Focal Point Ireland: national report for 2018 - Treatment

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

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Please use the following citation:
Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (2019) ***Focal Point Ireland: national report for 2018 - treatment***. Dublin: Health Research Board.

Other reports in this National report series can be found at
http://www.drugsandalcohol.ie/php/annual_report.php

(2019) *Focal Point Ireland: national report for 2018 – drug policy*.
(2019) *Focal Point* Ireland: national report for 2018 – prison.
(2019) *Focal Point* Ireland: national report for 2018 – drug markets and crime.
(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 – harms and harms reduction.*
(2019) *Focal Point Ireland: national report for 2018 – drugs.*

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T0. Summary

National Profile

Ireland's national drug strategy is structured around cross-cutting goals rather than the pillars of the previous national drug strategy. The main aims are to minimise the harms caused by the use and misuse of substances and to promote rehabilitation and recovery. Therefore, there is a focus on the need for a range of treatment, rehabilitation, and recovery services using the four-tier model. The strategy also recognises the need for timely access to appropriate services for the client.
The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment. Drug treatment is therefore provided not only through a network of HSE services (public), but also through non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment.

A range of treatment options is available for problem drug users, mainly in outpatient settings but also in residential settings. Almost all opioid substitution treatment (OST) provided is methadone, although buprenorphine in combination preparations is now available but for a limited number of clients. In 1998, the first formal methadone treatment protocol (MTP) was introduced in order to ensure that treatment for problem opiate use could be provided wherever the demand existed. Outpatient methadone treatment for problem opiate users is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics, or through specialised general practitioners (GPs) in the community. The first national comprehensive clinical guidelines for OST were published in 2016.

Trends

There were no changes in trends between 2016 and 2017. The majority of drug treatment (more than 75%) is provided through publicly funded and voluntary outpatient services. Outpatient services include low-threshold and specialised OST GPs in the community. Inpatient treatment is mainly provided through residential centres run by voluntary agencies.

Opioids (mainly heroin) are the main problem illicit drug used by entrants to treatment, followed by cannabis and cocaine. The proportion of all entrants to treatment reporting an opioids as their main problem drug has decreased year on year since 2004, from a peak of 65% in 2004 to 45% in 2017. Over this period, cannabis has been consistently reported as the second most common main problem drug, with the proportion increasing from 21% in 2004 to 25% in 2017. For new entrants to treatment, cannabis has been the main problem drug since 2010, replacing opioids (mainly heroin).

The most notable trend is the continued increase in the number of cases presenting for treatment for problem cocaine use. Previously, the highest proportion was reported in 2007 at 13%, with this proportion dropping steadily until 2012 when it stabilised; however, since then the number of cases increased to a new peak of 17% in 2017 (compared with 12% in 2016).

The majority of cases have been treated previously. The proportion of new entrants to treatment remained unchanged in 2017, at 38%. The proportion of new entrants has fluctuated, from 39% in 2004 to a peak of 47% in 2009 and down to 38% in 2017.

The majority of OST clients receive methadone in specialist outpatient clinics, with a smaller number receiving it from specialist GPs and an even smaller proportion (less than 5%) in prison. The number of clients registered for OST on 31 December each year has increased from 3,689 in 1998 to 10,316 in 2017.

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

T1. National profile

T1.1 Policies and coordination

T1.1.1 Main treatment priorities in the national drug strategy

Treatment and rehabilitation in the National Drugs Strategy

Treatment and rehabilitation are covered under the second goal of the document *Reducing Harm, Supporting Recovery*, the national drug strategy 2017 to 2015 (Department of Health 2017). The main aims of the strategy are to minimise the harms caused by the use and misuse of substances and to promote rehabilitation and recovery. The second goal focuses on the range of treatment, rehabilitation, and recovery services available to users. It recognises that "timely access to appropriate services relevant to the needs and circumstances of the person concerned is of fundamental importance" (p. 33). There are two objectives to the goal; the first relates to treatment and rehabilitation and is described below, and the second focuses specifically on people who inject drugs and the issues of overdose and drug-related deaths – this is considered in more detail in the Harms and Harm Reduction workbook.

The first objective under this goal is "To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs". It focuses on improving access to a range of services, both for users generally and for some groups in particular. The HSE follows a four-tiered person-centred model of rehabilitation which is based on the principle of 'continuum of care'. This continues to be the national framework through which treatment and rehabilitation services are delivered, with all substances of misuse being dealt with and with a focus on polydrug use.

There are a number of actions under each objective; the time frame for their delivery is from 2017–2020.

In terms of improving access to services, actions include:

- Strengthening the implementation of the National Drugs Rehabilitation Framework (Doyle and Ivanovic 2010) by developing a competency framework on key working, care planning, and case management; and by extending the training programme on the key processes of the Framework.
- Expanding the availability and geographical spread of relevant quality drug and alcohol services and improving the range of services available, based on need. This will be done by identifying and addressing gaps in provision in the four tiers, increasing the number of treatment episodes provided across the range of services, and strengthening the capacity of services to address complex needs.
- Improving the availability of OST by examining potential mechanisms to increase access through the expansion of GP prescribing and nurse-led prescribing, and through the provision of OST in community-based settings and homeless services.
- Enhancing the quality and safety of care in the delivery of OST by implementing the HSE's Clinical Guidelines for Opioid Substitution Treatment and reviewed in line with National Clinical Effectiveness Committee processes (see Section T1.5.1 below).

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

For example, these actions aim to:

- Expand addiction services for pregnant and postnatal women
- Respond to the needs of women who are using drugs and/or alcohol in a harmful manner by improving the range of wraparound services available
- Expand the range, availability, and geographical spread of services for those under 18 years of age
- Examine the need to develop specialist services to meet the needs of older people with long-term substance use issues, and
- Improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the National Clinical Programme for Mental Health in order to address dual diagnosis, and by developing joint protocols between mental health services and drug and alcohol services.

For more information on the drug strategy, see T1.1.2 in the Drug Policy workbook.

T1.1.2 Governance and coordination of drug treatment implementation

The HSE is identified as the lead agency with responsibility for the delivery of most of the treatment- and rehabilitation-related actions under the national drug strategy 2017-2025 (Department of Health 2017). However, other agencies identified as having lead responsibility on specific actions include the Department of Health, Tusla – The Child and Family Agency, and the Irish Prison Service.

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

The HSE supports the non-statutory sector to provide a range of health and personal social services, including the drug projects supported by the Local and Regional Drugs and Alcohol Task Forces, which receive annual funding of more than €20 million. This funding is governed by way of service arrangements and grant aid agreements. The HSE's Primary Care Division assists the Task Forces drugs to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance Group, and seeks to ensure that funded organisations support and promote the aims and objectives of the national drug strategy.

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

T1.1.3 Further aspects of drug treatment governance

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

The Central Treatment List (CTL) was established under Statutory Instrument No 225 following the 1998 *Report of the Methadone Treatment Services Review Group* (Methadone Treatment Services

Review Group 1998). This list is a complete register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and is administered by the HSE National Drug Treatment Centre.

There are comprehensive *Clinical Guidelines for Opioid Substitution Treatment* (Health Service Executive 2016).

T1.2 Organisation and provision of drug treatment

T1.2.1 Outpatient drug treatment system – main providers

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also Sections T1.1.2 and T1.4.1 in this workbook). There are an unknown number of private organisations that also provide outpatient addiction treatment, such as counselling. Very few of the private agencies contribute data to the Treatment Demand Indicator (TDI) figures. Some addiction treatment is also provided and/or funded through the HSE Mental Health Division and are included in TDI under the category of specialised drug treatment centre. However Many outpatient mental health services do not provide data for TDI at this time.

The majority of treatment (either outpatient or inpatient) reported through TDI is provided through specialised drug treatment centres (63% of all treatment services; 78% of all outpatient services). Only 11% of outpatient treatment reported through TDI is provided through low-threshold services. This is because these agencies provide many additional services which do not meet the inclusion criteria for TDI, e.g. needle exchange only, social support, food, etc.

GPs are primary care medical practitioners who have completed the specialist training and can therefore provide OST to clients who are stable. As such, they represent an important part of drug treatment in Ireland, particularly for stable clients on OST. For further information, see Section T1.4.10 below. Not all GPs choose to provide OST, and some GPs may provide other drug treatments, such as benzodiazepine and alcohol detoxification or brief interventions. These other interventions are not currently captured for TDI due to resource issues. The coverage of GPs in TDI has dropped over the past number of years, representing only 1.3% of all treatment services reported through TDI or 1.6% of all outpatient services reported through TDI. As such, TDI does not accurately reflect the total number of OST clients treated by GPs in the community (see Table V below). This is again due to resource issues.

T1.2.2 Further aspects of outpatient drug treatment provision

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

	Total number of units	National Definition (Characteristics/Types of centre included within your country)	Total number of clients
Specialised drug treatment centres	314	Treatment facilities where the clients are treated during the day (and do not stay overnight).	5,341

	Total number of units	National Definition (Characteristics/Types of centre included within your country)	Total number of clients
		Includes OST clinics, any specialised addiction service (e.g. counselling), therapeutic day care, and socioeconomic training units	
Low-threshold agencies	82	Aim to prevent and reduce health-related harm associated with problem drug use, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. May provide low- dose OST, general medical assistance, brief interventions, and needle exchange.	764
General primary health care (e.g. GPs)	356	Specially trained GPs who provide OST in primary care.	112
General mental health care			
Prisons (in-reach or transferred)	28	In-reach provided by voluntary services funded by the Irish Prison Service and others. Includes some prison medical units which provide OST.	616
Other outpatient units			

Source: Standard table 24.

T1.2.3 Further aspects of outpatient drug treatment provision and utilisation

No information

T1.2.4 Ownership of outpatient drug treatment facilities

All OST treatment is publicly funded, whether provided in a clinic or by a GP. All HSE outpatient services provide free treatment to those who are entitled to such. Many non-statutory agencies, which include low-threshold agencies, are wholly or partly funded by the HSE (see also Section T1.1.2 in this workbook). The proportion of agencies which are fully funded by the HSE is not currently available and is recorded as “other” in Table II, indicating that this is unknown. There is an unknown number of private organisations also providing outpatient addiction treatment, such as counselling. Some of this treatment may be covered by private health insurance; however, the proportion is not known. All addiction treatment in prison is provided free of charge.

Table II Ownership of outpatient facilities providing drug treatment in your country (percentage).

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
Specialised drug treatment centres				100	100%
Low-threshold agencies				100	100%
General primary health care (e.g. GPs)	100				100%
General mental health care				100	100%
Other outpatient units (1)					100%
Other outpatient units (2)					100%

T1.2.5 Inpatient drug treatment system – Main providers and client utilisation

Inpatient addiction treatment services are provided mainly through non-statutory agencies. There are two dedicated inpatient hospital HSE detoxification units, which account for 11% of all inpatient cases reported through TDI, but other non-statutory agencies also provide inpatient detoxification services. The coverage of inpatient services is high in TDI. The number of residential beds has

increased over the past number of years; as of January 2017, it was estimated that there were 144 detoxification beds and 643 residential rehabilitation beds in Ireland (Harris 2017).

Mental health services provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures, which show that in 2016, 943 cases were admitted to psychiatric facilities with a drug disorder. Of these cases, 415 were treated for the first time. For further information, see 'Drug admissions to psychiatric facilities' in Section T1.2.3 of the Harms and Harm Reduction workbook.

T1.2.6 Further aspects of inpatient drug treatment provision

Table III. Network of inpatient treatment facilities (total number of units)

	Total number of units	National Definition (Characteristics/Types of centre included within your country	Total number of clients
Hospital-based residential drug treatment	2	Wards or units in hospitals where the clients may stay overnight. This figure refers to the two hospital inpatient detoxification units. There are also 66 psychiatric hospitals for inpatients, but these do not currently report to TDI.	189
Residential drug treatment (non-hospital based)			
Therapeutic communities			
Prisons			
Other inpatient units (1.please specify here)	51	Centres where the clients may stay overnight. They include therapeutic communities, detoxification units, and centres that offer residential facilities. It is not possible to differentiate between residential inpatient and therapeutic communities, so both are reported together in this section.	1,517
Other inpatient units (2.please specify here)			

Source: Standard table 24

T1.2.7 Ownership of inpatient drug treatment facilities

Inpatient addiction treatment services are provided mainly through non-statutory agencies. Most of these agencies are partially or wholly funded by the HSE (see also Section T1.1.2 in this workbook). The number of clients and the proportion of treatment which are funded fully by the HSE are not currently available and are recorded as "other" in Table II, indicating that this is unknown. Some of this treatment may be covered by private health insurance; however, the proportion is not known. Inpatient mental health services would be provided care free of charge to social welfare clients with the appropriate entitlements. Some of the mental health services treatment can be covered by private health insurance; however again, the proportion is not known.

Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all Therapeutic communities are public/government-owned facilities and about 20% are non-government (not for profit) owned facilities.

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
Hospital-based residential drug treatment				100	100%
Residential drug treatment				100	100%
(non-hospital based)					100%
Therapeutic communities					100%
Prisons	100			100	100%
Other inpatient units (1 - please specify here)					100%
Other inpatient units (2- please specify here)					100%

T1.3 Key data

T1.3.1 Summary table of key treatment related data and proportion of treatment demands by primary drug

Opioids (mainly heroin) and cannabis are the two main drugs for which cases sought treatment in 2017.

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped slightly to 44.9% in 2017, compared with 46.9% in 2016 (see Figure II and Figure III). This continues the overall downward trend in the number of cases presenting to treatment for problem opioid use over the past number of years. Heroin continues to be the main drug in this category, representing 84.5% of all those reporting an opioid as their main problem drug in 2017; this is similar to 2016, when 84.7% reported problem heroin use.

The second most common drug reported was cannabis, again with a similar proportion to previous years. Almost one-quarter of cases (24.6%) reported cannabis as their main problem drug in 2017, which was only a slight decrease from 2016 (26.6%) (see also the Drugs workbook). The trend for problem cannabis use has stabilised over the past number of years. The majority (60.4%) of those reporting cannabis as their main problem drug in 2017 had never been treated before, compared with 60.9% in 2016 and 63.1% in 2015.

Cocaine remains the third most common drug reported in 2017 (16.8%). This is a definite continuation of the increasing trend, with 12.2% of cases reporting problem cocaine use in 2016 and 8.7% in 2015. The proportion recorded in 2017 is the highest recorded over the past years. Slightly more than half of cases in 2017 had never been previously treated (52.3%), similar to 2016 (51.6%).

Benzodiazepines were the fourth most common drug reported (9.8%), similar to 2016. Unlike cannabis and cocaine, only 34.6% of cases with problem benzodiazepine use had never been treated before.

Amphetamines (0.5%) and ecstasy (0.5%) continued to make up a very small proportion of the main problem drugs reported in 2017, with no change from the previous years.

T1.3.2 Distribution of primary drug in the total population in treatment

No new information

T1.3.3 Further methodological comments on the Key Treatment-related data

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

T1.3.4 Characteristics of clients in treatment

No new information

T1.3.5 Further top level treatment-related statistics

Table T1.3.5.1: Summary table – Clients in treatment

	Number of clients
Total clients in treatment	8,539
Total OST clients	10,316
Total number of clients entering treatment	Data on OST and TDI are from different sources. These data are collected using different methodologies. Additionally, because there is some duplication, the data cannot be combined or compared meaningfully.

Source: ST24 and TDI

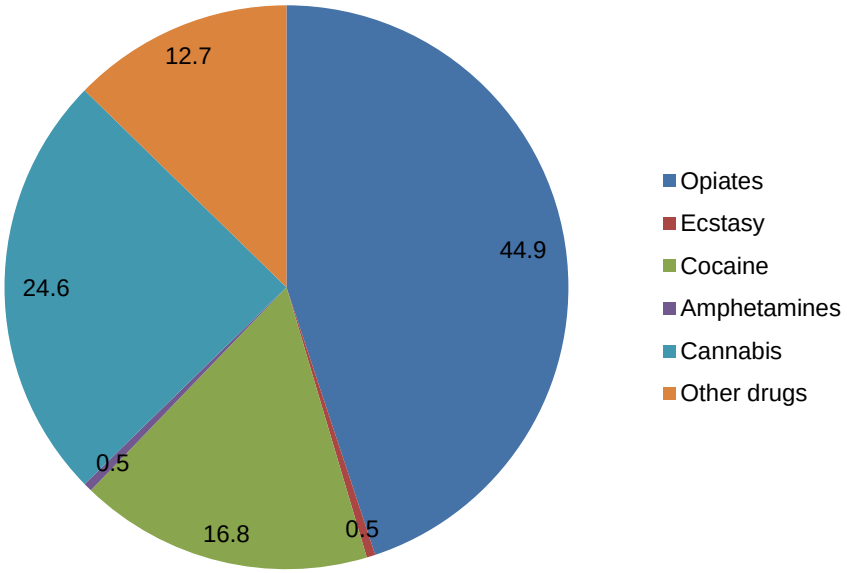

Figure T1.3.5.1 Proportion of treatment demands by primary drug

Source: TDI

T1.4 Treatment modalities

T1.4.1 Outpatient and inpatient services

The types of treatment and services offered vary, depending on the ethos and primary purpose of individual drug treatment centres. The majority of OST is provided by designated HSE clinics, which often also offer other specialist services including psychiatry, counselling, social services, and general medical activities such as vaccinations (see also Section T1.4.9 below). Development of a

care plan and case management are an integral part of a client's treatment programme (Doyle and Ivanovic 2010). Other services that do not offer OST may provide a wide variety of treatments, including counselling, group therapy, socioeconomic training, complementary therapies, relapse prevention, etc. Clients who require specialised services which are not available in the service they are currently attending will be referred on to a service which can provide that treatment. It is not mandatory for GPs to provide OST (see also Section T1.4.9).

There is no public information available regarding waiting lists for the range of therapies provided or regarding the saturation of services. For further information, see Standard Questionnaire Q27 for EMCDDA data collection period 2017.

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

T1.4.2 Further aspect of available outpatient treatment services

No information

T1.4.3 Availability of core interventions in inpatient drug treatment services

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

Detoxification: There are two dedicated HSE hospital inpatient detoxification units (with a total of 18 beds). Ten other residential centres, provided by voluntary/non-statutory services, also offer detoxification as part of their suite of residential treatments. There is one centre that provides adolescent residential detoxification, which has four beds.

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

Development of a care plan and case management are an integral part of a client's treatment programme (Doyle and Ivanovic 2010).

Some residential services cannot provide OST due to staffing and governance issues, but will facilitate clients to continue their OST through an outpatient service. Detoxification-only programmes

will offer a different range of services compared to longer-stay residential rehabilitation services, depending on the length of the programme.

Clients who require specialised services which are not available in the service they are currently attending will be referred on to a service which can provide that treatment. For further information, see Standard Questionnaire Q27 for EMCDDA data collection period 2017.

The data in Table VII should be interpreted under the proviso that the interventions are available if appropriate to the service, as there is no State-mandated model of treatment for inpatient services. For therapeutic communities and prisons, the response is not applicable.

Table VII. Availability of core interventions in inpatient drug treatment facilities.

	Hospital-based residential drug treatment	Residential drug treatment (non-hospital based)	Therapeutic communities	Prisons
Psychosocial treatment/ counselling services	not known	>75%		
Screening and treatment of mental illnesses	>75%	>75%		
Individual case management	>75%	>75%		
Opioid substitution treatment	>75%	>75%		
Other core outpatient treatment interventions (please specify in 1.4.1.)	not known	not known		

T1.4.4 Further aspect of available inpatient treatment services
No information

T1.4.5 Targeted interventions for specific drug-using groups
There are drug liaison clinics in several maternity hospitals. A total of 60 deliveries were to mothers attending a drug liaison midwife in 2016 (see also Section T1.3.6 in Harms and Harm Reduction workbook) (The Rotunda Hospital 2017).

There is also one residential centre that caters for women and their children. Otherwise, women can access treatment through the normal channels.

There are some specific outpatient services that cater for children under the age of 18 years (see also Section T1.4.11 below for research on adolescents in OST). There is also one residential centre for children under the age of 18 years for both detoxification and residential rehabilitation.

T1.4.6 E-health interventions for people seeking drug treatment and support online
The information website www.drugs.ie offers a free online 'Live Help' chat service for people to contact confidentially, which is run by the Ana Liffey Drug Project and funded by the HSE. It is open to both those using drugs and those affected by the drug use of others. A summary of the data for 2017 (by quarter) has been provided by the Ana Liffey Drug Project (personal communication, Ms Nikki Killeen, Ana Liffey Drug Project, 2018).

There were 665 calls recorded in the period from January to November 2017. The number of calls per month ranged from 45 to 104. The proportion of callers who were men ranged from 10% to 35% of all callers; however, the gender was unknown for the majority of callers. The proportion of callers who were calling about themselves ranged from 36% to 50% over the four quarters. Other

categories of callers were partners, siblings, friends, parents, and other or unknown who were calling about the drug use of others.

For nearly every quarter, cannabis was the most common drug mentioned, ranging from 17% to 33% of calls. This was followed by alcohol and cocaine.

T1.4.7 Treatment outcomes and recovery from problem drug use

Recent research conducted in Ireland examined outcomes in a cohort of opioid-dependent patients post-detoxification (Ivers*, et al.* 2018). This study examined patients completing detoxification in the three major drug dependency units in Ireland during a 14-month period (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 with after three, six, and nine months. The primary outcome was abstinence following detoxification.

The authors concluded that patients who opt for aftercare post-detoxification have significantly better outcomes at follow-up when compared with those who opt for 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 cheaper to provide. For more details, please see Section T1.6.1 of the Harms and Harm Reduction workbook.

T1.4.8 Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations

No information

T1.4.9 Main providers/organisations providing Opioid substitution treatment

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

In 2017, according to data from the Central Treatment List (CTL) (see also Section T2.2 below), 53% of patients were receiving treatment in specialist outpatient clinics, 40.9% from GPs, 6% in prison, and less than 0.2% in an inpatient setting (personal communication Caroline Walsh, CTL, 2018). The proportion of clients receiving treatment from GPs has increased slowly but steadily over the years, from 31.7% in 2001 to 41.2% in 2015, stabilising at 41.5% in 2010. The change seen between 2001 and 2015 likely reflects the policy to move stable OST clients back to primary care where they can receive all their care from their own GP, including OST, as well as reflecting the increase in specialist GPs in the community. The proportion of clients receiving treatment in

specialist outpatient clinics has decreased from 59% in 2008 to 53.7% in 2016. No change was seen in 2017 for this service type.

Data on annual waiting times for OST are not available; however, in October 2017, the national average waiting time between referral for OST and assessment for OST was 2.8 days. In October 2017, the average waiting time between assessment and treatment (or exit from the waiting list) was 26.5 days (Byrne 2017, 14 December, Byrne 2017, 17 January).

T1.4.10 Number of clients in OST

The number of clients registered for MMT on 31 December each year is reported by the CTL (see also Figure IV in Section T2.2 below, as well as Standard Table 24). On 31 December 2017, 10,316 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Walsh, CTL). This represents a very slight increase (2.3%) on 2016, compared to the 1.7% increase between 2015 and 2016. The CTL is a national register of all clients on MMT.

Almost all clients receive methadone as their opiate substitute, as historically this has been the primary drug of choice for treating opiate dependency in Ireland.

In 2017, Suboxone was available for prescription for a small number of patients where clinically appropriate. In 2017, 133 patients were prescribed Suboxone (almost all in HSE outpatient OST clinics) (personal communication, Mr Joseph Doyle, National Social Inclusion Office, 2018). These numbers are not included as yet in the overall numbers of patients receiving OST reported above or in Standard Table 24, which currently only apply to methadone. As of 31 December 2017, there were 87 clients registered on Suboxone. It is envisaged that the numbers treated with Suboxone will increase in 2018.

T1.4.11 Characteristics of clients in OST

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, data on all heroin-dependent patients (aged under 18.5 years) commencing OST were examined from one outpatient multidisciplinary addiction treatment service in Dublin.

The authors concluded 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 one-half of adolescent heroin users were heroin-abstinent. The authors state that these findings should act as a 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. For more details, see Section T1.6.1 in the Harms and Harm Reduction workbook.

T1.4.12 Further aspect on organisation, access and availability of OST

The majority of OST in Ireland is provided through GPs who undergo additional training, and through the Methadone Treatment Programme (MTP), which has been running for 20 years. The aim of this study was to make recommendations to improve OST and MTP treatment (Van Hout*, et al.* 2018).

A single focus group containing 11 pre-selected national key stakeholders and experts took part in a guided one-off discussion. A broad range of expertise was represented, including clinical, addiction and social inclusion management, harm reduction, homelessness, specialist GPs, and academics. Three participants came from national non-statutory agencies, while the majority of the panel oversaw OAT design and implementation. A written guide exploring relevant issues around OAT and MTP was used in the focus group discussion. Transcripts of the audio recording were subjected to content analysis to generate overall themes.

Four themes emerged from the content analysis of the discussion on current barriers within treatment and possible solutions: OAT Choices and Patient Characteristics; Systemic Barriers to Optimal OAT Service Provision; GP Training and Registration in the MTP; and Solutions and Models of Good Practice: Using What You Have.

The main barriers and solutions raised were as follows.

- OST choices and patient characteristics
- There was lack of choice in OST; Suboxone® use is restricted, whereas methadone is widely available yet viewed more negatively by patients.
- There was a change in characteristics of those seeking OST; with OTC opioid abuse becoming more prevalent, accessing treatment is proving difficult for the new cohort of patients both in terms of location and stigma associated with some addiction services.
- Treatment pathways for polydrug use are lacking.
- Patients' behavioural issues often require measures at methadone dispensing pharmacies. This was keenly felt in regard to all female practices supervising male patients.
- The age profile of long-term methadone users may limit the relevance of any new treatment models.
- The current long-term MTP was described as complex and overly medicalised (e.g. tapering) and requires a broader approach.
- Systemic barriers to optimal OST service provision
- Provision of OST was described as urban-centric, creating a logistical barrier for rural patients.
- The sole route of treatment is often through large methadone clinics that may be off-putting for some patients.
- Complexities around patient's addresses can limit the available services.
- Waiting lists for treatment and the requirement for regular consultations exist.

- Stipulations on referring patients to Level 1 GPs2 and restrictions in numbers managed by Level 1 GPs exist.

GP training and registration in the MTP

- Complexity around registration with the HSE and the negative perception of OAT were viewed as affecting the uptake of Level 1 and Level 2 training.
- GP registrars not exposed to the opioid-dependent cohort were seen to be less willing to be involved in training and OST.
- Level 1 and Level 2 structures were viewed as too complex for new GPs entering employment in services that do not currently have MTP.
- Difficulties around becoming a Level 2 prescriber exist.
- In some areas, GPs were seen as unwilling to take on complex patients due to a lack of resources.
- Solutions and models of good practice: using what you have
- The training of all GPs in methadone prescribing and other OAT was seen as a way to change attitudes.
- Supports – such as counselling – that are available in clinics should be available in some capacity to GP services.
- Informal support meetings within GP practices or telemedicine to deal with the complexity of some cases should be available.
- Family support systems should be used from the outset, in addition to shared care and key working.
- The potential for community pharmacies and nurses to contribute to care, including the provision of necessary vaccinations, should be realised.

This study was a first step in identifying barriers to optimal OAT provision. Key experts identified a number of possible solutions that the Irish College of General Practitioners (ICGP) will seek to advance in the relevant arenas and expand upon through further independently run research.

The authors acknowledge a number of limitations to the research, including: the use of a single focus group containing 11 preselected experts; the sample not being likely to be nationally representative of experiences or opinions; no patient voices being included; and the fact that the involvement of members of the ICGP's Substance Misuse Programme in discussion and facilitation may have limited the views shared by others in the group.

T1.5. Quality assurance of drug treatment services

T1.5.1 Quality assurance in drug treatment

No information

T2. Trends

T2.1 Long term trends in numbers of clients entering treatment and in OST

New treatment entrants (Figure T2.1.1)

In 2017, there were 3,253 new entrants recorded in the National Drug Treatment Reporting System (NDTRS) (see also TDI table and Figure III), continuing a downward trend since 2014. New treatment entrants represented 38.1% of all cases in 2017. The proportion of new entrants in treatment has fluctuated over the 10-year reporting period, with a peak of 47.2% in 2009, but has stabilised since 2014 at around 39%.

Between 2007 and 2010, opioids (mainly heroin) were the main problem drug reported by new entrants to treatment, but this was superseded by cannabis in 2011 and this trend continues. The number of cocaine cases has fluctuated over the past 10 years, peaking among new entrants in 2009 at 19%, dropping steadily thereafter until 2012, and then increasing year on year to a peak of 23% in 2017 (compared with 16.1% in 2016). Both amphetamines and ecstasy are only very rarely reported as main problem drugs by new entrants to treatment.

In 2017, 'other drugs' (mainly benzodiazepines) were the fourth largest group of drugs reported by new entrants as their main problem drug, as was the case in previous years.

All treatment entrants (Figure T2.1.2)

In 2017, a total of 8,539 entrants were recorded in the NDTRS (see also TDI). This is a decrease in the number of cases reported compared with 2016 (8,954). Of the cases recorded in 2017, the majority had been previously treated (57.0%), very similar to 2016 (56.7%).

In 2017, opioids (mainly heroin) were the main problem drug used by entrants to treatment. The absolute number presenting for problem opioid use decreased again slightly in 2017 to 3,837, compared with 4,202 in 2016. The number of cases reporting problem opioid use peaked in 2010 at 4,929, and has shown an almost consistent downward trend since then.

Since 2007, cannabis has been consistently reported as the second most common problem drug, with the proportion decreasing slightly from 28.3% in 2016 to 24.6% in 2017.

The most notable finding is the continued increase in the number of cases presenting for treatment for problem cocaine use. Previously, the highest proportion was reported as 13.3% in 2007, dropping steadily until 2012 when it stabilised; however, the number of cases since then has increased to a new peak of 16.8% in 2017 (compared with 12.2% in 2016).

Both amphetamines and, to a lesser extent, ecstasy, are reported very rarely as main problem drugs by entrants to treatment in Ireland.

In 2016, 'other drugs' (mainly benzodiazepines) were the fourth largest group of problem drugs reported, which is similar to previous years.

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

T2.2 Additional trends in drug treatment

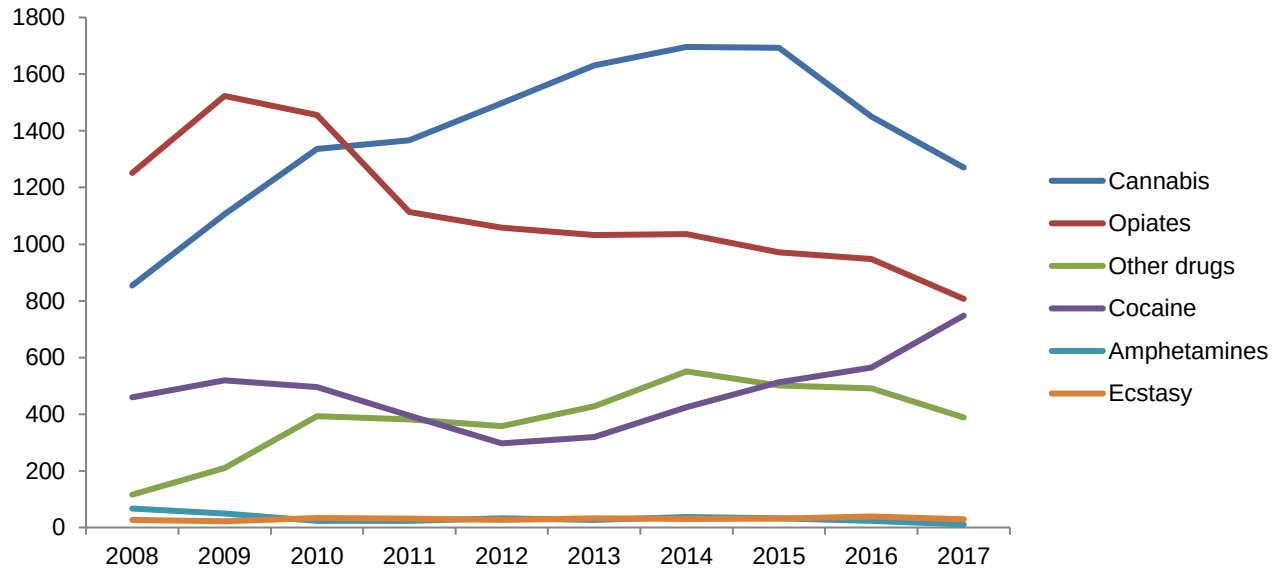

Figure T2.2.1 Trends in numbers of first-time clients entering treatment, by primary drug, 2004–2017
Source: TDI

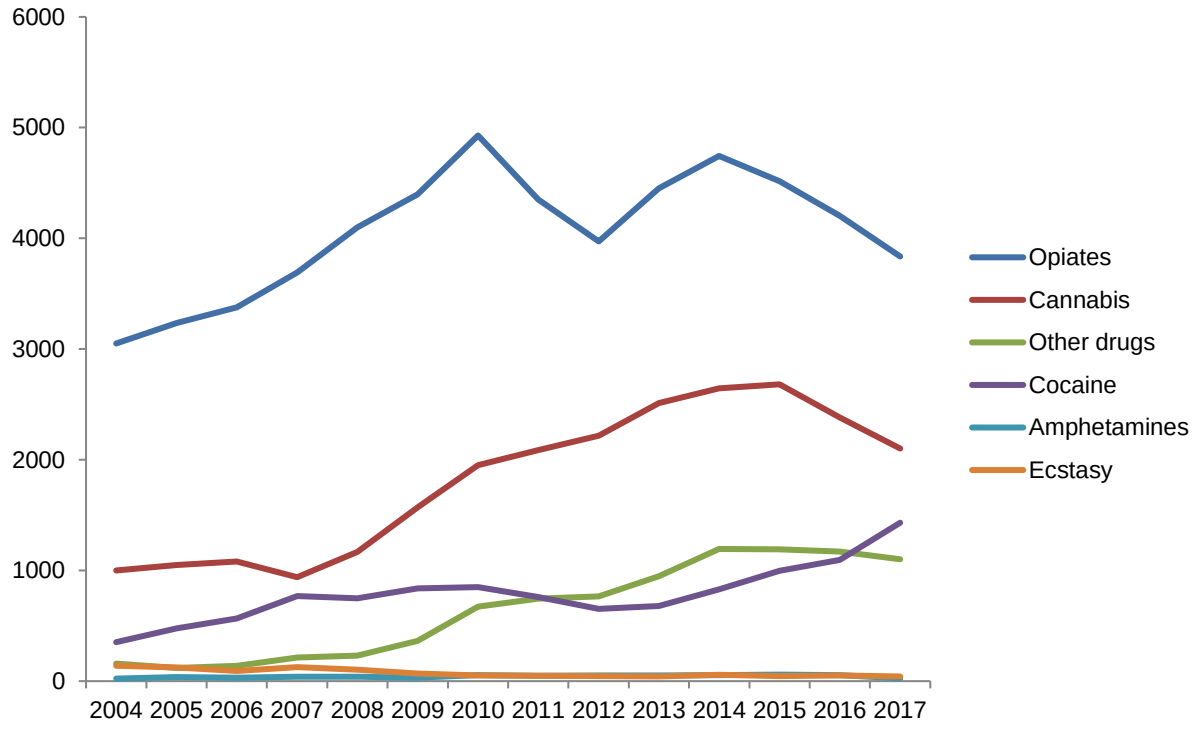

Figure T2.2.2. Trends in numbers of all clients entering treatment, by primary drug, 2004–2017
Source: TDI

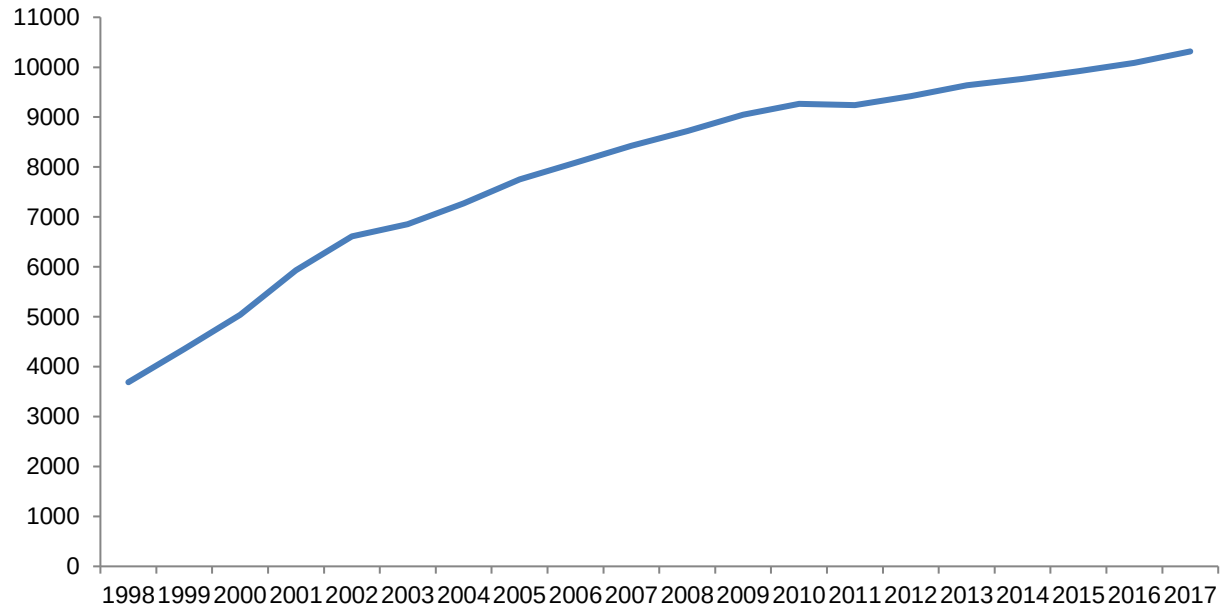

Figure T2.2.3 Trends in numbers of clients in opioid substitution treatment, 1998–2017
Source: ST24

T3. New developments

No information

T4. Additional information

T4.1 Additional Sources of Information

No information

T4.2 Further Aspects of Drug Treatment

No information

T4.3 Psychiatric comorbidity

In 2017, the HSE established a National Clinical Programme for Co-morbid Mental Illness and Substance Misuse. The aim of this programme is to recommend a comprehensive model of care. This programme will be led by a National Working Group under the direction of a National Clinical Lead (Harris 2017, Harris 2017, 13 July).

T5. Sources, methodology and references

T5.1 Sources

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

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

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

T5.2 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

Acknowledgements

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

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

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

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