Focal Point Ireland: national report for 2019 - Treatment

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

Authors of the national report
Lucy Dillon, Brian Galvin, Ciara Guiney, Suzi Lyons, and Sean Millar

Head of Irish Focal Point
Brian Galvin

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T0. Summary

National Profile

Ireland’s current national drugs strategy is structured around cross-cutting goals rather than the pillars of the previous national drugs 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; however, since November 2017, Suboxone (buprenorphine and naloxone in-combination preparation) is now available for patients where clinically appropriate. 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 opioid 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

The majority of drug treatment (more than 75%) continues to be 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 opioid as their main problem drug has decreased year on year since 2004, from a peak of 65% in 2004 to 42% in 2018. Over this period, cannabis has been consistently reported as the second most common main problem drug, with the proportion of entrants reporting problem cannabis use peaking at 29% in 2013, and decreasing slightly year on year to 23% in 2018. For new entrants to treatment, cannabis has been the most frequently reported 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 has increased to a new peak of 22% in 2018, compared with 17% in 2017.

The majority of cases entering treatment have been treated previously. The proportion of new entrants to treatment remained relatively unchanged in 2018, at 40%. 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 over the past 20 years, from 3,689 in 1998 to 10,332 in 2018, with the number plateauing over the past four years.

On August 2nd 2019 the Government announced the launch of a Health Diversion Approach to the possession of drugs for personal use with the agreement to adopt a more health-led approach to possession for personal use. The Health Diversion Approach offers alternatives to criminal prosecutions for the first two instances in which people are found in possession of drugs for their personal use. The 'health and brief intervention screening' will be carried out by trained HSE staff using the Screening and Brief Intervention for Problem Alcohol and Substance Use (SAOR) programme.

T1. National profile

T1.1 Policies and coordination

T1.1.1 Main treatment priorities in the national drug strategy

Treatment and rehabilitation are covered under the second goal of the national drug strategy, Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025 (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 2017–2025. 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 of the model, 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 (Health Service Executive 2016) (see Section T1.5.1 of this workbook).

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; 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 wrap-around 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 in order 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 Section 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 in this workbook. 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. Although the coverage of GP services in TDI has dropped over the past two years, the actual number of cases reported increased slightly. In 2018, 2.1% of all treatment services reported through TDI, compared with 1.3% in 2017. This is due to concerted efforts by the National Drug Treatment Reporting System (NDTRS) team to improve returns in this area. GPs represent 2.3% of all outpatient services reported through TDI. TDI still does not accurately reflect the total number of OST clients treated by GPs in the community (see Table V), but efforts will continue over the next year to improve this.

T1.2.2 Further aspects of outpatient drug treatment provision

Table V 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	323	Treatment facilities where the clients are treated during the day (and do not stay overnight). Includes OST clinics, any specialised addiction service (e.g. counselling), therapeutic day care, and socioeconomic training units	6,481
Low-threshold agencies	80	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.	856
General primary health care (e.g. GPs)	358	Specially trained GPs who provide OST in primary care.	206
General mental health care			
Prisons (in-reach or transferred)	29	In-reach provided by voluntary services funded by the Irish Prison Service and others. Includes some prison medical units which provide OST.	1,017
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 10% 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 2017, 896 cases were admitted to psychiatric facilities with a drug disorder. Of these cases, 414 were treated for the first time. For further information, see Section T1.2.4 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.	169
Residential drug treatment (non-hospital based)			
Therapeutic communities			
Prisons			
Other inpatient units (1.please specify here)	56	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.	1,170
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 Ireland (percentage).

	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%

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
(non-hospital based)					100%
Therapeutic communities					100%
Prisons	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 entered treatment in 2018. Of note, in 2018, the percentage of cases entering treatment for cocaine (22.1%) has increased again and is almost at the same level as cannabis (23.0%).

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped slightly in 2018 to 42.2%, compared with 44.9% in 2017 (see Figure II and Figure III). This continues the overall downward trend in the number and proportion of cases presenting to treatment for problem opioid use over the past decade, for example compared with 64.6% in 2004. Heroin continues to be the main drug in this category, representing 87.8% of all those reporting an opioid as their main problem drug in 2018; this is similar to figures for 2017, when 84.5% of problem opioid users reported heroin as their main drug.

The second most common drug reported was cannabis, which was also reported in similar proportions to previous years. Almost one-quarter of cases (23.0%) reported cannabis as their main problem drug in 2018, which was only a slight decrease from 2017 (24.6%; see also the Drugs workbook). The proportion of cases treated for problem cannabis use peaked in 2013 at 28.9% and has dropped slightly almost every year since then to 23.0% in 2018.

The majority (66.0%) of those reporting cannabis as their main problem drug in 2018 had never been treated before, compared with 60.4% in 2017.

Cocaine remains the third most common drug reported in 2018 at 22.1%, now just behind cannabis (23.0%). This is a continuation of the upward trend over the past number of years but represents a significant increase compared with 2017 (16.8%), 2016 (12.2%) and 2015 (8.7%). This is compared to the previous peak in the proportion of cases treated for problem cocaine use of 13.3% in 2007. This notable increase in the number of cocaine cases represents a significant change in drug treatment trends in Ireland (see Section 2.2 of this workbook). In 2018, 56.3% of cocaine entrants had never been previously treated, which was similar to 2017, when 52.3% had never been previously treated.

Benzodiazepines were the fourth most common drug reported (9.7%), similar to 2017 (9.8%). Unlike cannabis and cocaine, only 36.1% of cases with problem benzodiazepine use had never been treated before.

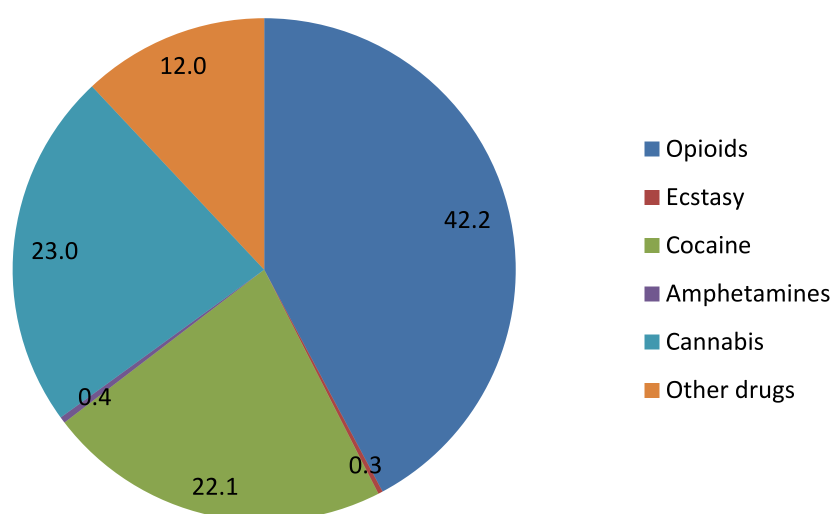
Amphetamines (0.4%) and ecstasy (0.3%) continued to make up a very small proportion of the main problem drugs reported in 2018, with no change from previous years.

Table V: Summary table - Clients in treatment

	Number of clients
Total clients in treatment	9899
Total OST clients	10 332
Total All clients entering treatment	Data on OST and TDI are from different sources, are collected using different methodologies, and also have some duplication; therefore, they cannot be combined or compared meaningfully.

Source: ST24 and TDI

Figure I. Proportion of treatment demands by primary drug



Source: TDI

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
No new information

T1.3.4 Characteristics of clients in treatment
No new information

T1.3.5 Further top level treatment-related statistics
No new information

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 services such as vaccinations (see also Section T1.4.9 of this workbook).

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

HSE data for 2018 showed that 89.0% of clients aged 18 years or older started treatment within one month after assessment (Table 1.4.1.1) (Health Service Executive 2018). Ninety-six per cent (96.1%) of clients aged under 18 years started treatment within one week following assessment. Also see Section T1.4.12 of this workbook for specific OST waiting times.

Table 1.4.1.1 Waiting times for OST 2018, HSE annual figures

Key performance indicators	Reported actual, 2017	Target, 2018	Reported actual, 2018	% variance from target, 2018
Number and percentage of substance misusers (over 18 years of age) for whom treatment has commenced within one calendar month following assessment	4295 98.4%	4946 100%	3061 89.0%	-13.6% -11.0%
Number and percentage of substance misusers (under 18 years of age) for whom treatment has commenced within one week following assessment	280 92.5%	333 100%	230 96.1%	-9.4% -3.9%

Source: (Health Service Executive 2018) (p. 114)

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; counselling is mainly provided by in-reach services.

There are no data currently available for Table VI, with the exception of individual case management.

Table VI. Availability of core interventions in outpatient drug treatment facilities

	Specialised drug treatment centres	Low-threshold agencies	General primary healthcare (e.g. GPs)	General mental health care
Psychosocial treatment/ counselling services	not known	not known	not known	not known
Screening and treatment of mental illnesses	not known	not known	not known	not known
Individual case management	>75%	>75%	not known	not known
Opioid substitution treatment	not known	not known	not known	not known
Other core outpatient treatment interventions (please specify in T1.4.1.)	not known	not known	not known	not known

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. More detailed information on the services offered by the non-hospital based residential services (mainly run by voluntary services) can be found in Section T1.5.3 in the Harms and Harm Reduction workbook).

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 required by the client.

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 treatments which are not available in the service they are currently attending will be referred on to a service which can provide those treatments.
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, this 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

Homeless admissions to psychiatric hospitals

Research into the profile of homeless people admitted to psychiatric hospitals showed that there was a 44% increase in annual admissions, from 188 in 2007 to 271 in 2016 (Daly, *et al.* 2019). Most were male, three quarters were aged under 45 years and 15% were admitted for problem drug use while a further 12% were admitted for problem alcohol use. The authors concluded that the prevalence of schizophrenia and alcohol and drug disorders in this group differed from the national profile of psychiatric admissions, a factor which needs to be considered when planning and providing treatment (for more detailed information see Section T1.4.1 in the Harms and Harm Reduction workbook).

Senior drug users

There are no specific services for senior drug users; they can access treatment through the normal channels. Of note, recent research shows an increasing number of people aged 50 years and older are entering treatment for opioid use, a trend not previously observed (see Section T1.4.7 of this workbook) (Carew and Comiskey 2018). This may have implications for future service planning.

NPS users

There are no specific services for NPS users; they can access treatment through the normal channels.

The number of cases seeking treatment for problem NPS use is very small in Ireland (for further information see Section D, T1, Drugs workbook). A 2017 study examined the impact of the changes in legislation for NPS looking at national treatment data (Smyth, *et al.* 2017). The original research, while acknowledging other possible explanations, hypothesised that the findings "are consistent with a hypothesis that the legislation and consequent closure of the headshops contributed to a reduction in NPS-related substance use disorders in Ireland". A new study has now looked the impact of the changes in NPS legislation but this time using drug-related psychiatric admissions (DRPAs) data rather than treatment data (Smyth, *et al.* 2020). This research supported the findings of the original paper. The findings of this paper are presented in Section T4.1 of the Prevention Workbook.

Recent undocumented migrants (asylum seekers and refugees):

There are no specific services for undocumented migrants. Asylum seekers and refugees who apply for a State medical card can access free treatment provided by public services.

Women (gender- specific)

There are drug liaison clinics in several maternity hospitals in Ireland. In 2017, 100 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin. Of those, 56 were receiving OST (see also Section T1.3.6 in the Harms and harm reduction workbook, 2019) (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.

Under-aged children and adolescents

There are some specific outpatient services that cater for children under the age of 18 years. There is also one residential centre for children under the age of 18 years for both detoxification and residential rehabilitation.

One specific service run by the HSE, the Adolescent Addiction Service (AAS), provides support and treatment in relation to alcohol and drug use for young people and their families from the Dublin suburbs. Services provided include advice, assessment, counselling, family therapy, professional consultations, and medications if required (2018). In 2017, the AAS worked with 44 young people, with a mean age of 15.5 years (range: 14–18 years), and their families. Cannabis/weed continued to be the main substance used by clients at 97%, while alcohol use was at 95% and cocaine (48%).

Of those who exited treatment, 58% had a planned discharge, 27% declined further treatment, and 15% moved out of the area. Of those who had planned discharges, less than 5% had an onward referral to residential treatment or long-term residential aftercare. The majority of young people (82%) were seen by a family therapist only, with 18% having a psychiatric assessment. For more in-depth information please see Section T1.4.1 in the Harms and Harm Reduction workbook.

Other target groups

Treatment data in Irish prisons. 2009 to 2014

A recent Irish study analysed trends in addiction treatment demand in Irish prisons from 2009 to 2014 using available national surveillance data, in order to identify any implications for practice and policy (Cannon*, et al.* 2019). In 2008, the National Drug Treatment Reporting System (NDTRS) began to collect information on drug treatment in Irish prisons, mainly from in-reach voluntary services, which provided counselling only. In total, 6% of all treatment episodes recorded by the NDTRS between 2009 and 2014 were from prison services. It was found that the number of prison service treatment episodes increased from 964 in 2009 to 1,063 in 2014. Opioids were the main reason for treatment, followed by alcohol, cocaine, and cannabis. The percentage of treatment episodes with a history of ever injecting drugs increased from 20.9% in 2009 to 31.0% in 2014. For more in-depth information see Section T2.1 of the Prison workbook.

There are 19.8 full-time Addiction Counsellor posts filled across the Irish prison estate. The IPS have advised that 2,750 prisoners benefitted from addiction counselling services in 2018 (Flanagan 2019, 13 June).

T1.4.6 E-health interventions for people seeking drug treatment and support online

The informational website www.drugs.ie offers a free online chat service, Live Help, for people to contact confidentially, which is maintained by the HSE. It is open to both those using drugs and those affected by the drug use of others. There is also a free HSE drugs and alcohol telephone and text service, again open to those using alcohol and other drugs and those affected by the drug use of others. For further information please see Section T1.2.2 in the Prevention workbook.

T1.4.7 Treatment outcomes and recovery from problem drug use

Data from the NDTRS covering the 19-year period from 1996–2014, inclusive, which is the source of the TDI figures, was used to examine treatment trends for older adults who use opioids (Carew and Comiskey 2018). The NDTRS is an epidemiological database on treated problem drug and alcohol use in Ireland. Treatment records where an individual started treatment for the first time and an opioid was the primary problem drug were selected, and the data were explored using statistical techniques in order to assess changes in the characteristics of cases accessing treatment over time.

A total of 18,692 individuals entered treatment for the first time for opioid use during the study period. The number of treatment admissions peaked in 2009, with the number of admissions declining in subsequent years. Heroin was the main problem opioid across all years, accounting for 92.7% (n=17,331) of all treatment entries, while methadone accounted for 2.2% (n=417) and over-the-counter and other prescribed opioids accounted for 4.6% (n=852) of treatment entries. A small number of other opioid types were reported (0.5%, n=92), including opium and unspecified opioid drugs.

Population figures were used to calculate annual treatment incidence rates, which were analysed for trends over time. Trends in admissions fluctuated across the study period and several significant trends were observed. Overall, age-adjusted treatment incidence has declined over the last 18 years. Significant downward trends were observed in age-adjusted rates for the years 1996−2004, with an annual percentage change (APC) of −7.0% (CI: −10.1 to −3.9, p=0.003), and also in the

period 2009−2014 (APC=−8.6, CI: −14.6 to −2.9, p=0.012). However, in the interim years (2004−2009), there was a significant upward trend (APC=13.4, CI: 3.1−24.9, p=0.012).

The examination of treatment incidence by age revealed a downward trend among younger age groups and an upward trend among older age groups. In the early years of the study (1996−2002), incidence was concentrated among younger age groups and became more dispersed as time passed. The largest significant downward trends were observed among 15−19-year-olds in the years 2009−2014 (APC=−25.0, CI: −36.2 to −11.9, p<0.001) and among 20−24-year-olds in the years 2010−2014 (APC=−12.9, CI: −21.5 to −3.3, p<0.001). Upward trends were detected among older age groups: (1) incidence was low in early years of the study among those aged 25−49 years and increased by varying amounts; and (2) there was a rising incidence that did not previously exist among 50−74-year-olds. The largest significant upward trends were among 35−39-year-olds in the years 2003−2009 (APC=27.4, CI: 9.2−48.6, p=0.003), as well as among 40−44-year-olds (APC=14.6, CI: 10.7−18.6, p<0.001) and 45−49-year-olds (APC=13.6, CI: 9.2−18.1, p<0.001) across the duration of the study period.

Other key findings from the study included the following:

- The results show evidence of subgroups within the treatment population: those who seek treatment quickly and those who take much longer to seek treatment. There is also evidence of late-onset drug users – individuals who begin drug use later in life.
- The profile of people entering treatment for opioid use has changed; people entering treatment are now older, have been injecting for longer, and are taking longer to enter treatment:
    - The median age for commencing opioid use increased by three years (from 18 to 21 years) (U=32 6141.5, p<0.001).
    - The median age of individuals entering treatment increased by 11 years (from 20 to 31 years) (U=145 465.5, p<0.001).
    - The median opioid-using duration prior to treatment increased by five years (from two to seven years) (U=170 807.5, p<0.001).
    - One-half of the individuals started injecting within one year of first using opioids. The median time between first injecting and commencing treatment increased by six years for men and two years for women.

The study authors highlight that:

- In recent years, an increasing number of people aged 50 years and older are entering treatment for opioid use, a trend not previously observed.
- Results show how service need has changed over the last two decades and provide an indication of future service need, which is essential for planning purposes. These findings also highlight how treatment data can be used to identify hidden groups at risk of chronic harm which may require prioritising in policy and practice.

The authors note that although drug treatment data are collected across 30 European countries, this study is the first large-scale examination of ageing and opioid use trends. The study provides evidence to underpin policy development and changes in practice. Current drug policies and treatment services are predominantly focused on the needs of the known profile of younger drug users, and it is inevitable that existing services will need to adapt to the ageing population. The changing composition of this group suggests that a wide range of services will be required into the future, and that integrated approaches across addiction and healthcare services would be beneficial in identifying and treating addiction problems among ageing drug users.

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 opioid substitution treatment (OST) for problem opioid users is provided only through HSE drug treatment clinics, satellite clinics, or specialised GPs in the community, and is provided free of charge. Under the opioid treatment protocol (Methadone Treatment Services Review Group 1998) (Health Service Executive 2016), GPs in the community are contracted to provide OST at one of two levels: Level 1 or Level 2. Level 1 GPs are permitted to maintain OST treatment for problem opioid users who have already been stabilised on OST. Each GP qualified at this level is permitted to treat up to 15 stabilised problem opioid users. Level 2 GPs are allowed to both initiate and maintain OST treatment. Each GP qualified at Level 2 may treat up to 35 problem opioid users. Practices where two Level 2 GPs are practising are permitted to treat up to 50 problem opioid users.

In 2018, according to data from the Central Treatment List (CTL) for methadone maintenance treatment (MMT as of 31 December 2018 (see also Section T2 of this workbook), 51.9% of patients were receiving MMT in specialist outpatient clinics, 41.6% from GPs, 6.4% in prison, and less than 0.2% in an inpatient setting (personal communication, Caroline Walsh, CTL, 2019). The proportion of clients receiving MMT 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 51.9% in 2018.

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 Figure IV in Section T2 of this workbook, as well as Standard Table 24). On 31 December 2018, 10,332 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Walsh, CTL, 2019). This is almost identical to the number registered for 2017 (10,316). The CTL is a national register of all clients on MMT.

Almost all clients receive MMT as their opioid substitute, as historically this has been the primary drug of choice for treating opioid dependency in Ireland. Since November 2017, Suboxone has been available by prescription for patients where clinically appropriate. In 2018, 220 patients were prescribed Suboxone in HSE outpatient OST clinics and by GPs with the appropriate training (Byrne 2019, 12 February). This is an increase of 65% compared with 2017, when 133 patients were prescribed Suboxone. As of 31 December 2018, there were 177 clients registered on Suboxone. These numbers are not included as yet in the overall number of patients receiving OST reported above or in Standard Table 24, which currently only apply to methadone. They should be combined for 2019 data onwards.

T1.4.11 Characteristics of clients in OST

The CTL also provides data on all clients registered for MMT during the year from 2005 onwards (personal communication, Caroline Walsh, CTL, 2019). This is different from what is reported in T1.4.10 and in Figure IV and Standard Table 24, which report on clients in treatment as of 31 December of each year. This total data shows a 32% increase in the number of clients registered in the 14-year period from 2005–2018, from 8,962 in 2005 to 11,741 in 2018 (Table 1.4.11.1). Over this period, the majority of clients were male (71% in 2018, similar to previous years). The mean age increased from 31 years in 2005 to 40 years in 2018. The proportion of clients under 25 years of age decreased from 16% in 2005 to 3% in 2018.

Table 1.4.11.1 All clients registered for MMT, 2005 to 2018

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All OST clients	8962	9428	9760	10 213	10 668	10 787	10 711	10 832	10 951	11 206	11 338	11 413	11 496	11 741
First substitution	809	852	804	862	953	763	609	737	721	726	752	669	662	661

Source: Central Treatment List

The proportion of clients receiving their first methadone substitution decreased from 9% in 2005 to 6% in 2018 (Table 1.4.11.1). Again, the majority of clients receiving their first substitution were male (74% in 2018, similar to previous years). The mean age increased from 28 years in 2005 to 33 years in 2018. The proportion of clients under 25 years of age decreased from 40% in 2005 to 7% in 2018.

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

Waiting times for OST assessment and treatment

Annual data from the HSE on 2018 key performance indicators show that the average waiting time for OST from referral to assessment was 6.4 days (Health Service Executive 2018). The average waiting time between assessment for OST and treatment (or exit from a waiting list) was 24.9 days, a significant decrease compared with the 2017 average time of 155.5 days.

Table 1.4.12.1 HSE annual figures: Waiting times for OST, 2018

Key performance indicators	Reported actual, 2017	Target, 2018	Reported actual, 2018	% variance from target, 2018
Average waiting time from referral to assessment for OST	5.5 days	3 days	6.4 days	>100.0%
Average waiting time from OST assessment to exit from waiting list or treatment commenced	155.5 days	28 days	24.9 days	−11.1%

Source: (Health Service Executive 2018) (p. 114)

OST in prison

OST is provided in 10 out of the 12 prisons in Ireland. There are approximately 530 prisoners MMT on methadone stabilisation treatment within the prison service on any given day (Flanagan 2019, 12 February). In 2017, the IPS provided OST service to almost 1,700 prisoners, which means that 17% of the prison population availed of OST in Ireland in that year (McCaffrey 2019, 17 January) (also see Section T1.3.3 in the Prison Workbook and ST24).

Clients' experiences of OST

A recent Irish study aimed to identify reasons why clients remain 'trapped' in the high-risk, specialist clinical setting (Moran, *et al.* 2018). It was found that factors resulting in clients initiating and

sustaining an OUD involved continuous hardship into adulthood, mental illness, and concurrent benzodiazepine use disorder, with subjects stating that these circumstances often resulted in loneliness and a lack of life purpose. Living environments, a mistaken understanding of their illness, and poor communication with allied health professionals further perpetuated their OUD. Participants stated that positive factors influencing periods of abstinence were familial incentives and a belief in the efficacy of methadone. Clients' own suggestions for improving their journeys included employing a multisectoral approach to managing OUD and educating themselves and others on opioid agonist treatments. Please see Section T3.3 in the Harms and Harm Reduction workbook for an in-depth summary of this study.

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 II)

In 2018, there were 3,958 new entrants recorded (also see TDI). This is a 21% increase in the number of new treatment entrants compared with 2017, when 3,253 new entrants were reported.

Proportionally, in 2018, new treatment entrants represented 40.0% of all cases compared with 38.1% 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 it has stabilised since 2014 at around 39%.

Between 2008 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. However, the marked increase in the proportion of new entrants reporting problem cocaine use continued into 2018, rising to 31.1% from 23.0% in 2017. The number of cocaine cases has fluctuated over the 10-year reporting period, peaking among new entrants in 2009 at 19.0%, dropping steadily thereafter until 2012, and then increasing year on year to this current peak of 31.1% in 2018.

Both amphetamines and ecstasy are only very rarely reported as main problem drugs by new entrants to treatment.

In 2018, 'other drugs' (mainly benzodiazepines) was 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 III)

In 2018, a total of 9,899 entrants were recorded in the NDTRS (see also TDI). This is a 15.9% increase in the number of cases reported compared with 2017, when 8,539 cases were reported (see Section T2.2 of this workbook for further information). Of the cases recorded in 2018, the majority had been previously treated (55.6%), which was very similar to 2017 (57.0%).

In 2018, opioids (mainly heroin) were the main problem drug used by entrants to treatment, reported by 42.2% of entrants compared with 44.9% in 2017. However, the absolute number presenting for problem opioid use increased in 2018 to 4,178, compared with 3,837 in 2017. The number of cases reporting problem opioid use peaked in 2010 at 4,929, and has shown a general downward trend since then.

Since 2004 cannabis has been consistently reported as the second most common problem drug. The proportion of cases reporting cannabis as their main problem drug peaked at 28.9% in 2013, with the proportion decreasing almost every year since then to 23.0% in 2018.

The very notable increase in the number of cases presenting for treatment for problem cocaine use continued in 2018. Previously, the highest proportion was reported in 2007 at 13.3%, dropping steadily until 2012, when it stabilised; however, the number of cases since then has increased to a new peak of 22.1% in 2018, compared with 16.8% in 2017.

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

In 2018, 'other drugs' (mainly benzodiazepines) was 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

There has been a notable 15.9% increase in the number of cases entering treatment reported between 2017 and 2018, from 8,539 to 9,899. This has been partially driven by the increased reporting of data by two main prisons and improved returns by other services reporting to the NDTRS. These improved returns are in part due to the additional efforts by the NDTRS team to improve returns to the reporting system for 2018. However, some of the increase may very well be due to the significant increase in the number of cases reporting problem cocaine use, in particular new entrants to treatment. There has been no increase in the number of cocaine-specific services, with cocaine cases receiving treatment in general addiction services.

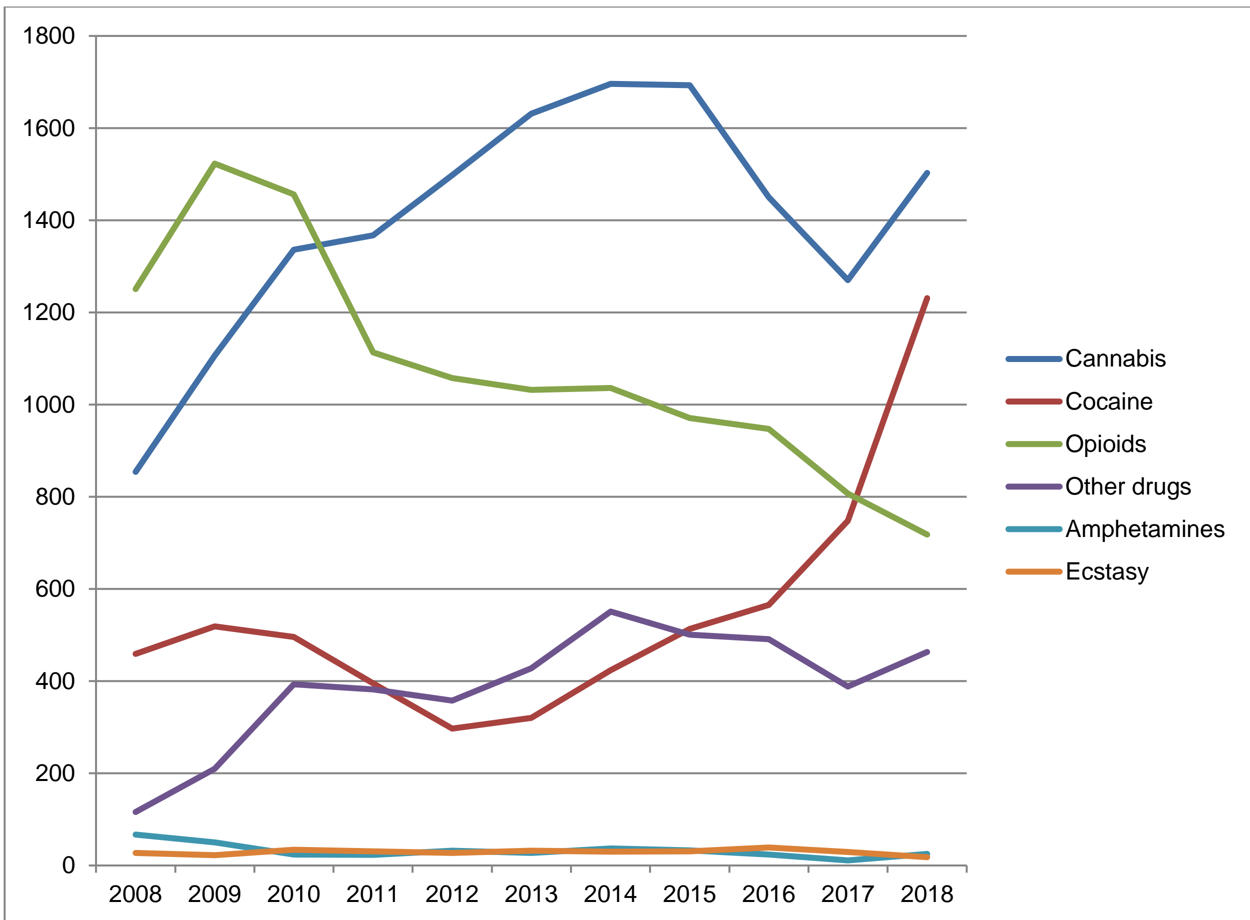


Figure II Trends in numbers of first-time clients entering treatment, by primary drug, 2008–2018
Source: TDI

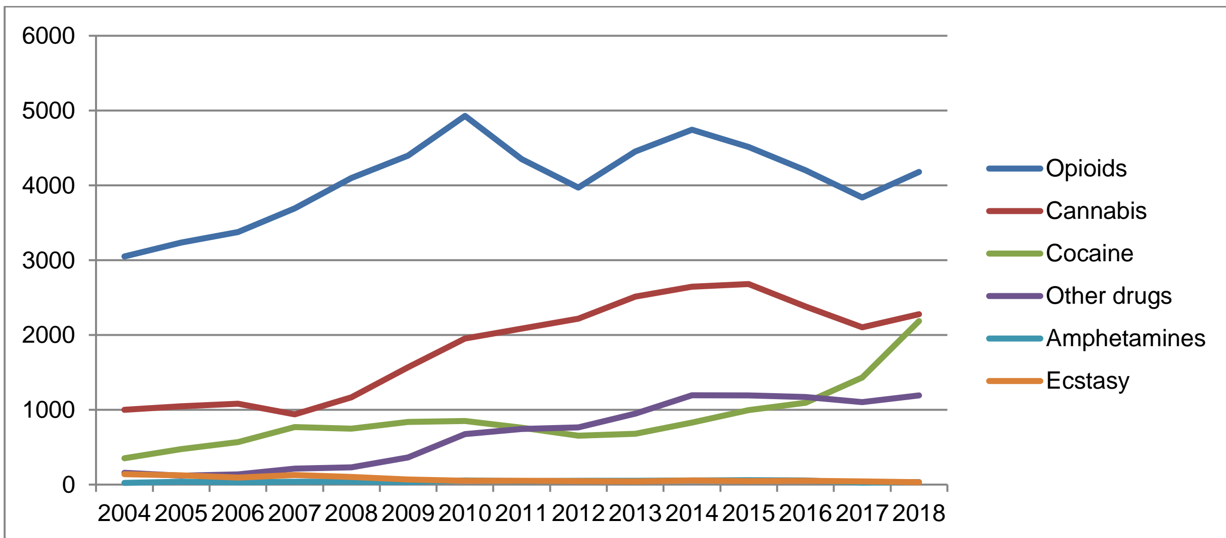


Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2004–2018
Source: TDI

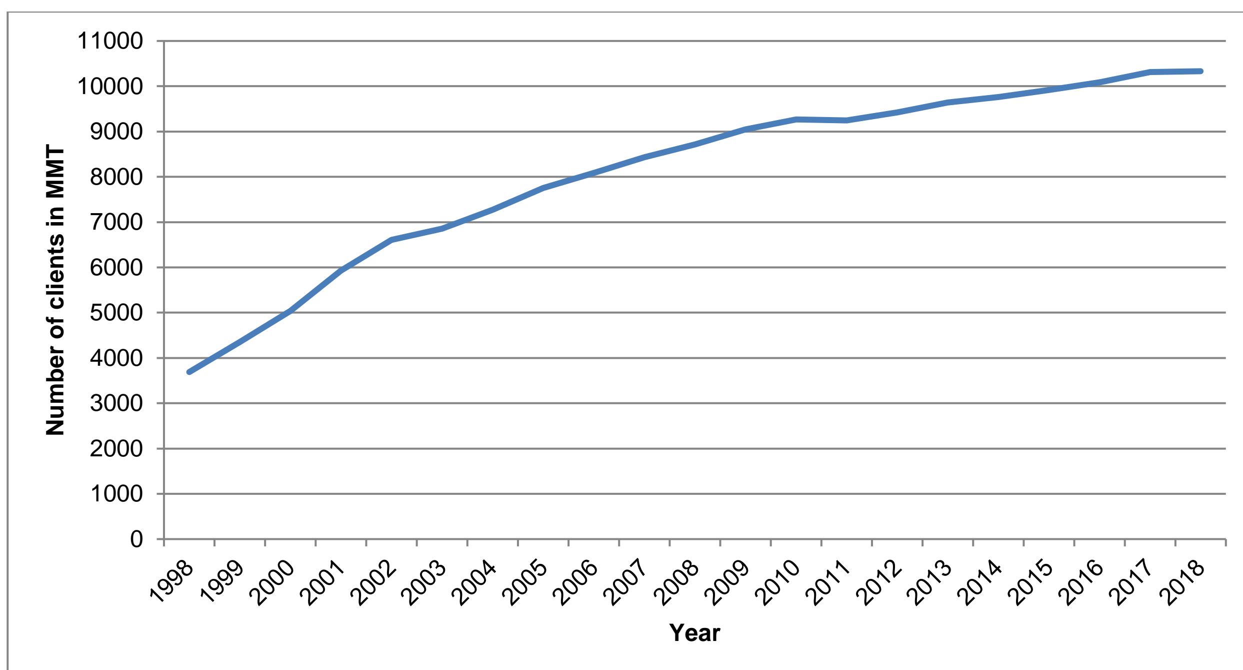


Figure IV Trends in numbers of clients in opioid substitution treatment, 1998–2018
Source: ST24 and CTL (MMT only)

T3. New developments

Changes to government policy on possession of drugs for personal use

On August 2nd, 2019 the Government announced the launch of a Health Diversion Approach to the possession of drugs for personal use with the agreement to adopt a more health-led approach to possession for personal use. The Health Diversion Approach offers alternatives to criminal prosecutions for the first two instances in which people are found in possession of drugs for their personal use. The action taken by An Garda Síochána will depend on the number of times an individual has been caught in possession. The 'health and brief intervention screening' will be carried out by trained HSE staff using the Screening and Brief Intervention for Problem Alcohol and Substance Use (SAOR) programme. New posts will be created across the HSE's Community Healthcare Organisation Areas for staff trained in SAOR to carry out the brief intervention. It is expected that this will lead to referrals on to treatment when deemed necessary. At the time of writing there was no further detail available on how the new approach will be implemented. For further information on the Health Diversion Approach and the body of work that informed the Government's decision to take such an approach. For more information please see Section T3.1 of the Policy Workbook.

Standardised assessment and care plan for addiction services

A process service to develop a standardised assessment and care plan document in conjunction with prison and homeless services has been led by Cork/Kerry addiction services. In line with the National Drugs Rehabilitation Framework (NDRF), this is to ensure that people affected by drug and alcohol misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway, regardless of what service they first access. Given the diversity of the supports that may be required during rehabilitation, the NDRF states that no one individual or agency has the range of competencies, expertise or resources to meet all the needs of a Service

User. The case management framework is designed to co-ordinate the services being received and to identify through assessments which supports should be sought for the Service User. Under this framework, service user's needs and input are central to the development and on-going implementation of their individual care plan. In this document, particular attention is given to 'Consent and Confidentiality' and to ensuring that service users are clear on what this means for them. Specific training on key-working, care planning and case management that incorporates this documentation has been developed to support workers in the field (Personal communication, Ms Aoife Davey, HSE, 2019).

The National Social Inclusion Office, in support of goal 2 of Reducing Harm Supporting Recovery, "Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery", is supporting the roll out of this standardised document nationally. Four areas have been chosen to implement the pilot. It is also being used as part of the Housing First National Implementation Plan 2018-2021 (Department of Health 2017).

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 CTL and the NDTRS.

The CTL is an administrative database used to regulate the dispensing of methadone treatment. Established under S.I. No. 225, it is a complete register of all patients receiving methadone (as a treatment for problems with opioid 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 Health Research Board on behalf of the Department of Health.

T5.2 References

Adolescent addiction service (2018). Adolescent addiction service report 2018. Health Service Executive, Dublin. Available at https://www.drugsandalcohol.ie/29358/

Byrne, C. (2019, 12 February) Dail Eireann debate. Written answer - medicinal products data., Vol. 979 No. 2. Available at https://www.drugsandalcohol.ie/30763/

Cannon, A., Nally, F., Collins, A., Fay, R. and Lyons, S. (2019). Trends in addiction treatment in Irish prisons using national surveillance data, 2009–2014. International Journal of Prisoner Health, **15**, (2). Available at https://www.drugsandalcohol.ie/30318/

Carew, A. M. and Comiskey, C. (2018). Treatment for opioid use and outcomes in older adults: a systematic literature review. Drug and Alcohol Dependence, **182**, 48-57. Available at http://www.drugsandalcohol.ie/28129/

Cronin, B., Ryan, G. and Lyons, S. (2014). Pharmacist-patient structured methadone detoxification in Mountjoy Prison. Drugnet Ireland, (51). Available at http://www.drugsandalcohol.ie/22927/

Daly, A., Craig, S. and O'Sullivan, E. (2019). A profile of psychiatric in-patient admissions with no fixed abode (NFA) 2007-2016. Irish Medical Journal, **112**, (1). Available at https://www.drugsandalcohol.ie/30179/

Department of Health (2017). Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017 - 2025. Department of Health, Dublin. Available at http://www.drugsandalcohol.ie/27603/

Doyle, J. and Ivanovic, J. (2010). National drugs rehabilitation framework document. Health Service Executive, Dublin. Available at www.drugsandalcohol.ie/13502/

Flanagan, C. (2019, 12 February) Dáil Éireann Debate. Written answers 321 & 322 Drug-related expenditure. Available at http://www.justice.ie/en/JELR/Pages/PQ-12-02-2019-321

Flanagan, C. (2019, 13 June) Dáil Éireann Debate. Written answers 116- Prison medical service. Available at https://www.oireachtas.ie/en/debates/question/2019-06-13/116/

Harris, S. (2017) Dail Eireann debate. Written answer [residential addiction treatment]. Available at https://www.hse.ie/eng/about/personalpq/pq/2017/july-2017/billy-kelleher-pq-32056-17.pdf

Harris, S. (2017, 13 July) Dail Eireann debate. Written answers 542 & 546- drug rehabilitation clinics. Available at https://www.drugsandalcohol.ie/27865/

Health Service Executive (2016). Clinical guidelines for opioid substitution treatment. Health Service Executive, Dublin. Available at http://www.drugsandalcohol.ie/26573/

Health Service Executive (2018). Health Service Executive annual report and financial statements 2017. Health Service Executive, Dublin. Available at https://www.drugsandalcohol.ie/29196/

McCaffrey, C. (2019, 17 January) Dáil Éireann Debate. Committee of Public Accounts. Available at https://www.oireachtas.ie/en/debates/debate/committee_of_public_accounts/2019-01-17/

Methadone Prescribing Implementation Committee (2005). Review of the Methadone Treatment Protocol. Department of Health and Children, Dublin. Available at http://www.drugsandalcohol.ie/5962/

Methadone Treatment Services Review Group (1998). Report of the methadone treatment services review group. Department of Health and Children, Dublin. Available at http://www.drugsandalcohol.ie/5092/

Moran, L., Keenan, E. and Elmusharaf, K. (2018). Barriers to progressing through a methadone maintenance treatment programme: perspectives of the clients in the Mid-West of Ireland's drug and alcohol services. BMC Health Services Research, **18**, (1), 911. Available at https://www.drugsandalcohol.ie/30195/

Smyth, B. P., Lyons, S. and Cullen, W. (2017). Decline in new psychoactive substance use disorders following legislation targeting headshops: Evidence from national addiction treatment data. Drug and Alcohol Review, **36**, (5), 609-617. Available at http://www.drugsandalcohol.ie/27172/

Smyth, B. P., Daly, A., Elmusharaf, K., McDonald, C., Clarke, M., Craig, S. , *et al.* (2020). Legislation targeting head shops selling new psychoactive substances and changes in drug-related psychiatric admissions: a national database study. Early Intervention in Psychiatry, **14**, (1), 53-60. Available at https://www.drugsandalcohol.ie/30436/

The Rotunda Hospital (2017). Rotunda hospital annual report 2016. The Rotunda Hospital, Dublin. Available at https://www.drugsandalcohol.ie/28546/

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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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

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