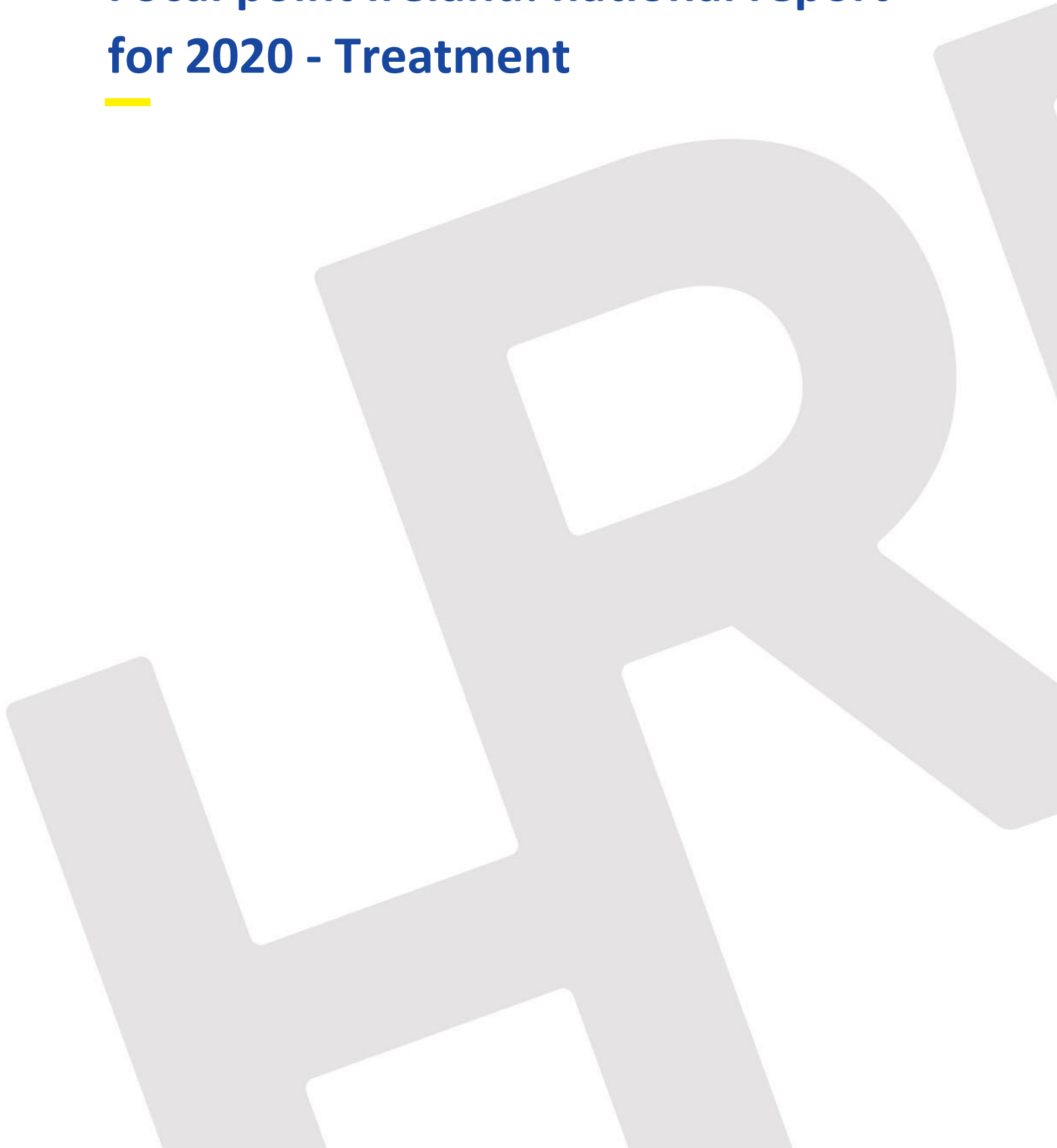


Focal point Ireland: national report for 2020 - Treatment



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

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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) has been 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 opioid 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 cocaine and cannabis. 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 39% in 2019.

Cannabis had been consistently reported as the second most common main problem drug for many years; however, in 2019, cocaine became the second most common main problem drug for the first time. The very notable increase in the number of cases presenting for treatment for problem cocaine use continued in 2019, but to a lesser extent. Previously, the highest proportion was reported in 2007 at 13.3%, dropping steadily until 2012, when it stabilised; however, the proportion of cases has increased since then to a new peak of 24.1% in 2019, compared with 22.1% in 2018.

From 2004 to 2018, cannabis was consistently reported as the second most common main 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 until 2017; since then, the proportion has stabilised.

The majority of cases entering treatment have been treated previously. The proportion of new entrants to treatment remained relatively unchanged in 2019, at 39%. The proportion of new entrants has fluctuated, from 39% in 2004 to a peak of 47% in 2009, but the proportion has stabilised at around 39% over the past number of years.

Among new entrants to treatment, cannabis has been the most frequently reported main problem drug since 2010, when it surpassed opioids (mainly heroin).

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 (fewer than 5%) receiving it in prison. The number of clients registered for OST as of 31 December each year has increased over the past 20 years, from 3,689 in 1998 to 10,318 in 2019 with the number plateauing over the past 5 years.

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 drugs 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 to 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 opioid substitution treatment (OST) by examining potential mechanisms to increase access through the expansion of general practitioner (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 the 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 wraparound services available
- Expand the range, availability, and geographical spread of services for those aged under 18 years
- Examine the need to develop specialist services in order to meet the needs of older people with long-term substance use issues
- Improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health Clinical Programme 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 national drugs 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 2017–2025 national drugs strategy (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 Social Inclusion Office, which is part of the HSE's Primary Care Division. This office promotes and leads on integrated approaches to healthcare at different levels across the statutory and voluntary sectors, including the development of integrated care planning and case management approaches between all relevant agencies and service providers.

The HSE supports the non-statutory sector to provide a range of health and personal social services, including the drug projects supported by the local and regional Drug and Alcohol Task Forces, which receive annual funding of 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 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 drugs strategy.

Introduced in 2015, the HSE's Performance 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 and the Primary Care Division Operational Plan. Addiction services are provided by the National Social Inclusion Office, 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 opioid use and standardise treatment, in 1998 a more formalised MTP was introduced to ensure that treatment for problem opioid 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 the GP's experience.

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

In 2016, the HSE published comprehensive *Clinical Guidelines for Opioid Substitution Treatment* (Health Service Executive 2016). In 2020, additional guidelines for in-hospital OST were published by the HSE in conjunction with the College of Psychiatrists of Ireland, the Irish College of General Practitioners, and the Pharmaceutical Society of Ireland (Health Service Executive 2020a). This new document is an adjunct to the existing guidelines. A brief summary of the key points which are specific to the hospital setting is provided below:

- The main objective of drug treatment in hospital is to stabilise drug misuse as quickly as possible in order to treat a drug-related or non-drug-related condition.
- Occasionally, patients may use the opportunity afforded by a hospital admission to reduce their drug use or to complete a detoxification. This may be useful, but if unplanned, it is likely to result in relapse upon leaving hospital, in turn exposing the patient to a higher risk of overdose.
- Transfer of care upon both admission and discharge requires a coordinated response by treating staff.
- Routine planned admissions to hospital are preferable.
- Acute hospital settings and mental health inpatient units should have access to naloxone in case of opioid overdose.

Opioid substitutes or other controlled drugs should only be prescribed following a comprehensive assessment. The assessment aims are to:

- Facilitate treatment of an emergency or acute problem or in order for an elective procedure to take place
- Confirm the patient is taking drugs (through history, examination, and urine analysis)
- Identify any complications of drug misuse and evaluate risk behaviours (blood-borne viral screening, nutrition, and alcohol intake)
- Consider psychiatric comorbidity.

Prescribing in this instance should be a straightforward continuation of the patient's usual dose of OST while in hospital. Communication between the hospital and community is vital for safe patient care. The CTL should be contacted to confirm that the patient is receiving OST. Confirmation of the dose by the patient alone is not adequate, rather confirmation of the last dose received at the clinic should be sought by contacting the clinic or dispensing pharmacy directly.

Where there is uncertainty about recent compliance, care must be exercised when initiating OST. Local drug treatment services should be contacted upon initiation in order to ensure continuity of care upon discharge.

Initial dosing guidelines are also outlined:

- Only prescribe following assessment.
- Polydrug and alcohol misusers may develop multiple withdrawal symptoms, so these may need to be discerned in order to prioritise treatment.
- Methadone may initially mask alcohol or benzodiazepine withdrawal symptoms.
- Care should be exercised when prescribing additional drugs, such as sedatives, to individuals who may also be using illicit substances. Interactions between 'street drugs' and psychotropic drugs should always be considered.
- Clinicians should refer to a text, such as *The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition* (2018).
- Where it is appropriate to initiate OST in hospital to reduce risk of withdrawal, methadone or buprenorphine can be used.
- OST induction should always follow the MTP. However, close supervision in hospital may allow for a modified protocol.
- Signs of intoxication, such as drowsiness, slurred speech, or pupil constriction, indicate the need to discontinue or reduce the dose of the drug.
- Hospitals should contact the CTL before prescribing buprenorphine products in order to ensure continuity post-discharge, as HSE approval is required before buprenorphine products can be reimbursed in the community setting.

Opioid-dependent patients in hospital may be taking other drugs and misusing alcohol. Misuse of benzodiazepines or alcohol could lead to associated withdrawal symptoms and seizures so benzodiazepine prescribing should only be initiated once the level of dependence has been established through history taking and noting any symptoms of withdrawal.

Within the inpatient setting, it is appropriate to provide a withdrawal regimen over 1–4 weeks, with a starting diazepam dose of no more than 30 mg daily, administered in divided doses. Routine prescribing of benzodiazepines, Z drugs, or gabapentinoids should be avoided while the patient is in hospital, especially the use of pregabalin as an anxiolytic. Patients may also need a simultaneous detoxification from alcohol. For useful tools and schedules, see the Community Detoxification Guidelines (Ana Liffey Drug Project 2016).

Other issues related to the patient's hospital stay include consideration of anaesthesia or the requirement that a patient fast before surgery (nil by mouth). The following should be considered:

- Specialist advice should be sought from the anaesthetist for perioperative care.
- Methadone should be restarted post-operatively, once the patient can take oral medication.
- Should the patient have to continue fasting (nil by mouth) post-operatively, both potential opioid withdrawal and pain should be managed using a conventional opioid such as morphine injection/infusion.

- If monitoring indicates that the patient may be in opioid withdrawal or pain, referral to a specialist pain team may be required.

On discharge from hospital, for patients not previously in treatment, attendance at the emergency department or hospital admission may present a window of opportunity to put them in touch with other services. It is essential to link with services well in advance of the patient's discharge in order to ensure continuity of care.

On discharge, the following information should be given:

- General health promotion advice
- Contact details for further help, such as needle exchange, drug treatment services, or self-help groups (refer to the directory of services for your area on www.drugs.ie)
- Advice on overdose prevention
- Advice on reducing the risk of blood-borne viruses and hepatitis B vaccination
- Advice on loss of tolerance in hospital.

Where a patient is receiving an opioid prescription upon admission from the community, this should be continued on discharge with prescribing responsibility transferring back to the GP or HSE addiction clinic. Discharge planning is best done in collaboration with local drug treatment services, the GP, and the community pharmacy. On the day of discharge, certain details will need to be confirmed:

- Patients should receive their substitution dose on the day of discharge; their clinic or GP and community pharmacy should be contacted to confirm that they have received that day's dose.
- Provide details of other drugs prescribed while they were an inpatient.
- Prior to discharge, confirmation is needed that the patient is registered with a methadone-prescribing GP and a community pharmacy for continuation of OST.

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's 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 the 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.

Only 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 years (it was 44.2% in 2019), the actual number of cases reported has increased slightly over the past number of years (also see Standard Table 24). In 2019, 3.3% of all treatment episodes reported through TDI were from GPs, compared with 2.1% in 2018. This is due to concerted efforts by the National Drug Treatment Reporting System (NDTRS) team to improve returns in this area. However, TDI still does not accurately reflect the total number of OST clients treated by GPs in the community (see Table I), but efforts will continue over the next year to improve this.

T1.2.2 Further aspects of outpatient drug treatment provision

Table I 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	316	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	6,658
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.	923
General primary health care (e.g. GPs) General mental health care	389	Specially trained GPs who provide OST in primary care.	334
Prisons (in-reach or transferred)	21	In-reach provided by voluntary services funded by the Irish Prison Service and others.	832

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 in TDI is high. 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 2018, 995 cases were admitted to psychiatric facilities with a drug disorder, similar to previous years. Of these cases, 408 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.	164
Residential drug treatment (non-hospital based)			
Therapeutic communities			

	Total number of units	National Definition (Characteristics/Types of centre included within your country)	Total number of clients
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.	1356
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 facilities which are fully funded by the HSE are not currently available and are recorded as 'Other' in Table IV, 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 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 (non-hospital based)				100%	100%
Therapeutic communities					100%
Prisons	100				100%
Other inpatient units (1 - please specify here)					100%
Other inpatient units (2- please specify here)					100%

T1.2.8 Further aspects of inpatient drug treatment provision and utilisation

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 cocaine are the two main drugs for which cases entered treatment in 2019. Of note, a change in the trends from previous years was recorded in 2019. The percentage of cases entering treatment for cocaine (24.1%) has surpassed those for cannabis (23.4%), making cocaine the second most common drug treated (Figure I).

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped again in 2019 to 38.8%, compared with 42.2% in 2018. This continues the overall downward trend in the number and proportion of cases presenting to treatment for problem opioid use, for example compared with 64.6% in 2004. Heroin continues to be the main problem drug in this category, with 86.8% of all problem opioid users reporting heroin as their main problem drug in 2019; this is similar to figures for 2018, when 87.8% of problem opioid users reported heroin as their main problem drug.

Cocaine has surpassed cannabis for the first time as the second most common problem drug reported. Both the number and percentage of cases entering treatment for problem cocaine use has increased, from 22.1% (n=2,186) in 2018 to 24.1% (n=2,471) in 2019. This is a continuation of the upward trend observed over the past number of years (also see the Drugs workbook). Just over one-half (50.3%) had never been treated before.

Cannabis has dropped to third most common drug for the first time, although it was reported in similar proportions as previous years. In 2019, 23.4% of cases reported cannabis as their main problem drug, compared with 23.0% in 2018 (also see the Drugs workbook). The proportion of cases treated for problem cannabis use peaked in 2013 at 28.9%, but dropped slightly almost every year until 2018, when it was 23.0%. The majority (62.5%) of cases reporting cannabis as their main problem drug in 2019 had never been treated before, compared with 66.0% in 2018.

Benzodiazepines remain the fourth most common problem drug reported; the proportion in 2019 was 10.1%, similar to 2018 (9.7%). Unlike cannabis and cocaine, only 32.8% of cases with problem benzodiazepine use had never been treated before.

Amphetamines (0.3%) and ecstasy (0.4%) continued to make up a very small proportion of the main problem drugs reported in 2019, with no change from previous years. The majority of treatment entrants for problem use of these drugs had never been treated before.

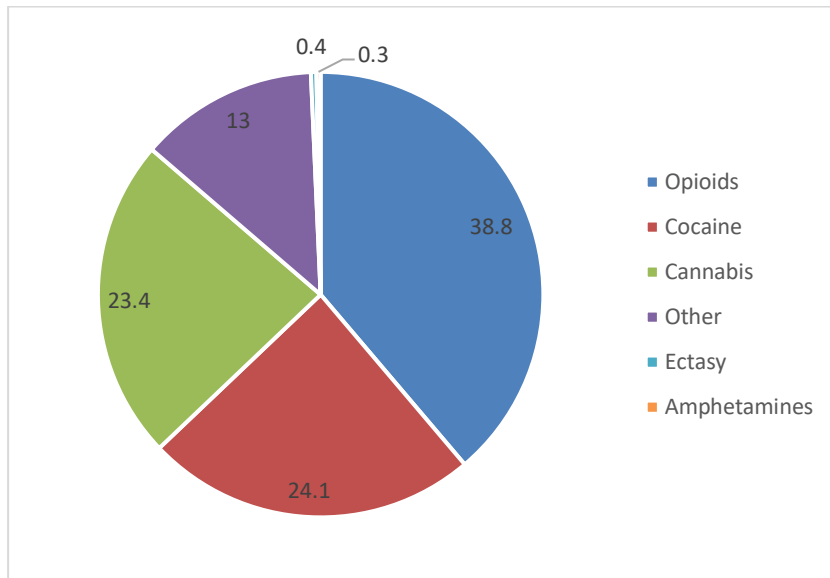
Table V: Summary table - Clients in treatment

	Number of clients
Total clients in treatment	10 267
Total OST clients	10 318
Total All clients entering treatment	Data on OST and TDI are from different sources, are collected using different methodologies, and also have duplication between them; therefore, they cannot be combined or

	Number of clients compared meaningfully.

Source: ST24 and TDI

Figure I. Proportion of treatment demands by primary drug



Source: TDI 2020

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).

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 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 with 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

Senior drug users

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

NPS users

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

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 2018, 106 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital 2019). Of those, 39 were receiving OST (see also Section T1.3.6 in the Harms and harm reduction workbook, 2020).

There is just one residential treatment 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 aged under 18 years. There is also one residential treatment centre for children aged under 18 years for both detoxification and residential rehabilitation.

A qualitative study looked at the experiences of young people in Dublin who were in treatment for their cannabis use (James, *et al.* 2019). Overall, respondents were reported to have spoken favourably about treatment. They valued the opportunity to talk with well-informed, non-judgemental professionals about their situation. However, these findings may have been impacted by the interviews having been carried out by a member of staff from one of the treatment centres.

Other target groups

No new information.

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, that people can contact confidentially, which is maintained by the HSE. It is open both to those using drugs and to 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 to 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

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 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 2019, according to data from the Central Treatment List (CTL) for methadone maintenance treatment (MMT) as of 31 December 2019 (see also Section T2 of this workbook), 52.9% of patients were receiving MMT in specialist outpatient clinics, 41.1% from GPs, 5.9% in prison, and less than 0.2% in an inpatient setting (personal communication, Caroline Walsh, CTL, 2020). 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. 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 52% in 2018, stabilising at 53% in 2019.

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, the national register of all clients on MMT (see Figure IV in Section T2 of this workbook, as well as Standard Table 24). On 31 December 2019, 10,318 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Walsh, CTL, 2020). This is almost identical to the number registered at the end of 2018 (10,332).

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. As of 31 December 2019, there were 262 clients registered on Suboxone, compared with 177 clients in 2018 and 110 in 2017. 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 patients on methadone.

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, 2020). This is different from what is reported in Section 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 31% increase in the number of clients registered in the 14-year period from 2005 to 2018, from 8,962 in 2005 to 11,741 in 2018, followed by a slight decrease to 11,620 in 2019 (Table 1.4.11.1). In 2019, the majority of clients were male (71%), similar to previous years. The proportion of clients aged under 25 years decreased from 16% in 2005 to 2.5% in 2019. The proportion of clients receiving their first methadone substitution decreased from 9% in 2005 to 4.8% in 2019 (Table 1.4.11.1).

Table 1.4.11.1 All clients registered for MMT, 2005–2019

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
All OST clients	8962	9428	9760	10213	10668	10787	10711	10832	10951	11206	11338	11413	11496	11741	11620
First substitution	809	852	804	862	953	763	609	737	721	726	752	669	662	661	563

Source: Central Treatment List

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

Length of time in treatment

Data from the HSE showed that as of 31 December 2018, of the 10,333 clients in treatment, 10.3% had been in OST treatment since 1998 or earlier (Table 1.4.12.1) (Curran 2019, 15 October).

Table 1.4.12.1 Number of clients in OST, 31 December 2018, by year of treatment commencement

Year treatment commenced	No. of clients	%
1998 and earlier	1060	10.3
1999	350	3.4
2000	291	2.8
2001	346	3.3
2002	342	3.3
2003	267	2.6

Year treatment commenced	No. of clients	%
2004	325	3.1
2005	271	2.6
2006	307	3.0
2007	295	2.9
2008	337	3.3
2009	381	3.7
2010	353	3.4
2011	470	4.5
2012	455	4.4
2013	495	4.8
2014	586	5.7
2015	704	6.8
2016	787	7.6
2017	1121	10.8
2018	790	7.6

Risk of death associated with interruptions in MMT

A retrospective cohort study was carried out in all specialist addiction services in Dublin South West and Kildare looking at the risk of death associated with interruptions in MMT for the years 2010–2015 (Durand, *et al.* 2020). This study confirmed that the first 4 weeks after treatment initiation and after stopping treatment have the highest risk for mortality among patients in MMT in Ireland. While this trend is similar to the findings of studies conducted in the United Kingdom, mortality rates observed in this study were higher. This may be due to ageing among problem opioid users, along with higher levels of comorbidity. The increased risk at treatment initiation could be attributed to continued use of illicit opioids or other respiratory depressant drugs, or could be tolerance related. There were no deaths recorded in the first 4 weeks after transfer between services. Given that many of those transfers were to and from prison, this may reflect the policy of keeping a person's place in community MMT until they are released from prison. For more in-depth information, see Section T1.1.5 of the Harms and harm reduction workbook.

Oral fluid testing for methadone maintenance patients – accuracy and acceptability

A study investigated how accurate and acceptable oral fluid testing is to methadone maintenance patients and doctors as a means of substance detection (O'Callaghan, *et al.* 2019). According to the authors, drug testing during MMT is crucial, as it provides doctors with important insights into patient stability and contributes to decisions about the level, frequency, and supervision of methadone delivery. In Ireland, unsupervised urine testing is commonly used and preferred by GPs. However, unsupervised urine samples can be subject to falsification, and the 2010 external review of the Irish Methadone Maintenance Treatment Protocol (Farrell and Barry 2010) called for discontinuing supervised urine testing due to its inherent infringement on patient privacy. Testing oral fluid rather than urine is an alternative method for detecting drug metabolites under supervision, without compromising patient privacy. However, its window of detection is shorter than that of urine testing. Hence, the current study examined how accurately oral fluid testing could detect drug metabolites in comparison with urine testing and self-reporting. It also investigated patients' and doctors' views on the acceptability of each method and on methadone maintenance generally.

The study was carried out with seven GPs from January to April 2016. Of the 65 invited patients, 55 (85%) agreed to participate. The average age of participants was 42.5 years, and about two-thirds were male. The

authors compared how many patients in the sample (N=55) were identified as having consumed a substance by means of (a) unsupervised urine testing, (b) supervised oral fluid testing, or (c) self-reporting. Patient views were captured with an eight-item questionnaire administered by GPs.

For most drugs, results from oral fluid testing were similar to those from urine testing, with the exception of benzodiazepine detection.

- Methadone: Consumption of methadone was confirmed through all three methods for all participating patients (N=55).
- Benzodiazepines: Detection of benzodiazepines was superior in urine testing (n=41) and self-reporting (n=37) compared with oral fluid testing (n=18).
- Opioids: Detection of opioids was highest by means of self-reporting (n=16), and much lower through both urine (n=3) and oral fluid testing (n=5). Additionally, only self-reporting could identify the type of opioid (heroin: n=3; painkillers: n=13).
- Cocaine and amphetamines: Self-reporting was superior in capturing cocaine consumption (n=6) compared with both urine (n=2) and oral fluid testing (n=1). Only one patient self-identified as having consumed amphetamines, which was picked up by neither urine nor oral fluid testing.

Most patients (95%) and the seven participating GPs evaluated oral fluid testing as acceptable and straightforward, with 60% of patients preferring oral fluid testing and 13% preferring urine testing.

GPs noted that additional time was necessary to perform both tests. Three of them stressed the lack of reliability in the detection of benzodiazepines through oral fluid testing. Contrary to author expectations, only 15% of patients were against supervised urine testing. The authors attributed this to potential reluctance among patients to express negative views to their doctors directly, as well as possible altered levels of self-esteem and expectations for privacy among methadone patients.

Discussion and conclusions

The current study found that, for most drugs, results from oral fluid testing were similar to those from urine testing, but that these results were inferior for benzodiazepines. O'Callaghan *et al.* attributed this to the longer window of detection of benzodiazepines in urine compared with oral fluid. However, while many participants reported using benzodiazepines (67%), the authors state that as 61% had a prescription for them, drawing into question the importance of their detectability. Hence, the authors conclude that oral fluid testing is an acceptable addition for drug screening in MMT, and that it is especially advantageous if a urine sample cannot be supplied. Additionally, they found that self-reporting as a measure of concomitant drug use was as or more worthwhile compared with urine or oral fluid testing.

However, the authors suggest that studies with larger samples are necessary in order to further investigate the detectability of drugs through oral fluid testing, especially when considering the low number of patients recorded as having consumed cocaine and amphetamines (through self-reporting or testing). Overall, given the increasing drug-related mortality observed in Ireland, the authors stress the importance of more research in this area.

Patient experience of methadone maintenance treatment (MMT)

A study investigating how accurate and acceptable oral fluid testing is to methadone maintenance patients and doctors as a means of substance detection also looked at patients' experiences of MMT (O'Callaghan, *et*

al. 2019). Fifty-five patients participated in the study, which was conducted between January and April 2016. A summary of the findings is as follows:

- Overall, negative views of MMT were more frequent than positive ones among the patient sample.
- **Detoxification:** More options for detoxing off methadone were desired by 20% of patients.
- Positive perceptions: Perceived positive aspects of MMT included that it allows for stabilisation (28%), is an alternative to drug use (25%), and facilitates better functioning (18%).
- Negative perceptions: Perceived negative aspects of MMT included that it is addictive (30%), is associated with stigma (12%), is a long-term treatment (11%), causes dental issues (11%), and causes physical side effects (10%).

Overall, given the increasing drug-related mortality observed in Ireland, the authors stress the importance of more research on substance use, as well as into the perspectives and experiences of MMT patients.

Another qualitative study looked at the experiences of long-term participants in MMT in Dublin (Mayock, *et al.* 2018). The study examined the experiences and perspectives of 25 people (16 male, 9 female) who first accessed MMT a minimum of 10 years earlier, and who reported at least one episode of OST since first accessing treatment. Study participants were recruited through specialist addiction clinics, community and voluntary addiction services, primary care services, and supported temporary accommodation services. Interviews were conducted between August 2017 and February 2018.

The average age of research participants was 43 years. Almost one-third (32%) of participants were aged 35–39 years, 56% were aged 40–49 years, and the remaining 12% were aged 50 years or older. Almost two-thirds (64%) of participants had first accessed MMT more than 20 years previously. The key findings were as follows:

- The majority of participants reported that MMT had positively impacted at least one aspect of their lives. The most commonly reported benefit was stability and normality, with improved capacity to fulfil roles as parents, family members, and friends.
- The average age of first drug use was 14 years of age, while the average age of first heroin use was 19 years of age.
- Levels of educational attainment were low among participants, with about one-quarter (24%) having no educational qualifications and more than one-half (52%) not progressing beyond Junior Certificate level.
- Almost one-third (32%) of participants were homeless or living in unstable accommodation at the time of the interview. More than one-half (56%) of the study participants had experienced homelessness at some point in their lives.
- Mental health problems, including depression, were widely reported among study participants.
- Many participants reported having chronic illnesses, including hepatitis C, liver cirrhosis, and a range of respiratory, renal, and coronary diseases.
- Negative experiences were reported by many participants, including negative interactions with treatment services and healthcare professionals, and little autonomy in their treatment progression, particularly in relation to long-term rehabilitation planning.

- Stigma was a dominant experience reported by study participants. Stigma was reported on many levels, including within treatment settings and within the communities where participants resided. Participants reported feeling stereotyped and disrespected within their treatment setting, and many reported attempting to conceal their methadone use and clinic attendance from family and friends. Other forms of stigma related to being an older person in treatment and fear of judgement or rejection due to continued engagement in treatment.
- Participants perceived themselves as stigmatised healthcare service users, with many feeling excluded from employment and having little prospect of further education.
- Levels of social reintegration among participants were reported as extremely low. The majority reported being unemployed with no realistic prospect of employment.
- Most participants did not have access to the economic, social, or personal resources needed to support and sustain recovery.

The study shows the complex characteristics of people who are long-term MMT participants. The authors highlight issues experienced by this group, including physical and mental health problems, isolation, social exclusion, and loneliness. The authors note that age, combined with long-term drug use and treatment careers, indicate that this group has many challenging health, social, and economic needs. The study also highlights that, although methadone treatment had a positive impact on the lives of the study participants, multifaceted and multidisciplinary supports – including education, training, housing, and family welfare – are needed in order to achieve social reintegration.

Hepatitis C screening and care for OST patients in Ireland

A 2018 study investigated compliance in Irish primary care practices with guidelines on screening for hepatitis C virus (HCV), other blood-borne viruses, and alcohol use disorder (Murtagh, *et al.* 2018). There was a high rate of lifetime HCV screening (95%) in this study, which was a considerable increase from 69% recorded in a previous 2003 study. In contrast, there was a low proportion of HCV-positive participants receiving treatment (17%). Compared with previous findings in Ireland, this study showed higher rates of patients testing positive for HCV (78%) and for hepatitis B virus (8%), whereas the positivity rate for HIV (6.3%) is lower than or similar to previous findings. However, these differences should be interpreted with caution due to the variation in sample sizes and in sources of comparison data.

OST in prison

OST is provided in 10 out of the 13 prisons in Ireland (see also Section T1.3.3 in the Prison workbook and Standard Table T24).

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 2019, there were 3,972 new treatment entrants recorded (also see the TDI). This is similar to the numbers reported in 2018, when 3,958 new entrants were reported.

Proportionally, in 2019, new treatment entrants represented 38.7% of all cases, compared with 40.0% in 2018. The proportion of new treatment entrants has fluctuated over the 10-year reporting period, peaking at 47.2% in 2009, but it has stabilised since 2014 at around 39%.

Until 2010, opioids (mainly heroin) were the main problem drug reported by new entrants to treatment, but this was surpassed by cannabis in 2011, and this trend continues. In 2019, 31.6% of new entrants reported cocaine as their main problem drug. There was a marked increase in the proportion of new entrants reporting problem cocaine use in 2017 (23.0%) and 2018 (31.1%). The number of cocaine cases has fluctuated over the 10-year reporting period, initially peaking among new entrants at 19.0% in 2009, then dropping steadily until 2012 before increasing year on year to a new peak of 31.6% in 2019.

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

In 2019, 'other drugs' (mainly benzodiazepines) was the fourth largest group of drugs reported by new treatment entrants as their main problem drug, as was the case in previous years.

All treatment entrants (Figure III)

In 2019, a total of 10,267 treatment entrants were recorded in the National Drug Treatment Reporting System (NDTRS; also see the TDI). This is a 3.7% increase in the number of cases reported compared with 2018, when 9,899 cases were reported (see Section T2.2 of this workbook for further information). Of the cases recorded in 2019, the majority (53.9%) had been previously treated, which was very similar to 2018 (55.6%).

In 2019, opioids (mainly heroin) were the main problem drug used by entrants to treatment, reported by 38.8% of all entrants compared with 42.2% in 2018. The number of cases reporting problem opioid use peaked in 2010 at 4,929, and has shown a general downward trend since then.

In 2019, cocaine (24.1%; n=2,471) overtook cannabis (23.4%; n=2,406) for the first time as the second most common problem drug reported.

From 2004 to 2018, cannabis was consistently reported as the second most common main 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 until 2017; since then, the proportion has stabilised.

The notable increase in the number of cases presenting for treatment for problem cocaine use continued in 2019, but to a lesser extent. Previously, the highest proportion was reported in 2007 at 13.3%, dropping steadily until 2012, when it stabilised; however, the proportion of cases has increased since then to a new peak of 24.1% in 2019, compared with 22.1% in 2018

Both amphetamines and, to a lesser extent, ecstasy are reported very rarely as main problem drugs by entrants to treatment in Ireland, with no discernible difference noted in 2019.

In 2019, 'other drugs' (mainly benzodiazepines) was the fourth most common group of main 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

The number of cases reported increased from 9,899 in 2018 to 10,267 in 2019. These improved returns are due in part to the additional efforts by the NDTRS team to improve returns to the reporting system for 2019, and to the benefits of the online data entry portal. However, some of the increase may still be due to the ongoing increase in the number of cases reporting problem cocaine use.

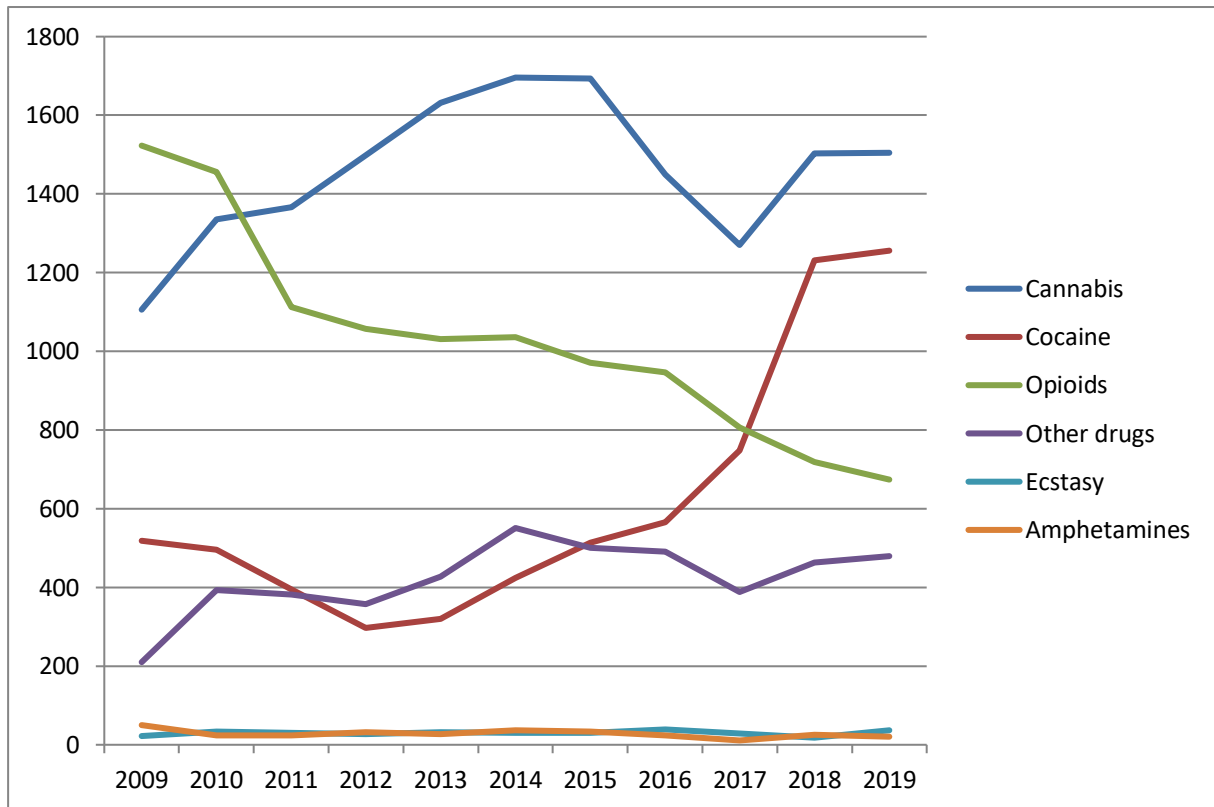


Figure II Trends in numbers of first-time clients entering treatment, by primary drug, 2009–2019

Source: TDI

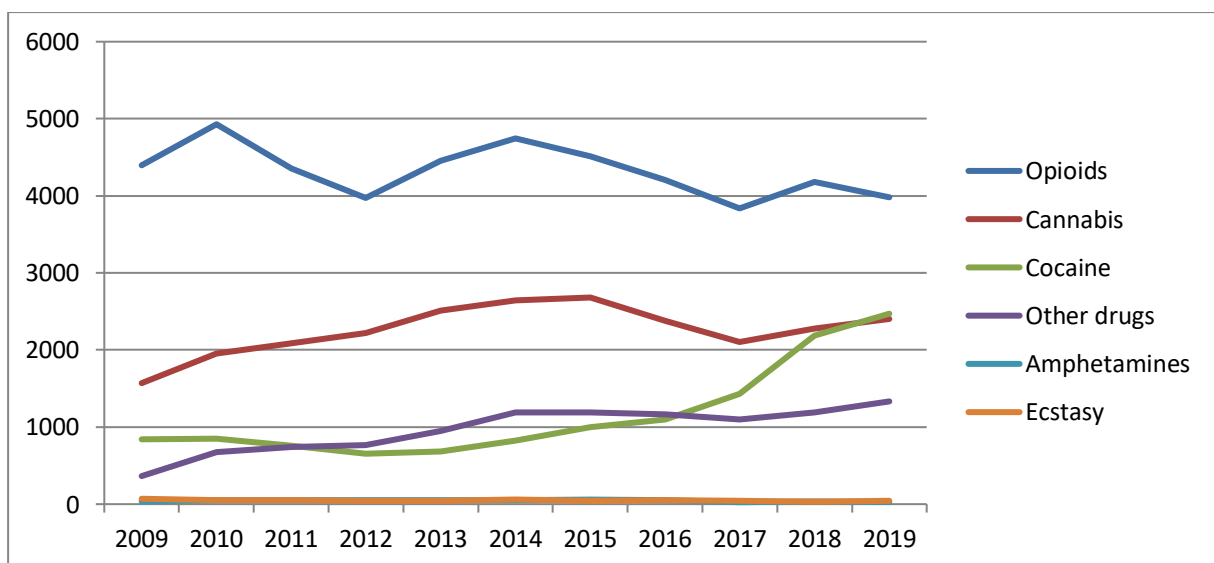


Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2009–2019

Source: TDI

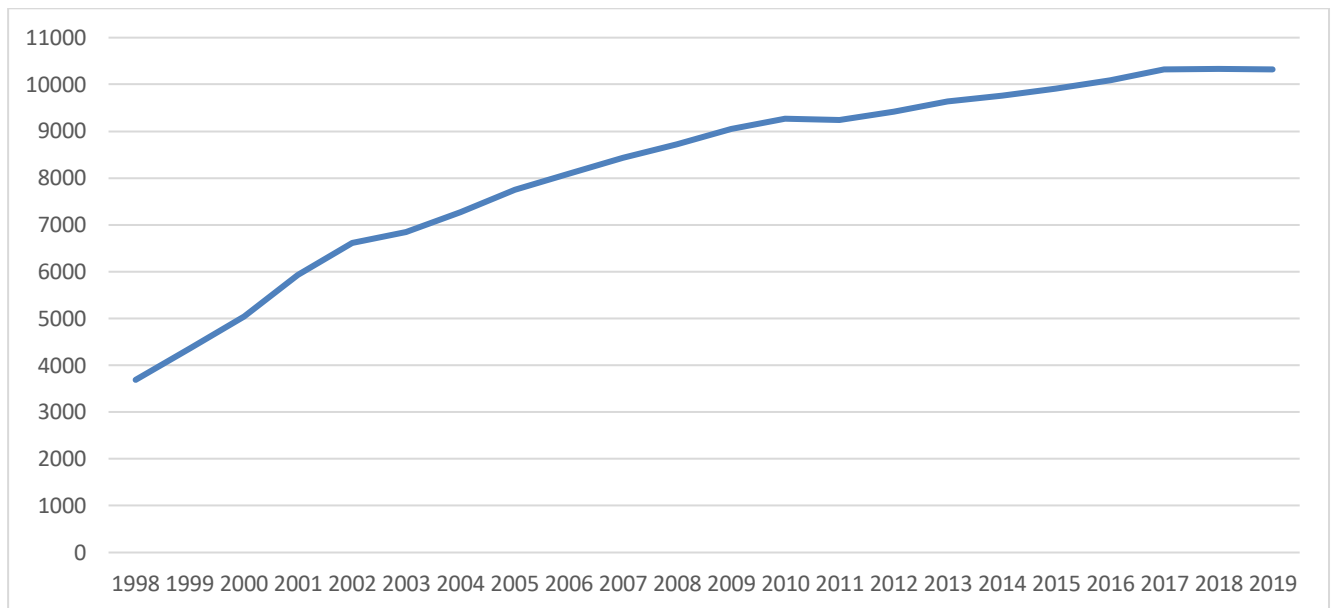


Figure IV Trends in numbers of clients in opioid substitution treatment, 1998–2019

Source: ST24 and CTL (MMT only)

T3. New developments

No information

T4. Additional information

T4.1 Additional Sources of Information

No information

T4.2 Further Aspects of Drug Treatment

Appropriate prescribing of pregabalin

In January 2020, the HSE’s Medicines Management Programme published a document on appropriate prescribing of pregabalin (common brand name Lyrica) (Health Service Executive 2020b). It advises that vigilance is required when prescribing pregabalin due to the risk of dependence, illegal diversion, and medical misuse. Currently, pregabalin has only three licensed indications in Ireland:

- Treatment of peripheral and central neuropathic pain
- Treatment of generalised anxiety disorder
- Adjunctive therapy in patients with partial seizures with or without secondary generalisation.

This follows on from advice provided by the Irish Medical Council to doctors in September 2019 to follow best practice guidelines when prescribing pregabalin and to only prescribe when absolutely necessary (Medical Council 2019).

Because of the risk of misuse or dependence, caution is advised when prescribing pregabalin for people with a history of drug or alcohol misuse, particularly as there is a risk of fatal interactions between pregabalin and alcohol in addition to other central nervous system depressant drugs, including opioids. All patients should be monitored for signs of misuse, diversion, or dependence. Withdrawal symptoms include anxiety, convulsions, depression, diarrhoea, dizziness, flu syndrome, headache, excessive sweating, insomnia, nausea, nervousness, and pain. The suggested tapering regime is to reduce the dose gradually by a maximum of 50–100 mg at a time. For further information on pregabalin and drug-related deaths, see Section T1.1.5 of the Harms and harm reduction workbook.

T4.3 Psychiatric comorbidity

No new information.

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. Established under S.I. No. 225/1998, it is a complete register of all patients in Ireland receiving methadone as a treatment for problems with opioid use. 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 Methodology

T5.3 References

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European Monitoring Centre for Drugs and Drug Addiction

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

The Coroner Service

Customs Drugs Law Enforcement, Revenue

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Drugs Policy Division, Department of Justice and Equality

Drugs Policy and Social Inclusion 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

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National Social Inclusion Office, Primary Care Division, Health Service Executive

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