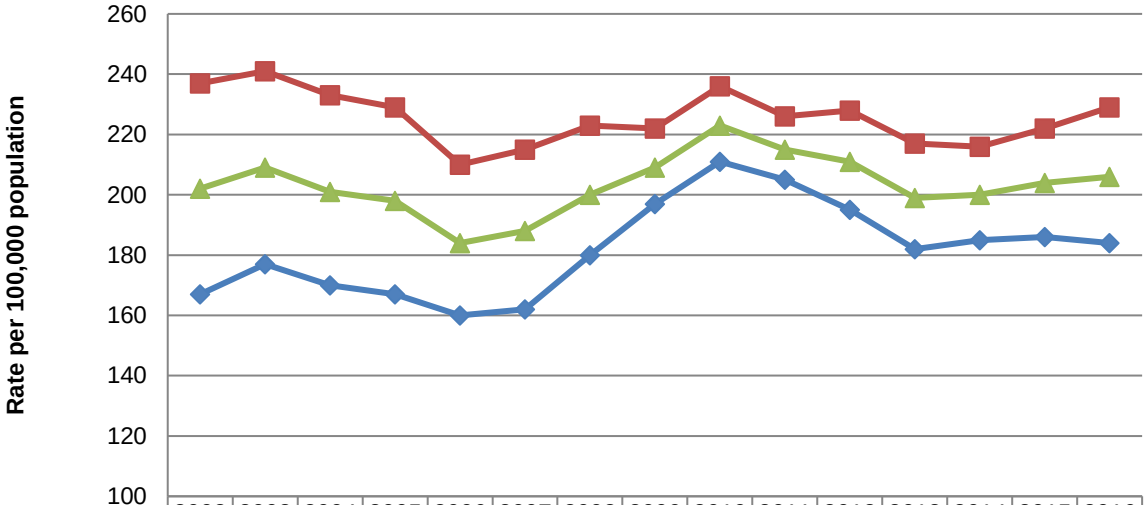
T1.4.1 Other drug-related health harms

National Self-harm Registry Ireland Annual Report, 2016

The 15th annual report from National Self-Harm Registry Ireland has recently been published (Griffin*, et al.* 2017). The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2016 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 11,485 recorded presentations of deliberate self-harm in 2016, involving 8,909 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 206 per 100,000 population. This is similar to the rate recorded in 2015 (204 per 100,000 population). While there were successive decreases in the self-harm rate between 2011 and 2013, the rate in 2016 was still 10% higher than in 2007, the year before the economic recession (Figure T1.4.1.1).



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Men	167	177	170	167	160	162	180	197	211	205	195	182	185	186	184
Women	237	241	233	229	210	215	223	222	236	226	228	217	216	222	229
All	202	209	201	198	184	188	200	209	223	215	211	199	200	204	206

Figure T1.4.1.1 Person-based rate of deliberate self-harm from 2002 to 2016 by gender
Source: National Suicide Research Foundation, 2017
'All' in the legend refers to the rate for both men and women per 100,000 population

In 2016, the national male rate of self-harm was 184 per 100,000 population, 1% lower than in 2015. The female rate was 229 per 100,000 population, which was 3% higher than in 2015. Since 2007, the male and female rates of self-harm have increased by 14% and 7%, respectively. With regard to age, the peak rate for men was in the 20–24 age group, at 516 per 100,000 population. The peak rate for women was among 15–19-year-olds, at 763 per 100,000 population.

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2016, occurring in 7,646 (67%) of episodes. As observed in 2015, overdose rates were higher among women (72%) than among men (59%). Minor tranquillisers and antidepressants/mood stabilisers were involved in 35% and 19% of drug overdose acts, respectively. In total, 32% of male and 47% of female overdose cases involved analgesic drugs, most commonly paracetamol, which was involved in 30% of all drug overdose acts. In 69% of cases, the total number of tablets taken was known, with an average of 29 tablets taken in episodes of self-harm that involved a drug overdose.

There was no increase in the number of presentations involving street drugs (cannabis, ecstasy and cocaine) compared with 2015 (n=547). Nevertheless, the 2015/16 levels are 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 significantly more frequently involved in male episodes of self-harm than in female episodes (34% vs 29%, respectively). The authors reported that, as in previous years, alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, and in the hours around midnight.
The authors concluded that these findings underline the need for ongoing efforts:

- To reduce access to minor tranquillisers and other frequently used drugs, including paracetamol
- To intensify national strategies to increase awareness of mental health issues
- To intensify further strategies to reduce access to alcohol.

Factors associated with alcohol involvement in suicide and self-harm in Ireland

Alcohol misuse and alcohol consumption are significant risk factors for suicidal behaviour. Persons diagnosed with alcohol use disorder have been shown to be at increased risk of suicide in a meta-analysis of cohort studies (Wilcox*, et al.* 2004), and the lifetime risk of suicide among those with alcohol use disorder has been estimated at 7% (Inskip*, et al.* 1998). In addition, subjects admitted with alcohol use disorder are more likely to present with self-harm during a 12-month follow-up period (Singhal*, et al.* 2014). However, although numerous studies have demonstrated an association between alcohol consumption and suicidal behaviour, very little attention has been paid to the factors associated with alcohol involvement in suicide and self-harm. A recent study conducted in Ireland sought to identify factors associated with alcohol consumption in cases of suicide and non-fatal self-harm presentations (Larkin*, et al.* 2017).

In this research, published in the journal *Crisis*, suicide cases in Cork, from September 2008 to June 2012, were identified through the Suicide Support and Information System. Emergency department presentations of self-harm for the years 2007–2013 were obtained from National Self-Harm Registry Ireland. Logistic regression analysis was used to estimate independent variable associations with alcohol use prior to or during a suicide or self-harm act.

Key findings included the following:

- Alcohol consumption was detected in the toxicology of 44% of 307 suicide cases.
- Among suicides, only younger age was significantly associated with having consumed alcohol among suicides.
- Alcohol consumption was noted in 21% of 8,145 self-harm presentations.
- Variables associated with having consumed alcohol in a self-harm presentation included male gender, older age, overdose as a method, not being admitted to a psychiatric ward, and presenting out-of-hours.

The study authors concluded that public health measures to restrict access to alcohol may be used to enhance suicide prevention, as population-based studies show reduced suicide rates following measures to restrict access to alcohol (Varnik*, et al.* 2007). In addition, as it was found that alcohol involvement was associated with different characteristics in self-harm presentations, but not in suicide cases, this may require a tailored clinical approach in order to minimise risk of further non-fatal or fatal self-harm.

T1.5 Harm reduction interventions

T1.5.1 Drug policy and main harm reduction objectives

Strategic aims and objectives of the current national drugs strategy with regard to harm reduction interventions are (Department of Community 2009):

- 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 well-being, 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 national drugs strategy, see Section T1.1 of the Policy workbook.

T1.5.2 Organisation of harm reduction services

The Health Service Executive (HSE) offer harm reduction programmes in Dublin, including needle exchange from fixed sites, mobile units and outreach work. Additional support services (Dublin-based or national) are provided by 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, as well as rehabilitation, education and community/family support. In addition, there are pharmacies providing needle exchange in each regional drug and alcohol task force (RDATF) area in Ireland.

T1.5.3 Provision of harm reduction services

Harm reduction services: Community-Based Organisations (CBOs)
Merchants Quay Ireland Annual Review, 2016

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and drug users. There are 19 MQI locations in 12 counties in the Republic of Ireland. In September 2017, MQI published its annual review for 2016 (Merchants Quay Ireland 2017). MQI aims to offer accessible, high-quality and effective services to people dealing with homelessness and addiction, in order to meet their complex needs in a non-judgemental and compassionate way. This section highlights services provided by MQI to drug users in Ireland in 2016.

Figure T1.5.3.1 MQI locations in Ireland
Source: MQI, 2017
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.; **12** Leixlip, Co Kildare.

MQI: Open access services

Assertive Outreach Service (AOS)

In line with the MQI mission statement to reach out to the most vulnerable in society, the Assertive Outreach Service (AOS) aims to make contact with drug users not engaged with other services and to provide them with accessible support options. The geographical zone covered by the AOS is predominantly around each MQI location (Figure T1.5.3.1). Clients are assisted with clothing, food and drug treatment options. The service engaged with 116 individuals in specific casework, and with over 1,000 individuals on an informal support basis, throughout 2016.

Intensive Engagement Service (IES)

Many of the drug users who avail of MQI's open access services are homeless and have financial and legal problems. The MQI morning service (10am to 1pm) is a one-to-one support function entitled the Intensive Engagement Service (IES). The IES provides support with accommodation; drug treatment; and training, medical, welfare and legal issues. In 2016, some 929 individuals availed of the IES, with 75% of people seeking help with accessing accommodation.

Health Promotion Unit

The Health Promotion 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, hepatitis B virus and hepatitis C virus infection prevention; and providing information on overdose and other risks. MQI also offers early referral to drug treatment services. In 2016, some 2,519 individuals used the service (a decrease of 6% on 2015); of these, 421 were new clients.

As part of the MQI health promotion remit, a total of 2,139 safer injecting workshops were undertaken with injecting drug users in 2016, an increase of 30% on 2015. There were 25,603 needle exchange visits, a decrease of 1% on 2015.

Naloxone Demonstration Project

Along with partners in the HSE, the National Family Support Network, and the Ana Liffey Drug Project, MQI was prominent in the national roll-out of the Naloxone Demonstration Project in 2015. Naloxone is an antidote for opioid overdose that reverses the depressant effects of opiates such as heroin. To date, more than 400 drug users have been prescribed naloxone, and an external evaluation concluded that the scheme was a success. MQI hopes that eventually all opiate drug users in Ireland will have access to this life-saving drug.

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 25 individuals throughout 2016.

MQI: Midlands services

With support and funding from the Midland Regional Drug and Alcohol Task Force (MRDATF) 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 services focused on the needs of the families of active drug users. The Midlands team comprises MQI staff, Department of Social Protection participants, those on work placement, and volunteers working across these four Midlands counties.

In November 2016, MQI was awarded the contract to provide a community-based drug and alcohol treatment support service in the Midlands region for individuals aged over 18 years and their

families. This service will complement and enhance existing statutory, community and voluntary services operating in the region in line with best international research and standards. This reorientation of services will ensure a harmonisation of treatment supports across the Midlands region, thus providing a more equitable and accessible service to all. Since the award of the contract, MQI has been engaged in transitioning the existing service to the new model of service delivery as required by the service contract.

Midlands Rehabilitation and Aftercare Service

MQI, with the support of the MRDATF 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 Midlands 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 individuals have their needs assessed and 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 2016. 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 they received one-to-one interventions and group support where required. There were 246 one-to-one sessions and 56 groups facilitated in 2016.

Midlands Family Support Services

Midlands Family Support Services is involved in 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. MQI works to proactively link people with other support or treatment services that may be relevant to their needs. In 2016, MQI provided interventions that supported 78 family members in coping with addiction-related issues.

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. MQI seeks to empower drug users and their friends and family with all of the information necessary to ensure that they keep themselves safe. In the Midlands region, the MQI Community Harm Reduction Service worked with 165 clients during 2016, providing 2,309 harm reduction interventions. The service facilitated an average of 120 needle exchanges

each month, operating in collaboration with the local pharmacy needle exchange scheme. MQI works on supporting clients in the 'pre-entry' phase before admission to residential rehab and detox. Nine clients from the Midlands region entered MQI residential drug treatment during the course of 2016.

MQI: Drug-free treatment services

St Francis Farm (SFF) Residential Rehabilitation and Detox Services

The St Francis Farm (SFF) Rehabilitation Service 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. During 2016, 53 clients were admitted to the SFF Rehabilitation Service; of these, 37 (70%) were male and 16 (30%) were female. This represents a 4% increase in admissions compared with 2015.

The 10-bed residential detoxification service at SFF delivers methadone and combined methadone/benzodiazepine detoxes for both men and women. The detox activity programme includes individual care planning, therapeutic group work, psychoeducational workshops, fitness training, and farm-work activities. During 2016, 72 clients were admitted for detox service; of these 54 (75%) were male and 18 (25%) were female. This represents a 14% increase in admissions compared with 2015.

Tabor Group Annual Report, 2017

The Tabor Group is a provider of residential addiction treatment services in Ireland. The Tabor Group aims to offer hope, healing and recovery to clients who suffer from addiction through integrated and caring services. In addition to three residential facilities, the organisation provides a continuing care programme to people who have completed treatment in order to assist with their recovery. It also offers counselling to families whose loved ones are struggling with an addiction. In June 2018, the Tabor Group published its annual report (Tabor Group 2018). This section highlights services provided by the Tabor Group to individuals with a substance use addiction in 2017.

Tabor Lodge: residential addiction treatment centre

Tabor Lodge is a residential addiction treatment centre for the treatment of people addicted to alcohol, drugs, gambling and food. It is situated 15 miles south of Cork city. Tabor Lodge is guided by the Minnesota Model of addiction treatment in delivering its treatment programme. This model is characterised by its understanding that addiction is primarily a substance use disorder. The primary focus of the treatment programme is to educate clients on the dynamics of this disorder as they manifest in the life of the individual. Another important focus of the treatment programme is to assist clients to develop the skills necessary to manage their disorder while going forward in their lives.

A total of 213 clients (67% male) were admitted to Tabor Lodge for residential treatment of addiction in 2017; of these, 183 completed treatment. A breakdown of the specific drug of choice for clients admitted to Tabor Lodge in 2017 is shown in Table T1.5.3.1. The *Tabor Group Annual Report, 2017* noted that clinical staff at Tabor Lodge have observed a changing profile of clients presenting for treatment in recent years, with mental health challenges and history of childhood trauma becoming more evident. With this in mind, staff at Tabor Lodge have become more informed about childhood trauma as a contributing factor to the development of addiction, and as a hindering factor in efforts to manage addiction disorders. In 2017, Tabor Lodge responded to the greater proportion of clients presenting for treatment with history of childhood trauma by initiating a training programme. This is designed to ensure that Tabor Lodge becomes more 'trauma informed' as an agency treating adults who are vulnerable to the ongoing debilitating impact of childhood trauma.

Table T1.5.3.1 Specific drug of choice for clients admitted to Tabor Lodge: residential addiction treatment centre in 2017

Drug of choice	Number of clients	Percentage of clients
Opiates	**18**	**8%**
Cocaine	**23**	**11%**
Cannabis	**9**	**4%**
Alcohol	**138**	**65%**
Stimulants	**3**	**1%**
Hypnotics and sedatives	**9**	**4%**
Other substances	**1**	**0.5%**

Source: Tabor Group, 2018

Fellowship House: men's residence extended treatment centre

The extended treatment programme for men is based on the Hazelden Minnesota Model and promotes 'total abstinence'. The aim is to build on, and consolidate, the work of recovery which has already begun in primary treatment – even if that treatment was not in the recent past and the client is struggling to maintain sobriety.

In 2017, 49 clients were admitted to Fellowship House for extended treatment; 13 of these were referred directly from Tabor Lodge and 36 were referred from other centres around Ireland. A total of 36 individuals completed the programme. A breakdown of the specific drug of choice for clients admitted to Fellowship House in 2017 is shown in Table 1.5.3.2. The report observed that cannabis ranking as the specific drug of choice remains high at 90%, with alcohol and ecstasy coming a close second at 88%. The report also noted that a majority of clients admitted for treatment are presenting with polydrug use, specifically the use of alcohol with other drugs.

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TableT1.5.3.2 Specific drug of choice for clients admitted to Fellowship House: men's residence extended treatment centre in 2017

Drug of choice	Number of clients	Percentage of clients
Alcohol	43	88%
Ecstasy	43	88%
Cannabis	44	90%
Cocaine	42	86%
Prescribed medication	36	73%
Heroin	13	27%
Methadone	9	18%
Speed	36	73%
LSD	28	57%
Other/Headshop	23	47%

Source: Tabor Group, 2018

Renewal: women's residence extended treatment centre

Renewal works with women who have completed a primary 28-day treatment programme. It provides a 12-week residential extended treatment programme where clients learn to find routine, balance and structure. Renewal is the only Minnesota Model extended treatment centre for women based in Ireland and was opened in 1999.

In 2017, 46 clients were admitted to Renewal and 25 completed the programme. Almost 60% of these clients were aged between 18 and 35 years. A breakdown of the specific drug of choice for admissions to Renewal in 2017 is shown in Table T1.5.3.3. In this year, all of the clients admitted presented with a history of alcohol abuse. However, the report also noted that there has been a considerable rise in the number of young women presenting with alcohol addiction alone.

Table T1.5.3.3 Specific drug of choice for clients admitted to Renewal: women's residence extended treatment centre in 2017

Drug of choice	Number of clients	Percentage of clients
Alcohol	46	100%
Ecstasy	21	46%
Cannabis	31	67%

Drug of choice	Number of clients	Percentage of clients
Cocaine	26	57%
Prescribed medication	24	52%
Heroin	7	15%
Methadone	3	7%
Speed	15	39%
LSD	6	13%

Source: Tabor Group, 2018

In addition to group therapy, lectures and one-to-one counselling, the Renewal programme team arranges family conferences – which help clients to re-connect with their families. The programme educates families about addiction and offers them support. In addition, it works in partnership with Tusla – Child and Family Agency, as many women have children in care and need help re-connecting and re-building the parent/child relationship.

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, the ADLP delivers a wide variety of low-threshold, harm reduction services that offer drug users pathways out of their current circumstances, including addiction and homelessness.

The ALDP is committed to impacting positively on the neighbourhood and the wider community. Consequently, it is active in managing antisocial behaviour in the area and, in return, it receives ongoing support from the local business community.

The services offered in Dublin are:

- Open access
- Assertive outreach
- Needle and Syringe Programme
- Medical services
- Harm Reduction Group
- Assessment for Residential Treatment
- Pre-entry to the Helping Women Recover Group
- Key working and case management
- Prison in-reach

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 for Residential Treatment
- Pre-entry to the Helping Women Recover Group
- Key working and case management
- Prison in-reach

The ALDP Online and Digital Services team also offers support and information to the general public, to drug users, as well as 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:

- Pharmacy – 111 sites in regions outside Dublin, Kildare and Wicklow
- Static – 24 sites mainly in Dublin city
- Outreach – 14 sites mainly in counties Dublin, Kildare, Laois, Offaly, Waterford and Wicklow.

Information on the number of syringes exchanged in Ireland in 2017 is discussed in the following sections.

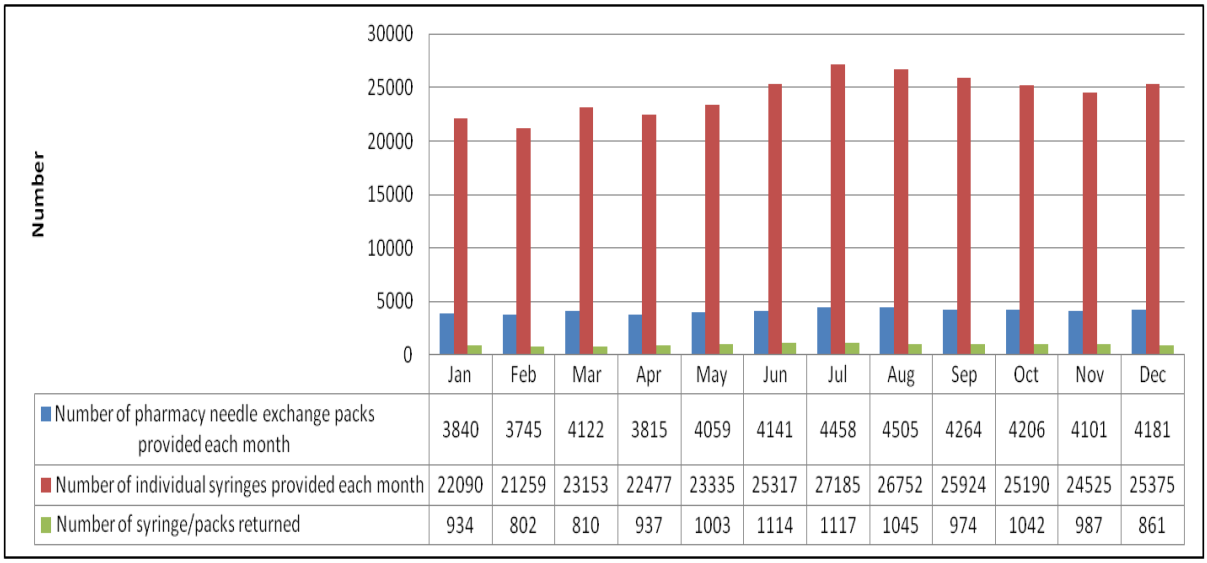
Pharmacy-based needle exchange: overview

The current national 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 2017, there were 111 pharmacies providing needle exchange in the Republic of Ireland.

Pharmacy-based needle exchange: number of syringes exchanged

Figure T1.5.3.2 shows the number of needle/exchange packs and individual syringes provided, and the number of syringe/packs returned, from pharmacy-based sites for the year 2017, by month. A total of 49,437 packs and 292,582 individual syringes were exchanged in 2017. The total number of syringe/packs returned in 2017 was 11,626.

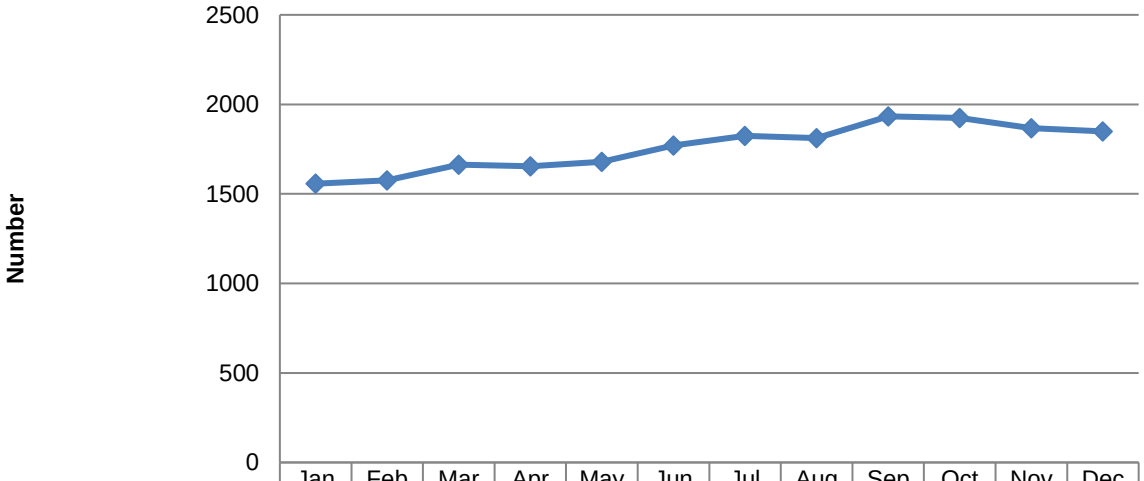


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of pharmacy needle exchange packs provided each month	3840	3745	4122	3815	4059	4141	4458	4505	4264	4206	4101	4181
Number of individual syringes provided each month	22090	21259	23153	22477	23335	25317	27185	26752	25924	25190	24525	25375
Number of syringe/packs returned	934	802	810	937	1003	1114	1117	1045	974	1042	987	861

Figure T1.5.3.2 Number of needle exchange packs and individual syringes provided from, and the number of syringe/packs returned to, pharmacy-based sites, by month, 2017

Source: Unpublished data from HSE, 2018

Figure T1.5.3.3 shows the number of unique individuals who attended pharmacy-based needle exchange sites in 2017. A total of 21,109 individuals attended pharmacy-based sites in 2017. The average of number of individuals attending each month in 2017 was 1,759. This compares with an average of 1,614 individuals who attended each month in 2016.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Unique individuals	1557	1576	1663	1655	1679	1770	1824	1812	1933	1924	1867	1849

Figure T1.5.3.3 Number of persons attending needle exchange, by month, 2017

Source: Unpublished data from HSE, 2017

Dublin areas 6 and 7 needle exchange: number of syringes exchanged

Figure T1.5.3.4 shows the number of individual syringes provided by static and outreach sites in Dublin areas 6 and 7, by location, for the year 2017. There were 59,855 individual syringes in total exchanged in 2017.

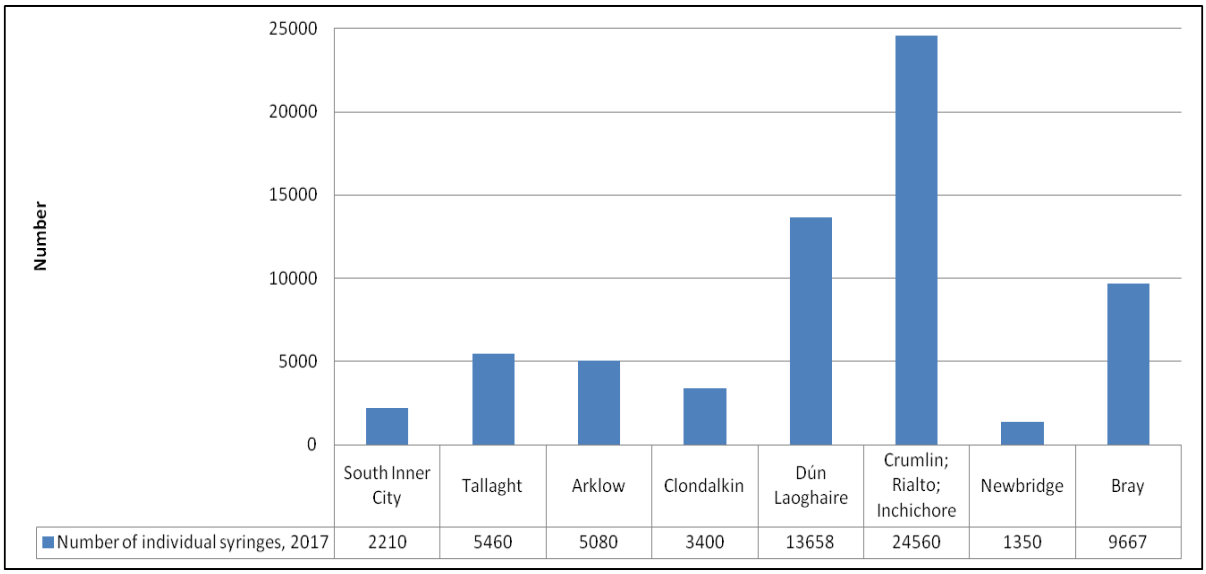


Figure T1.5.3.4 Number of individual syringes provided from static and outreach sites in Dublin areas 6 and 7, by location, 2017
Source: Unpublished data from HSE, 2018

Figure T1.5.3.5 shows the number of individuals who used needle exchange in Dublin areas 6 and 7 in 2017. Static and outreach sites reported a total of 5,406 encounters. However, it should be noted that this figure does not show unique individuals. As a result, service users may be counted more than once.

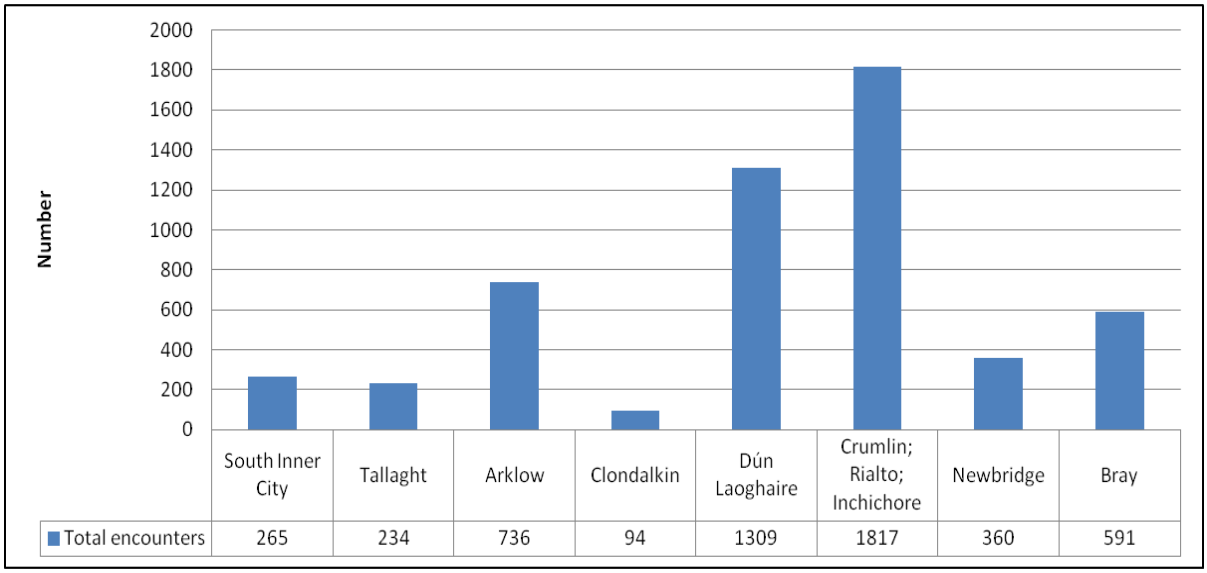


Figure T1.5.3.5 Number of individuals attending static and outreach sites in Dublin area 6 and 7, by location, 2017
Source: Unpublished data from HSE, 2018

Ana Liffey Drug Project (ALDP) needle exchange: number of syringes exchanged

The ALDP provides needle exchange services in Limerick city and three counties to people affected by problem substance use. Figure T1.5.3.6 shows the number of individual syringes provided by the ALDP, by location, for the year 2017. A total of 15,875 syringes were provided by the ALDP in 2017.

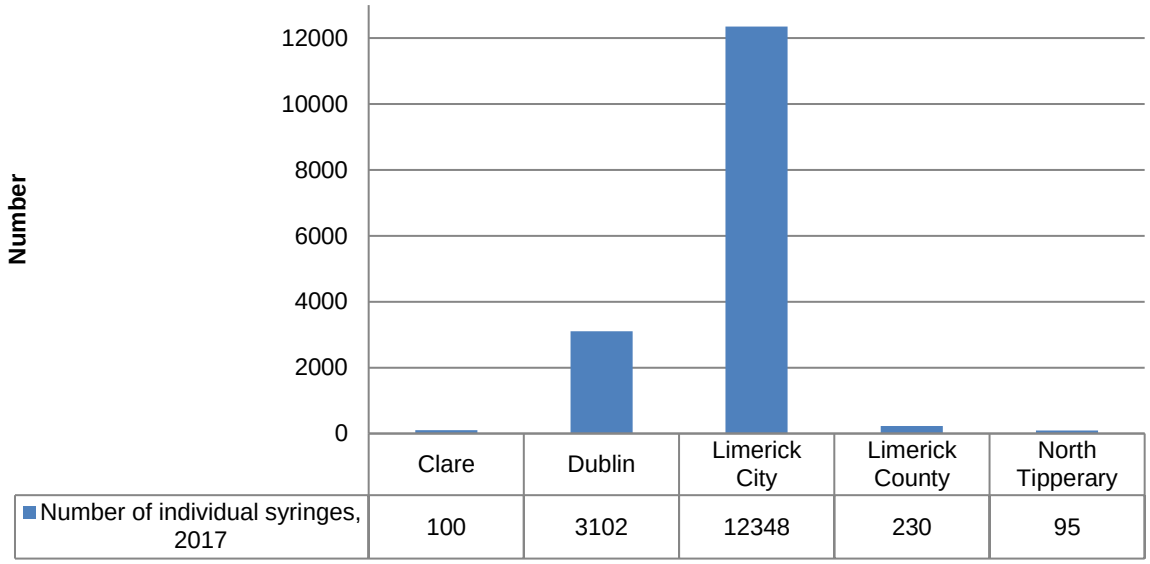


Figure T1.5.3.6 Number of individual syringes provided by the ALDP, according to location, 2017
Source: Unpublished data from the ALDP, 2018

MQI needle exchange

As previously discussed, MQI is a national voluntary agency providing services for homeless people and drug users. Its Dublin needle exchange Health Promotion Unit 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 syringes provided by the unit for each month in 2017 is shown in Figure T1.5.3.7. A total of 131,706 syringes were provided by the MQI Dublin Health Promotion Unit in 2017.

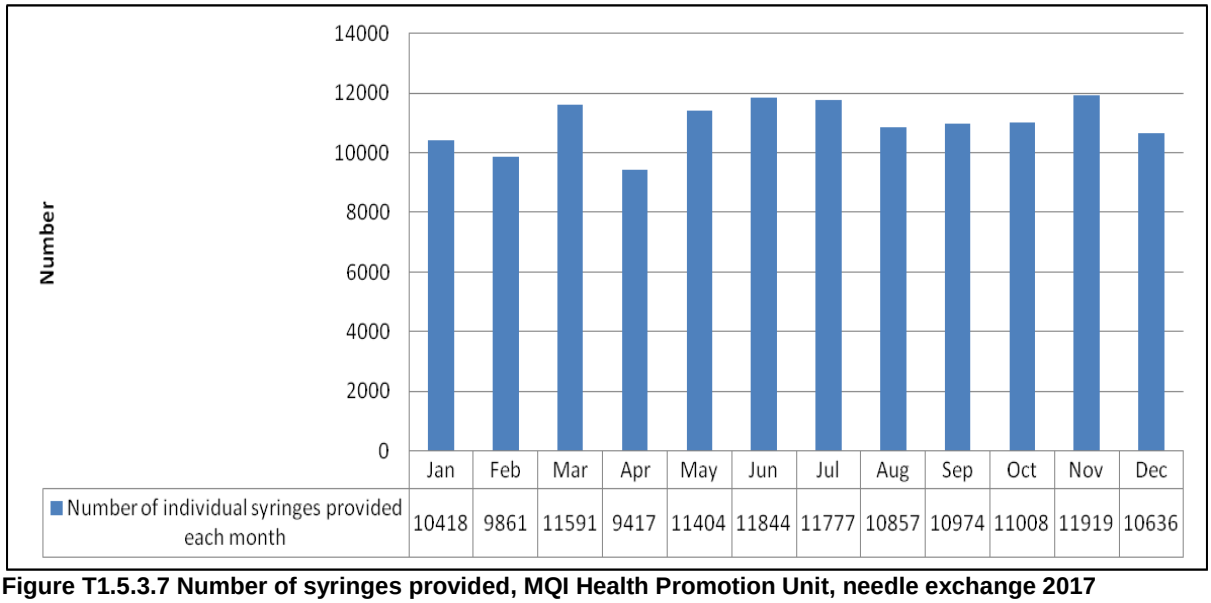
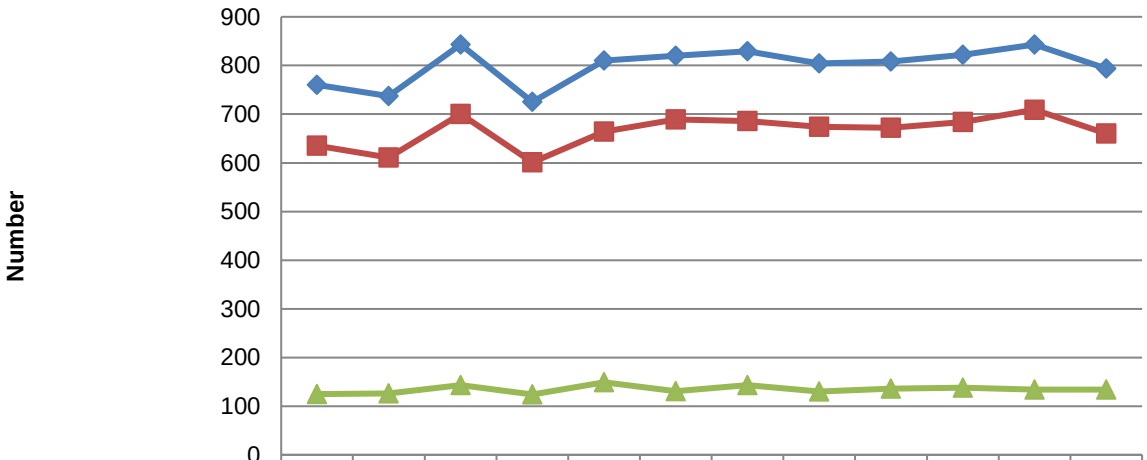


Figure T1.5.3.7 Number of syringes provided, MQI Health Promotion Unit, needle exchange 2017
Source: Unpublished data from MQI, 2018

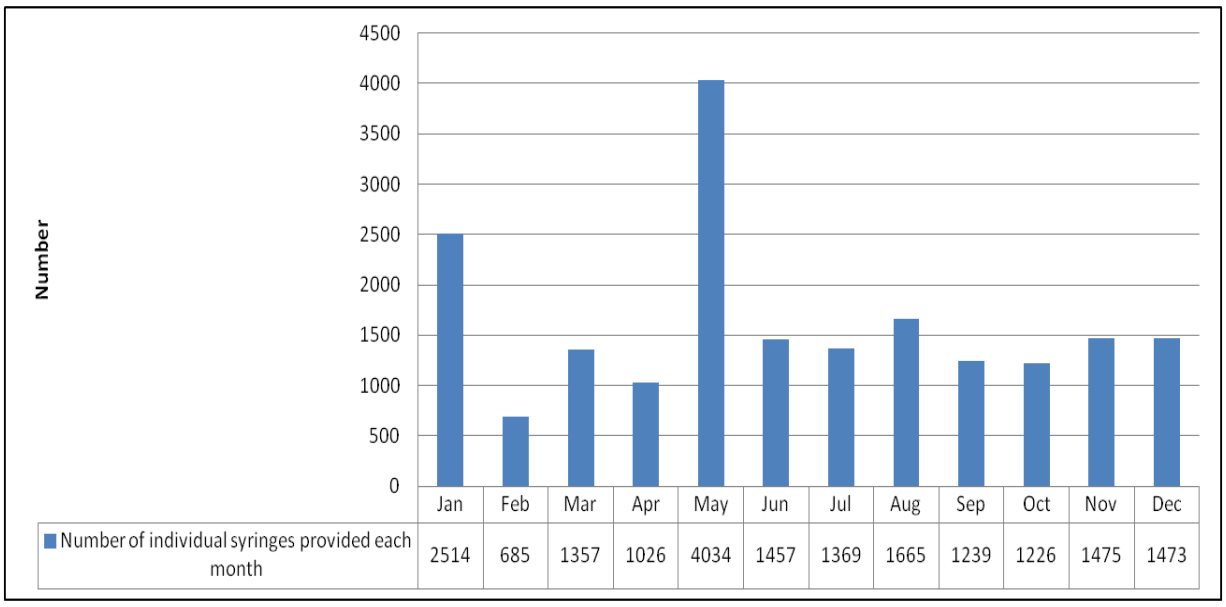
Figure T1.5.3.8 shows the number of unique individuals who attended the MQI Dublin Health Promotion Unit needle exchange in 2017. A total of 2,741 individuals attended in 2017. The average of number of individuals attending each month in 2017 was 228.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Unique Individuals	760	737	843	725	810	820	829	804	808	822	843	794
Male	635	611	700	601	664	689	686	674	672	684	709	660
Female	125	126	143	124	149	131	143	130	136	138	134	134

Figure T1.5.3.8 Number of individuals attending by month, MQI Dublin Health Promotion Unit needle exchange, 2017
Source: Unpublished data from MQI, 2018

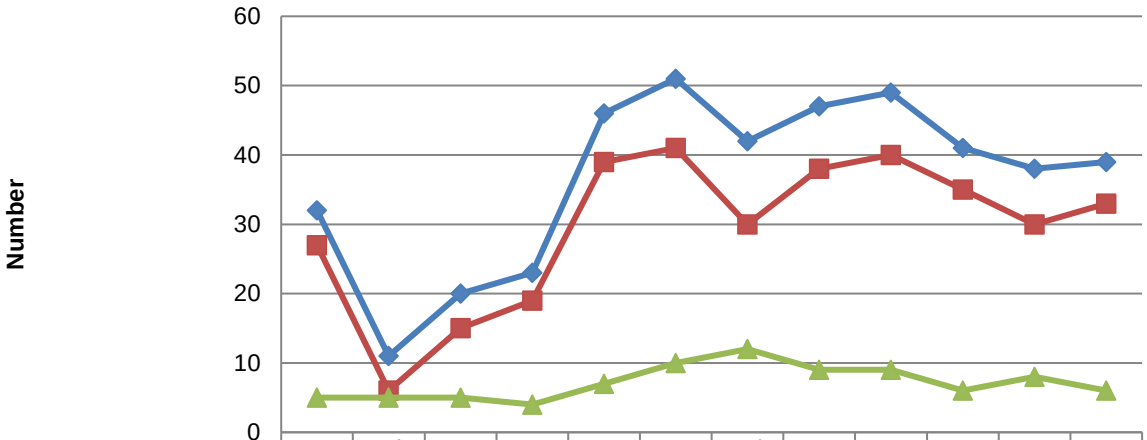
MQI administers the Midlands Family Support service and the Midlands Community Harm Reduction Service, providing outreach, and working with families of those actively using drugs in this task force region. The number of syringes provided by the MQI Midlands Community Harm Reduction Service for each month in 2017 is shown in Figure T1.5.3.9. A total of 19,520 syringes were provided by the MQI Midlands Community Harm Reduction Service in 2017.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of individual syringes provided each month	2514	685	1357	1026	4034	1457	1369	1665	1239	1226	1475	1473

Figure T1.5.3.9 Number of syringes provided, MQI Midlands Community Harm Reduction Service needle exchange, 2017
Source: MQI, 2018

Figure T1.5.3.10 shows the number of unique individuals who attended the MQI Midlands Community Harm Reduction Service for each month in. A total of 154 individuals attended in 2017.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Unique Individuals	32	11	20	23	46	51	42	47	49	41	38	39
Male	27	6	15	19	39	41	30	38	40	35	30	33
Female	5	5	5	4	7	10	12	9	9	6	8	6

Figure T1.5.3.10 Number of individuals attending by month, MQI Midlands Community Harm Reduction Service needle exchange, 2017
Source: MQI, 2018

Needle exchange in Ireland: total number of syringes exchanged

Table T1.5.3.4 shows the number of individual syringes exchanged from pharmacy, static, outreach and CBO sites in 2017. Using the most recent available data, a total of 519,578 individual syringes were exchanged in the Republic of Ireland in 2017.

Table T1.5.3.4 Total number of syringes exchanged from pharmacy, static, outreach and CBO sites in 2017

Provider	Pharmacy	Dublin (static and outreach)	ALDP	MQI	Total
Number of syringes	292 582	59 855	15 875	151 266	519 578

T1.5.4 Harm reduction services: availability and access

Irish medical students' experiences and attitudes towards community naloxone provision

Research conducted in 2014 by the National Advisory Committee on Drugs and Alcohol suggests that there are 18,988 opiate users in the Republic of Ireland (rate 6.18 per 1,000 population), indicating that Ireland has one of the highest estimated rates of problem opiate use across 17 countries in the European Union (Hay*, et al.* 2017). Opiate use disorder is an increasingly common condition in healthcare systems in Ireland, with over 200 opiate overdose deaths occurring annually (Irish Medical Organisation (IMO) 2015).

Naloxone is an antidote for opioid overdose that reverses the depressant effects of opiates such as heroin. Naloxone has been shown to reduce mortality among people who use opioids, and its distribution to trained lay users is effective for reducing fatal overdose (European Monitoring Centre for Drugs and Drug Addiction 2015). The Naloxone Demonstration Project was initiated in the

Republic of Ireland in 2015, and in that year 600 individuals were trained in how to use naloxone (Merchants Quay Ireland 2016).To date, more than 400 drug users have been prescribed naloxone and there have been five recorded 'overdose reversals' that may have contributed to lives being saved (Merchants Quay Ireland 2017).

Evidence suggests that there is support among general practitioners (GPs) in Ireland for wider naloxone availability (Klimas*, et al.* 2015). Nevertheless, medical students' exposure to patients with substance use disorders is limited and usually only occurs during general practice and psychiatry placements. In addition, there is a lack of formal substance use education at undergraduate level in Ireland, along with information regarding effective treatments such as naloxone. A recent study examined final-year medical students' learning experiences and attitudes towards opioid use disorder, overdose, and community naloxone provision as an emerging overdose treatment.

In this research (Tobin*, et al.* 2018) published in the journal *Addictive Behaviors,* an anonymous paper-based survey was administered to 243 undergraduate medical students undertaking their final professional completion module prior to graduation from University College Dublin. The results were compared with parallel surveys of GPs and GP trainees. A total of 197 medical students completed the survey (response rate: 81%), with just under half being male (45%), most being of Irish nationality (77%), and aged under 25 years (63%).

Results

The respondents reported feeling reasonably prepared to recognise key markers of opioid use disorder, but felt less prepared for other aspects of opioid use disorder management – consulting with a patient about their opioid use disorder; assessing addiction severity; formulating a treatment plan; or managing an opioid overdose. Most had taken a history from a patient with an opioid use disorder (83%) and one-third had witnessed at least one opioid overdose. Nevertheless, only a small proportion (10%) had seen naloxone administered, and only three had themselves administered naloxone in overdose. By contrast, 35% of GPs and 63% of GP trainees in parallel surveys had administered naloxone.

Just over half (52%) of student respondents saw a need for wider naloxone availability. For those students who were opposed to wider availability, concerns included potential use of naloxone, lack of evidence for the benefit of wider availability, and that it might encourage greater opioid use. A similar proportion of respondents (54%) supported wider naloxone availability among laypeople.

Conclusions

The study authors noted that while recognition of opioid use disorder was reasonably well reported, management competencies were, in general, less positive. Few had seen naloxone administered or had administered it themselves. In addition, despite evidence of the effectiveness of lay

administration of naloxone in preventing fatal overdose, 46% of respondents did not support wider naloxone distribution among laypeople. The authors suggest that these results may reflect students' lack of exposure to patients with substance use disorder and overdose, as well as gaps in education at undergraduate levels.

Detecting problem alcohol use in Irish general practice

A recent report from the World Health Organization demonstrated that almost 50% of Irish drinkers engage in heavy drinking on a regular basis, placing Ireland's binge drinking rates at the second highest of 174 countries studied (World Health Organization 2014). In addition, per capita alcohol consumption in Ireland has trebled over the past four decades (Organisation for Economic Co-operation and Development 2014). The increase has been associated with a younger profile among early drinkers, with research indicating a rise in alcohol use among students in Ireland and increasing levels of high-risk drinking (Davoren*, et al.* 2015). Policy-makers have attempted to combat this problem, as tailoring effective public health policy is crucial in tackling this burgeoning issue. Nevertheless, successive legislation has so far been largely ineffective in addressing the alcohol crisis in Ireland.

It is recognised that GPs commonly see patients with a range of alcohol-related risks and problems. GPs have thus been identified as appropriate professionals to screen for those at risk of problem alcohol use and to conduct brief interventions to influence patients to think more actively about their alcohol consumption. Nevertheless, despite the magnitude of the national alcohol problem and the detrimental effects on health and society, there is a surprising lack of data from general practice in Ireland on the documentation of alcohol use and treatment.

Recent research aimed to investigate the prevalence of documentation of problem alcohol use in patient records in Irish general practice and to describe the documentation of its diagnosis and treatment (O'Regan*, et al.* 2018). In this study, published in the journal *BMC Family Practice,* GPs affiliated with the Graduate Entry Medical School, University of Limerick were invited to participate in the study. Seventy-one per cent of the practices participated. One hundred patients were randomly selected from each participating practice and the clinical records were reviewed for evidence of problem alcohol use. Evidence included text in consultation notes; evidence of a pharmacological treatment or psychological intervention by the GP; evidence of a referral to another primary healthcare professional or specialist agencies, and/or diagnostic coding.

Key findings from the study included the following:

- Only 57 patients (1.5%, 95% CI: 1–2%) were identified as having problem alcohol use in the previous two years.

- Of the 40 participating practices, 14 (35%) had no patients in their sample with documented problem alcohol use.
- Patients with problem alcohol use were more likely to be male than those without any problem alcohol use documented (65% vs 47%, p=0.007).
- 23 patients (0.6%, 95% CI: 0.4–0.9%) were identified as having substance use other than alcohol documented in the previous two years.
- 29 (51%) of those with documented problem alcohol use were referred to other specialist services; 28 (49%) received a psychological intervention, mostly counselling or a brief intervention.

As this is the first large-scale study of patient records in general practice in Ireland that has examined the documentation of screening and treatment of problem alcohol use, the study authors highlight the current lack of documentation of alcohol problems and the need to reinforce positive attitudes among GPs in relation to preventive work.

Availability of, and access to, harm reductions services for drug users

See section T1.5.3 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 T1.3.3.

T1.5.5 Additional information on harm reduction activities

Supervised injecting facilities

As reported on in the 2017 National Report, the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was signed into Irish law on 16 May 2017. In the Introduction, the Act is summarised as: “An Act to provide for the establishment, licensing, operation and regulations of supervised injecting facilities for the purposes of reducing harm to people who inject drugs; to enhance the dignity, health and well-being of people who inject drugs in public places; to reduce the incidence of drug injection and drug-related litter in public places and thereby to enhance the public amenity for the wider community; and to provide for matters related thereto.” Following a procurement process, MQI was selected as the preferred bidder to deliver the service. As of July 2018, the service has yet to open. There have been delays due to a requirement for the service to secure planning permission. The HSE expects the service to be open before the end of 2018

Public consultation for a new safe injecting facility in Dublin

In October 2016, the Union for Improved Services, Communication and Education (UISCE) was invited to be part of the working group formed to discuss the proposed supervised injecting facility (SIF) that is planned to open in Dublin in 2018. UISCE provides an independent representative voice for people who use drugs, and helps to ensure the sharing of accurate, up-to-date information. In order to identify the most important features of the proposed facility to the community of end-

users, UISCE developed a short survey that included aspects identified by the working group as necessary to fully represent the opinions, thoughts and concerns of people who use drugs in public places.

In the survey, which was completed by 93 subjects (66% male), a set of questions focused on the person's experience with regard to the specific drugs that they choose to inject, how long they have been injecting, and where on the body they normally inject. UISCE also sought clarification from each participant about the characteristics of the areas where they normally inject, what is important about these locations, and how they would like to see a SIF administered. Additional questions about safety and comfort, before and after using drugs, were also included.

Survey findings

Key findings included the following:

- 76% of the respondents considered themselves homeless.
- 90% of the respondents affirmed they were currently injecting heroin.
- The average period of time that respondents reported injecting was 10 years, with a range of between 3 days and 30 years.
- In terms of the parts of the body that PWID use most frequently, the majority of the respondents affirmed that they use mostly the arms (52%), groin (31%) and legs (16%). Ten per cent stated that they inject all over the body (Figure T1.5.5.1).
- 49% of subjects said they inject between one and three times daily, with a majority stating that this was early in the morning (79%) and before they go to bed (73%) (Figure T1.5.5.2).
- 86% of the respondents had injected while on the streets and 75% stated that they feel unsafe when they are on the streets.

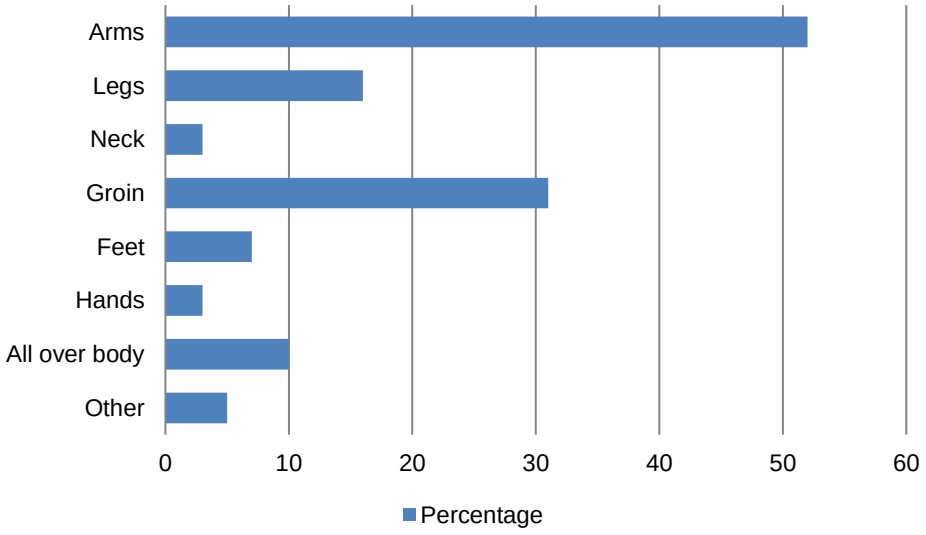


Figure T1.5.5.1 Preferred injecting location among UISCE survey respondents
Source: Unpublished data from the UISCE, 2018

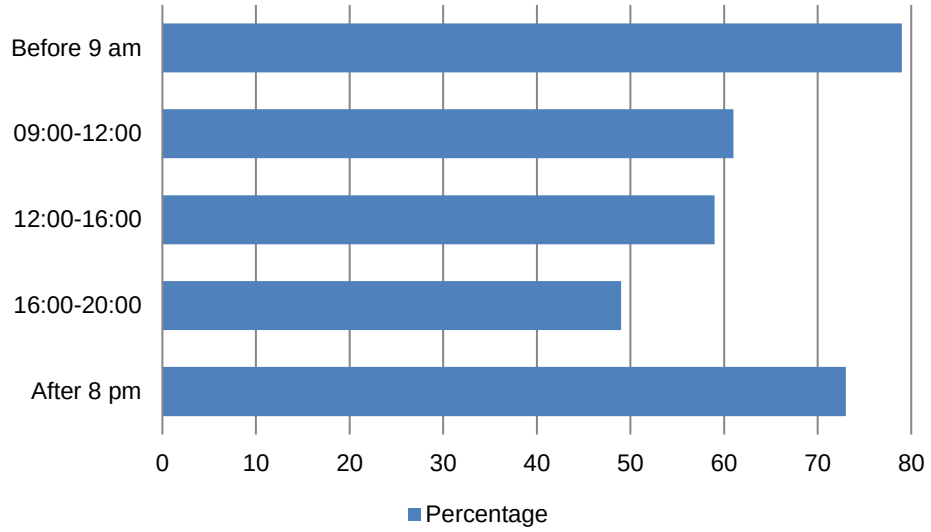


Figure T1.5.5.2 Daily injecting times among UISCE survey respondents
Source: Unpublished data from the UISCE, 2018

In terms of specific injecting locations, the answers varied: despite some respondents stating they would inject 'anywhere' or 'everywhere', the majority chose 'back lanes' or 'covered areas' ('parks', 'toilets', etc.). Almost all participants pointed out the importance of privacy, the need for good lighting, and highlighted the fact that the location served as 'shelter'. Furthermore, factors such as 'having other people around' (75%) and 'being close to where they bought the drugs' (74%) also stood out as having great importance when choosing a location. Regarding the sense of safety and comfort during and after injecting, more than 50% of respondents affirmed that they are, or have been, comfortable injecting in front of other people, while 23% stated they would feel uncomfortable having other people around.

When respondents were asked about location and opening hours for a SIF, the answers varied extensively. While some people affirmed that they would travel 'anywhere' or 'everywhere', the majority said they would like it to be near the city centre or even close to a clinic. Regarding opening hours, the majority of respondents agreed it should be a service available 24/7, with a few exceptions. Finally, regarding the ideal set-up of the facility, it was agreed that some basic equipment, such as mirrors, tables and chairs, were essential. The answers highlighted the need to feel comfortable and to have access to medical professionals.

Conclusions

UISCE concluded that there is demonstrable support from the community of people who inject drugs in public places in Dublin for a SIF, and this was indicated by the willingness of people to take part in the survey and share information to inform development. It was identified that a city centre location would be ideal. The percentage of people who identify as femoral injectors (31%) and the people who inject 'all over their body' (10%) highlight the need for space in the SIF to be designed with these people in mind. In addition, there is a need for education on safe injecting practices to be

made available. In the recovery space, as demonstrated by the responses, there will need to be coffee and tea facilities as well as a smoking area. In addition, as there are high numbers of people who are homeless, coupled with high numbers of people who say that their preferred action after using drugs is to sleep, UISCE recommends support for people to access day services from the SIF.

Preventing and reducing alcohol-related harm: the Sligo city alcohol strategy

The Sligo Healthy Ireland Project, in conjunction with the Northwest Regional Drug and Alcohol Task Force (NWRDATF), has developed an alcohol-related harm reduction strategy for Sligo city (Northwest Regional Drug and Alcohol Taskforce 2018). This five-year strategy will focus on four key areas: prevention, supply (including access and availability), screening (including treatment and support services), and research (including monitoring and evaluation). The overall goals are to address alcohol-related harm; ensure factors influencing alcohol supply are regulated and controlled; advocate for a range of alcohol treatment and support services; and use evidence and research to inform decisions in preventing and reducing alcohol-related harm in Sligo city.

Prevention

Specific goals with regard to prevention include raising public awareness of the burden of alcohol-related harm and of the benefits of effective action to prevent alcohol-related harm. To this end, the strategy will develop and implement a communication plan in relation to the harm caused by alcohol. The plan will focus on communicating the link between alcohol and health issues, family relationship issues, and social harms such as crime, violence, and public disorder. Effective measures to prevent and reduce alcohol-related harm will also be communicated.

Supply, access and availability

The strategy will aim to reduce the availability of alcohol in Sligo city, reduce the marketing of alcohol in public places, and promote responsible drinking practices. This will include a review of the density of alcohol outlets in Sligo city, the possibility of strengthening zoning regulations to reduce the availability of alcohol in the town, and limiting the availability of alcohol at civic, sporting and public events. In particular, the strategy will advocate for statutory regulations at a national level in relation to alcohol marketing to protect children and assist licensed traders to be aware of regulations on the sale of alcohol and underage drinking.

Screening, treatment and support services

The alcohol strategy aspires to increase the availability of alcohol screening and promote and advocate the development of treatment services to meet the needs of people affected by alcohol misuse. Specifically, the strategy will encourage the use of appropriate screening and brief advice tools across a range of services; assess and strengthen referral systems for existing alcohol treatment services in Sligo city; and advocate for additional services where gaps in service provision

have been identified. In addition, the strategy will aim to facilitate the development of family supports for those affected by alcohol and support the development of a range of services for young people affected by alcohol.

Research, monitoring and evaluation
A survey will be conducted to assess behaviours, attitudes and awareness in relation to alcohol use in Sligo city. During the five-year roll-out, a system will be developed to track the progress of the strategy. This will include assessing the impact of the strategy at appropriate stages and the level of public support. The NWRDATF is keen to engage the public in the discussion and debate on both the issues and the possible solutions to alcohol-related harm. As Seán O'Connor, coordinator of the NWRDATF explained:

> *There are strategies which can be put in place that are shown to reduce the amount of alcohol-related harm without interfering with anyone's enjoyment of a night out. We are hoping to enlist enough support from local people and local agencies to implement an appropriate strategy for Sligo city.*

T1.6 Targeted intervention for other drug-related health harms

T1.6.1 Targeted interventions for other drug-related health harms
Post-detoxification outcomes in opioid-dependent patients
Currently, there are more than 10,000 opioid-dependent patients receiving substitution therapy in Ireland (Ivers*, et al.* 2017), with the majority of those attending detoxification receiving methadone. Given the weak evidence base with regard to the efficacy of detoxification, many clinicians opt to continue substitute prescribing or may even dissuade opioid-dependent persons from detoxifying.

A small number of international studies have examined problem drug users in detoxification treatment. Follow-up studies have noted discernible reductions in heroin use as well as significant reductions in criminality, psychopathology, and injection-related health problems following treatment exposure (Ross*, et al.* 2005) (Teesson*, et al.* 2006) (Teesson*, et al.* 2008). Nevertheless, the majority of these studies are limited to two time points and fail to take into account longitudinal changes. Importantly, no studies to date have focused on aftercare post-detoxification.

Recent research conducted in Ireland examined outcomes in a cohort of opioid-dependent patients post-detoxification (Ivers*, et al.* 2017). In this study, which has been published in the journal *Drug and Alcohol Review*, patients completing detoxification in the three major drug dependency units in Ireland during a 14-month period were examined (n=143). Subjects opting for one of the three pathways post-detoxification (inpatient aftercare, outpatient aftercare, or no formal aftercare) were

assessed in the final week of detoxification and followed up after three, six and nine months. The primary outcome was abstinence following detoxification.

Results

An adjusted Cox regression model indicated that participants who opted for outpatient aftercare treatment had a lapse/relapse rate that was 52% higher than the inpatient aftercare group (hazard ratio=1.52, 95% CI: 0.75–3.08), although this difference was not statistically significant. Time to first use of drugs was considerably shorter for the no formal aftercare group (hazard ratio=7.68, 95% CI: 4.30–13.73) when compared with those who received inpatient aftercare, thus highlighting that any aftercare is significantly better than no aftercare. Furthermore, patients who attended any form of aftercare were more likely than the no formal aftercare group to be abstinent at nine-month follow-up. Abstinence rates for outpatient aftercare and inpatient aftercare were found to be equal after nine months.

Conclusions

The authors concluded that patients who opt for aftercare post-detoxification have significantly better outcomes at follow-up when compared with those who received no formal aftercare. In addition, the marginal benefit that the study demonstrated for inpatient aftercare over outpatient aftercare should be taken into account when planning services, as it is almost as effective and it is also cheaper to provide.

Opioid substitution treatment for heroin-dependent adolescents

Opioid dependence is a major health concern across the world. The most recent prevalence estimates of opiate use in the Republic of Ireland indicate that were 18,988 opioid users in Ireland in 2014, giving a rate of 6.18 per thousand population aged between 15 and 64 years (95% CI: 6.09–6.98) (Hay*, et al.* 2017). Six per cent of this estimated population were under 24 years of age. Although recent trends suggest that the prevalence of problem opiate use in Ireland may have stabilised, it should be noted that estimates remain high, with other comparable studies suggesting that rates of use remain among the highest in Europe. Opioid substitution treatment (OST) is the main first line treatment intervention for heroin dependence among adults. Nevertheless, while OST has been thoroughly evaluated in adult populations, few studies have examined its use in among younger age groups, and there are concerns that OST is underutilised in adolescents with heroin dependence.

A recent Irish study investigated changes in drug use among adolescents receiving OST and also examined treatment attrition during the first 12 months of treatment (Smyth*, et al.* 2018). In this study, which was published in the journal *BMC Pediatrics*, data on all heroin-dependent patients (aged under 18.5 years) commencing OST were examined from one outpatient multidisciplinary addiction treatment service in Dublin. Drug use was monitored twice weekly using urine drugs

screens (UDS). Change in the proportion of UDS negative for heroin was examined using the Wilcoxon signed rank test. Attrition was explored via a Cox regression multivariate analysis.

It was found that of 120 patients who commenced OST (51% female, mean age 17.3 years), 33% (n=39) persisted with OST until month 12. Of these patients, heroin abstinence was 21% at month 3 and 46% at month 12, although heroin use declined significantly from baseline to month 3 ($p<0.001$) and from month 3 to month 12 ($p=0.01$). Use of other drugs did not change significantly. Among factors associated with heroin abstinence, the study observed the following:

- None of the patients who had a previous psychiatric admission were abstinent ($p=0.02$).
- All of the patients who were using cocaine during month 12 were also using heroin ($p=0.02$).
- Abstinence was not significantly associated with higher medication dose ($p=0.88$).
- Early reductions in heroin use, as evidenced by provision of at least one heroin negative sample during induction, tended to be associated with reduced likelihood of heroin abstinence at month 12 ($p=0.07$).

Cox regression analyses indicated that patients who had no children, who grew up in families with two parents, were in an intimate relationship with another heroin user and who were abstinent from cocaine in pre-treatment drug screens demonstrated significantly lower rates of unplanned exit from treatment.

The authors concluded that the study confirmed that adolescents on OST can achieve substantial reductions in heroin use, with many doing so very early in treatment. In addition, after a year of treatment, almost half of adolescent heroin users were heroin-abstinent. The authors state that these findings should act as source of optimism for clinicians. Nevertheless, patient dropout from treatment remains a challenge, and cocaine use before and during treatment may be a negative prognostic factor.

T1.7 Quality assurance of harm reduction services

T1.7.1 Quality assurance of harm reduction services

No information

T1.7.2 Additional information on any other drug-related harms data

Street-based injecting in Dublin city centre

Ireland's current drugs strategy emphasises a health-led response to drug use in Ireland (Department of Health 2017). Consistent with this focus, a pilot supervised injecting facility (SIF) will open in Dublin city centre. As Ireland moves towards implementation of the country's first SIF, information with regard to public injecting among drug users in Dublin's inner city is important. A

recently published report from the Ana Liffey Drug Project (ALDP) examined street-based injecting in Dublin city centre (Keane*, et al.* 2017).

Harms associated with street-based injecting

The report highlighted the harms associated with street-based injecting. These include both private harms affecting individuals who are injecting and public harms which impinge on the community where injecting is occurring. Private harms include evidence suggesting that injecting in public places is conducive to hasty injecting, leading to safety and hygiene concerns. Public harms include drug-related litter in public and semi-public locations, thus creating a safety hazard to other individuals.

Street-based injecting in Dublin city

A small number of studies have attempted to assess the prevalence of street-based injecting among drug users in Dublin. In 2013, Merchants Quay Ireland reported that 14% of subjects who used their needle and syringe exchange service generally injected in public places (Jennings 2013). More recently, the ALDP asked individuals who use their Dublin services to take part in a survey. It was found that 28% of respondents reported injecting drug use in the previous seven days; 18% of respondents reported mostly injecting on the street or in a service during this time.

It was noted that the issues facing this group are many and complex, with polydrug use and sharing of paraphernalia being of particular concern. In addition, 28% of respondents in the ALDP survey indicated having prior experience of overdose. The risk of fatal overdose is a constant reality among street-based drug injectors. As the HSE notes:

> *Public injecting is visually apparent in Dublin city centre through people using drugs and from drug-related litter…. Between 2012 and 2014 there were 25 drug-related deaths among people who inject drugs in public places in Dublin and 18 drug-related deaths among people who inject drugs who were in touch with homeless services in Dublin* (Health Service Executive and and National Office for Social Inclusion 2017).

Public harms associated with street-based injecting

In late 2016, the ALDP undertook a small project to document drug-related litter in Dublin's north inner city. Each afternoon a staff member walked two alternating routes in the area for two weeks; each route was covered every second day. In total, 57 separate instances of drug-related litter were identified, with over 1,750 individual pieces of litter being recorded. Litter was observed in a number of locations, but there were two 'hot spots': the area bounded by Capel Street, Ormond Square, Mary's Abbey and Ormond Quay, and that bounded by Jervis Street, Middle Abbey Street, Lower O'Connell Street and Ormond Quay.

Evidence of water for injection, citric acid and syringe caps were most frequently observed, and were recorded at 84%, 82% and 78% instances, respectively. Syringes were observed at 53% and needles at 51% of the total instances. Faeces were recorded at over one-quarter of locations, thus highlighting the lack of public toilets in the area.

Conclusions

The authors concluded that street-based injecting is an issue that requires attention in Dublin city centre, as the current situation perpetuates the use of high-risk environments by PWID, and also results in creating drug-related litter. Providing injecting drug users with the opportunity to access safer injecting spaces (such as supervised facilities) is a pragmatic approach to addressing this issue, as these services have repeatedly been shown to be effective in reducing harm, including overdose (Potier*, et al.* 2014). Other interventions identified by the ALDP included the following:

- Peer-led approaches to promoting safer disposal/return of drug-taking paraphernalia
- Continued outreach to identify people engaging in street-based injecting
- The removal of barriers that hinder the ability of people engaged in street-based injecting from accessing the services they require

T2 Trends (not relevant in this section – included above)

T3. New developments

T3.1 New developments in drug-related deaths and emergencies

Characteristics of methadone-related overdose deaths and comparisons between those dying on and off opioid agonist treatment (OAT)

A national cohort study published online in Heroin Addiction and Related Clinical Problems aimed to describe characteristics of methadone-related overdose deaths in Ireland and to compare deaths occurring among those registered for opioid agonist treatment (OAT) with deaths among those not registered (Van Hout*, et al.* 2018). OAT involves the use of drugs such as methadone or buprenorphine to reduce cravings and withdrawal symptoms among those addicted to opioids such as heroin.

It is well established that OAT, including methadone substitution therapy, can reduce deaths among problem opiate users. However, OAT is also associated with a risk of accidental overdose, as patients can experience lowered tolerance for opioids following a period of abstinence. Individuals completing detoxification, leaving prison, or exiting OAT may therefore be especially vulnerable to accidental death by overdose. Previous research in Ireland found that people treated with methadone were nearly four times more likely to die in periods off treatment than in periods on treatment.

Methodology

The current study drew on the Irish National Drug-Related Deaths Index (NDRDI) to identify persons who had died of a drug overdose involving methadone between 2012 and 2013. The NDRDI is an epidemiological database that draws on four sources – the Coroner Service, the Hospital Inpatients Enquiry Scheme, the Central Treatment List (CTL), and the General Mortality Register through the Central Statistics Office – to provide comprehensive data on drug-related deaths. The NDRDI classifies drug-related deaths as poisonings or non-poisonings (fatal overdoses), where 'poisonings' are deaths resulting from the toxic effects of the consumption of a drug(s) and/or other substances, and excludes adverse reactions to prescribed medications. Included in the current study were methadone-related poisoning deaths.

Findings

Methadone was implicated in 182 poisoning deaths that occurred during the study period. Just over half of the deaths were among persons aged 34 years or less (54%), and the majority of deaths were among males (78%). During the two-year period, more people died off OAT treatment (61%) than on OAT treatment (39%).

The study further found that a large number of methadone-related deaths were among persons previously treated for substance dependency, and many involved more than one substance. It was not possible to identify how many of those dying of fatal overdose were opioid dependent or were using diverted methadone for recreational or self-medicating purposes, nor was it clear how many had previous contact with OAT providers. Nonetheless, the findings suggest the targeting of overdose prevention interventions (such as overdose recognition, cardiopulmonary resuscitation, and naloxone) to those accessing all types of drug treatment services and not just those offering OAT. Over one-third of the fatal overdoses involving methadone were in patients registered for OAT, highlighting the unique position of OAT providers in risk assessment and overdose prevention. The finding that a high number of deaths occurred in a private dwelling and in the presence of others, suggests that family and peers should also be involved in overdose prevention initiatives.

A key limitation of the study is that the number of deaths off treatment may have been underestimated, as patients are not removed from the CTL until 28 days after treatment ceases. A further limitation is that it was not possible to differentiate between groups not registered for OAT, in particular those on waiting lists for OAT; those who just completed treatment; and those on buprenorphine. The study was also limited by the incomplete data for some variables, resulting from missing data in the original data sources accessible to the NDRDI. Access to a greater number of data sources would ensure more comprehensive data that could further inform the development and targeting of overdose prevention. The authors conclude that knowledge of patient characteristics, along with improved risk assessment and OAT retention strategies, can be used to inform any future national drug overdose plan.

T3.2 New developments in drug-related infectious diseases

HIV in Ireland: knowledge, attitudes and stigma

Recent research published by HIV Ireland examined national HIV knowledge and attitudes and the stigma associated with HIV (HIV Ireland 2017). HIV Ireland is a registered charity operating at local, national and European levels. The principal aim of the organisation is to contribute towards a significant reduction in the incidence and prevalence of HIV in Ireland and towards the realisation of an AIDS-free generation. The present study involved the development of two surveys. The first survey aimed to measure knowledge and attitudes among the general Irish population. The second survey measured stigma and the experiences of those living with HIV. Subjects were required to be 18 years of age or older and the surveys were completed by 1,013 and 168 respondents, respectively.

HIV knowledge and attitudes among the general public

Almost all adults (98%) correctly thought that HIV can be transmitted by sharing needles and syringes. A similar proportion correctly thought that HIV can be transmitted by a man and a woman, or a man and a man, having sex without a condom. However, the study found that myths in relation to HIV transmission remain and that young people had less correct knowledge than older people in relation to most methods of HIV transmission.

Misperceptions regarding HIV transmission among the general public included the following:

- 70% of respondents believed HIV can be transmitted through a bite.
- 24% believed HIV can be transmitted through kissing.
- 10% believed HIV can be transmitted through sharing a glass.
- 9% believed HIV can be transmitted through using a public toilet.

The authors also noted that more than 50% of respondents believed that HIV can be transmitted through a blood transfusion. While theoretically possible, this is not a reality given the safeguards and screening used in Ireland. HIV Ireland suggested that this assumption may negatively affect experiences of health services.

Stigma and experiences of those living with HIV

The second survey found that stigma and the fear of stigma affect how people living with HIV experience their lives. Almost two-thirds (61%) of people feared being rejected in a relationship and almost half of this cohort (32%) had actually been rejected. Fifty-four per cent of respondents were single; the comparable figure in the general population was 38%. The majority (61%) of people living with HIV had not disclosed their HIV status at some point, as they were afraid they would be judged or treated differently if they did. The stress that stigma can cause may explain why in the

past year almost one in five (17%) respondents living with HIV had felt suicidal. More than one-third also reported having suffered from low self-esteem, and having felt anger, guilt or shame, and they blamed themselves for their HIV status.

Other key findings among subjects living with HIV included the following:

- 88% thought that some members of the general public believe that living with HIV is shameful.
- 35% agreed that some people do not want to associate with them, and 38% believed that some people think they deserve to have HIV.
- A majority believed that it was more stigmatising to have contracted HIV through sex (76%) and through injecting drug use (67%).
- 18% of respondents living with HIV have had their HIV status disclosed accidentally in a hospital setting.

Conclusions

The authors suggest that knowledge in the general population regarding HIV transmission is relatively good, potentially highlighting the work done in relation to HIV awareness raising in Ireland. Nevertheless, the study indicates that there is some room for improvement, in particular with regard to knowledge gaps and misperceptions among younger adults. Stigma still persists and affects the everyday lives of people living with HIV. While stigma is most sorely felt by the person immediately impacted upon, society at large is not immune from the effects resulting from HIV-related stigma, as it may reduce the likelihood of people getting tested. HIV Ireland hopes that this research will highlight these issues and provide data to support informed education, awareness raising, and effective policy development.

Integrated hepatitis C care for people who inject drugs

Background

Hepatitis C virus (HCV) infection is a major cause of chronic liver disease and death. Drug use remains the significant cause of new infections in the European Union, with estimates of HCV antibody prevalence among PWID ranging from 5% to 90% in 29 European countries (Lazarus*, et al.* 2014). In the Republic of Ireland and the European Union, primary care is a key area of focus in efforts to enhance HCV diagnosis and treatment among PWID. Recently developed HCV direct-acting antiviral drugs are well tolerated and delivered for shorter courses (8–12 weeks), with trials reporting more than 90% cure rates among PWID (Dore*, et al.* 2016). However, despite these highly effective treatments, many people at risk are unaware of their infection; in addition, obstacles may limit people's access to HCV care, resulting in many patients not being treated.

A recent paper, published in the journal *JMIR Research Protocols,* outlines the protocol for a study which will examine integrated HCV for PWID (McCombe*, et al.* 2018). The research will be a prospective, non-randomised, pre-post intervention feasibility study, and will be conducted in opium substitution treatment (OST)-prescribing general practices (GPs) from three sites across the HepCare Europe consortium (Dublin, London and Seville). A total of 24 OST-prescribing GPs have been recruited from the professional networks and databases of members of the research consortium. Patients were eligible for inclusion in the study if they were aged ≥18 years, were on OST, and had attended the practice for any reason during the recruitment period. Baseline data on HCV care processes and outcomes were extracted from the clinical records of participating patients.

Intervention and outcomes

The aim of the intervention will be to enhance identification and linkage to HCV care and treatment among patients attending primary care for OST, and it includes the following:

- Outreach of an HCV-trained liaison nurse into GP practices
- In-practice education for clinicians in relation to developments in diagnosis and treatment of HCV
- Enhanced access of patients to community-based evaluation of HCV disease, including novel approaches to diagnosis
- A researcher-facilitated practice audit of HCV care processes and feedback to GPs.

Primary outcomes measures of the study will include the proportion of participants who have been screened for HCV and the proportion of HCV antibody-positive patients who commenced/completed antiviral therapy and who achieved sustained virologic response.

Secondary outcomes will include the following:

- The proportion of those screened who tested HCV antibody positive
- The proportion of HCV-positive patients who have been assessed using novel approaches
- The proportion of HCV-positive patients who have been referred to specialist hepatology or infectious disease services
- The proportion of HCV-positive patients who have attended specialist hepatology or infectious disease services
- The proportion of HCV-positive patients who received an alcohol screening brief intervention
- The proportion of participants tested for anti-HIV antibody, anti-HBc (hepatitis B core) antibody, or hepatitis B surface antigen (HBsAg)
- The proportion of participants immunised against hepatitis B/A virus

- The experience and evaluation of the intervention among key informants (clinicians and patients)
- The number of patients attending GP for OST post-intervention for follow-up testing
- To evaluate the feasibility and possible efficacy of the intervention by comparing pre-post intervention data
- To evaluate the cost-effectiveness of the intervention
- To compare clinician knowledge, attitudes and practice pre-post intervention.

Conclusions

The authors of this research protocol state that the study is ongoing and has the potential to make an important impact on patient care and provide high-quality evidence to help clinicians make important decisions on HCV testing and onward referral. As a substantial proportion of HCV-positive patients on OST are not engaged with specialist hospital services, but qualify for direct-acting antiviral drugs treatment, the study has the potential to reduce HCV-related morbidity and mortality.

T3.2 New developments in harm reduction interventions

Reducing the harms of cocaine use in Ireland

On the 17 July 2018, a new campaign developed by the Ana Liffey Drug Project and the HSE was launched to raise awareness of the dangers of using cocaine (powder and crack) and on how to reduce the harms associated with snorting, smoking or injecting cocaine (Health Service Executive 2018, 17 July). The Republic of Ireland currently ranks fourth highest in the European Union for cocaine use among young adults. In addition, cocaine remains the third most common drug reported among people presenting to treatment services in Ireland; in 2016, 12.3% of cases reported problem cocaine use, the highest proportion since 2010.

While the campaign will stress that it is always safest not to take unknown or illicit drugs at all, if a person chooses to use cocaine, the campaign provides harm reduction advice. This includes the following:

- When buying, know the source and avoid using cocaine while alone.
- Use one drug at a time.
- Start with a small test dose and leave at least two hours between doses.
- Grind cocaine to remove small lumps; use a sterile straw and do not share.
- Carry a condom, as cocaine use may increase sex drive and lead to unprotected sex.

Research indicates that regular club goers and people who are part of the club/dance music scene have higher rates of drug use when compared with the general population. With this in mind, the awareness campaign will target clubs and public event spaces, colleges and addiction services with

information about cocaine powder. In addition, drug services, clinics and Drug and Alcohol Task Forces will be targeted with information about crack.

The Minister of State for Health Promotion and the National Drugs Strategy, Catherine Byrne, welcomed the campaign and stated “This is a very important campaign, focusing on providing information and raising awareness about cocaine among drug users and health professionals...Through our national drugs strategy, ‘Reducing Harm, Supporting Recovery’, we are working to strengthen early harm reduction responses to current and emerging trends and patterns of drug use, which would benefit people who use drugs, their families, and the community.”

High uptake of sterile crack pipes in response to surge in cocaine use in Dublin

An article published in July 2018 by The Journal.ie explained that needle exchange services in Dublin have noted a strong uptake of clean crack pipes by service users in response to a surge in availability and consumption of crack cocaine in 2018 (Hennessy and Brophy 2018, 22 July).

On 13 July 2018, MQI began providing clean crack pipes from its centre, which is located on Dublin city’s south quays; 69 pipes were dispensed in the scheme’s first week of operation. The ALDP, which runs an outreach needle and syringe programme from Middle Abbey Street in Dublin, began handing out reusable crack pipes in April 2017. Since that time, 287 pipes have been distributed. Of these, almost half (128) were handed out between March and July 2018. The ALDP noted that while most of the clients they deal with smoke crack, recently staff have been engaging with a cohort of people who are neck-injecting the drug, which the ALDP describes as a “very risky activity”.

Use of cocaine has now returned to Celtic Tiger levels (2004–2007) in Ireland and the HSE has recently launched a new harm reduction campaign, in conjunction with the ALDP, to provide information and advice to users about both cocaine powder and crack cocaine (Health Service Executive 2018, 17 July). Tony Geoghegan, CEO of MQI, noted that individuals they deal with are primarily street drug users, rough sleepers and people who are homeless, and that these would not necessarily be archetypal users, as cocaine use is much more spread across society. Nevertheless, Mr Geoghegan stated that it is important to address drug use in this cohort, as cocaine and crack have a propensity to cause harm very quickly.

T4. Additional information

T4.1 Additional sources of information

No information

T4.2 Further aspects of drug-related harms and harm reduction

No information

T5. Sources and methodology

T5.1 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

T5.2 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 drug 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 diseases. The HPSC has recorded new cases among injecting drug users of HIV since 1982, HBV since 2004, and HCV since 2006.

The **HIPE (Hospital In-Patient Enquiry)** is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and the HSE. It collects demographic, medical and administrative data on all admissions, discharges and deaths from acute general hospitals in Ireland. It was started on a pilot basis in 1969 and then expanded and developed as a national database of coded discharge summaries from the 1970s onwards. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, 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. The NPIRS does not collect data on the prevalence of psychiatric comorbidity in Ireland. The HRB publishes an annual report on the data collected in the NPIRS, entitled *Activities of Irish psychiatric units and hospitals*.

National Self-Harm Registry Ireland is a national system of population monitoring for the occurrence of deliberate self-harm, established at the request of the Department of Health and Children by the National Suicide Research Foundation. Since 2006/7 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 deliberate ingestion of a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences". All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are included. Not considered deliberate self-harm are accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm; alcohol overdoses alone, where the intention was not to self-harm; accidental overdoses of street drugs (drugs used for recreational purposes), without the intention to self-harm; and individuals who are dead on arrival at hospital as a result of suicide.

T5.3 References

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European Monitoring Centre for Drugs and Drug Addiction

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

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

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

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