DRUG TREATMENT IN IRELAND: KEY PATTERNS AND TRENDS: 2014 - 2021

DRUG INSIGHTS REPORT 3

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National Social Inclusion Office, 2023

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FOREWORD

I am very pleased to be able to welcome this report from the National Social Inclusion Office (NSO) entitled 'Drug Treatment Patterns in Ireland from 2014-2021.

This is the third insights report produced by the NSIO focusing on contemporary issues in relation to substance use patterns in Ireland following on reports covering 'Drug Related Deaths 2008 – 2017' and Naloxone Administration Patterns 2018 – 2020. This report focuses on identifying in a comprehensive manner the totality of cases receiving treatment for drug related issues in the country.

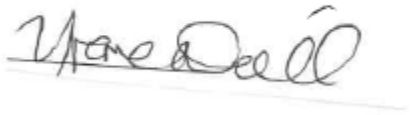
While the National Drug Treatment Reporting System (NDTRS) held by the HRB has been an invaluable tool to identify changing patterns of treatment provision over the years and enables Ireland to meet mandatory reporting requirements to Europe, there has always been an underestimate of those in receipt of Opioid Agonist Treatment due to a separate recording mechanism for that cohort, the Central Treatment List (CTL). The CTL is held separately under the Misuse of Drugs Regulations (S.I. 522/2017) and is hosted by the National Drug Treatment Centre (NDTC). This separation of the two treatment databases has resulted in a relative underreporting of the true numbers in receipt of treatment.

This report has worked with both the HRB and the NDTC to merge the separate databases and produce a more accurate reflection of the numbers in receipt of treatment for drug related problems in Ireland for the years 2014 – 2021. We can now say for example that in 2021, up to 23,332 cases received treatment and this was an increase of 10% from 2014. The report also projects figures until 2026 which will be an important tool for service planning and development.

The report also has examined the issues of ethnicity and homelessness among those receiving treatment to a greater extent than had been conducted to date. The report provides a number of recommendations to improve and develop services over the coming years and I look forward to progressing those recommendations in conjunction with the Addiction Services and the National Social Inclusion Office. A key

recommendation is to integrate the treatment data to allow for the production of reports like this to inform service delivery for this marginalised cohort of people into the future.

Congratulations to the authors and collaborators on the production of this report.



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23,332
cases receiving treatment in 2021

10%
increase since 2014

OPIOIDS
66%
main problem drug treated in 2021 (cocaine 16%, cannabis 11%)

COCAINE
34%
of *NEW CASES*, tripling since 2014

OPIOIDS
80%
of *PREVIOUSLY TREATED* cases, increasing a fifth since 2014

HOMELESS

11%
of all treatment was for cases experiencing homelessness in 2021

57%
increase in treatment for those experiencing homelessness from 2014 - 2021

OPIOIDS
86%
of main problem drugs treated in 2021 for cases experiencing homelessness
COCAINE 6%
BZPS 6%

ETHNICITY
91%
Irish (excluding Irish Travellers) treated in 2021

Greatest increase in treatment since 2014 among Irish Travellers (14%) and other ethnicities (28%)

Cocaine treatment increased for all ethnicities, but greatest among Travellers (525%) and other ethnicities (358%)

EXECUTIVE SUMMARY

Drug treatment services can significantly reduce the negative impact of drug use and dependence. In Ireland, these are provided by both statutory and non-statutory services in a range of settings. Services are organised in terms of a 'Four Tier Model of Care' with clients offered the least intense level of care according to need (Department of Health, 2017).

Drug treatment patterns are monitored on the National Drug Treatment Reporting System (NDTRS). Although this is a comprehensive case-based database (maintained by the Health Research Board), it does not contain all episodes of patients receiving Opioid Agonist Treatment (OAT). These are recorded on the Central Treatment List (maintained by the National Drug Treatment Centre) which is a register of all individual patients receiving OAT. To accurately reflect treatment provision, there is a need to utilise both datasets. This Insights Report provides an overview of drug treatment patterns in Ireland from 2014-2021 by supplementing data recorded on the NDTRS with that recorded on the Central Treatment List (CTL).

Drug treatment data was obtained for the NDTRS and CTL. CTL data for OAT was reconfigured to the same format as that on the NDTRS. Any OAT data on the NDTRS was replaced with the reconfigured CTL data. This was combined with non-OAT opioid treatment (from NDTRS) to give a minimum number receiving drug treatment. Treatment patterns from 2014-2021 are presented, including disaggregation by service provider, drug type, ethnicity, and people experiencing homelessness. The NDTRS data comprises cases commencing treatment within each calendar year (as per the EMCDDA reporting criteria).

The following represents the key findings emerging from the study:

- In 2021, there were up to 23,332 cases receiving treatment, an increase of 10% compared to 2014, with the proportion of new and previously treated cases remaining relatively stable during this period.
- By 2026, it is forecast that new cases could increase by 8% with an increase of 5% in previously treated cases.
- In 2021, the main service provider for treated cases were in outpatient settings (62%) and GPs (22%).
- Services experiencing increases in the numbers receiving treatment from 2014-2021 include pharmacy (24%), outpatients (22%), and GP (10%). Services experiencing a decrease include low threshold (23%), prison (50%), and inpatients (4%).
- The main problem drug treated in 2021 was opioids (66%), followed by cocaine (16%), cannabis (11%), benzodiazepines (BZP, 6%), and other drugs (2%). The largest proportion of new treatment cases were for cocaine (34%) and cannabis (31%), whereas opioid cases represented the largest proportion of previously treated cases (80%).
- With the exception of cocaine, there has been an overall decline in new treatment cases from 2014-2021. New cases for problem cocaine use have tripled since 2014 (having the highest number of new cases in 2021), which is forecast to increase by 55% up to 2026.
- For previously treated cases, there are 10-15 times more cases treated for opioids than any other drug from 2014-2021, with a 20% increase during this period. This is also forecasted to increase by a further 8% to 2026. There have also been increases in previously treated cases for cocaine (49%), cannabis (29%), BZP (149%), and other drugs (75%).
- In 2021, self-reported Irish ethnicity (excluding Irish Travellers) represented 91% of cases treated, with 3% Irish Travellers, 5% other ethnicities, and 1% unknown (NDTRS only). The overall number of Irish receiving treatment increased by 8.1% between 2014 and 2021, with Travellers increasing by 14.8%, while all other ethnicities have increased by 28.3%.

- For those treated in 2021, a larger proportion of those from a non-Irish ethnic background are treated for cannabis (33%), opioids (37%), and other drugs (9.4%), while a larger proportion of Irish are treated for cocaine (31%) and a larger proportion of Irish Travellers are treated for BZP (16%).
- From 2014-2021, the main patterns by ethnicity are:
    - All ethnicities have experienced a decline in cases treated for opioids and an increase for BZP.
    - Cocaine treatment has risen for all ethnicities, but more among Travellers and other ethnic groups.
    - Other ethnicities have increased treatment for other drugs (86%) and cannabis (66%) while such treatment amongst Irish and Travellers has declined.
- 11% of all treatment was for cases experiencing homelessness in 2021 (79% previously treated) which has increased by 57% since 2014.
- The main drugs that cases experiencing homelessness received treatment for in 2021 were opioids (86%), cocaine (6%), and BZP (6%), which have all increased since 2014 (by 49%, 925%, and 404% respectively).

The following recommendations are made:

1. Drug treatment data collection should to be streamlined so that treatment providers only have to send returns once for each person receiving treatment. The introduction of the long awaited Individual Health Identifier could be of benefit in this regard.

2. A process for integrating drug treatment data to facilitate ongoing analysis and the production of annual results for all available data sources should be developed by collaboration between the HSE Addiction Services and the HRB.

3. An ethnic identifier should be introduced to the Central Treatment List database as a matter of urgency. This should employ the same categories for ethnicity as used by the Central Statistics Office.

4. The feasibility of developing a system of screening for problem drug use in a range of health care settings should be further developed to engage those who require treatment in appropriate care. This should utilise existing approaches employed by the HSE such as SAOR (Screening and Brief Intervention for Problem Alcohol and Substance Use).

5. HSE Clinical Guidelines for Opioid Substitution Treatment should be updated incorporating modifications introduced during the COVID-19 pandemic that have proven beneficial.

6. Following the evaluation of HSE pilot cocaine treatment programmes, those treatment models that have been successful in addressing harms need to be embedded in treatment services.

7. The feasibility of disaggregating available datasets to investigate drug treatment patterns for prescribed and non- prescribed benzodiazepine (BZP) use should be explored.

8. Targeted drug treatment programmes aimed at specific marginalised groups need to be considered to help engage them in appropriate care. This should include the development of good practice guidelines for drug and alcohol services working with ethnic groups and utilise resources available from elsewhere in Europe.

9. KPI's should be reviewed (based on good practice guidelines) for drug and alcohol services that monitor performance in terms of meeting the needs of ethnic groups.

10. Consideration should be given to developing specific treatment programmes for those who are homeless and using substances in problematic ways. Existing programmes in existence internationally should be reviewed to determine if similar services could be developed in Ireland. These should provide treatment for a range of drugs in addition to opioids.

1. INTRODUCTION

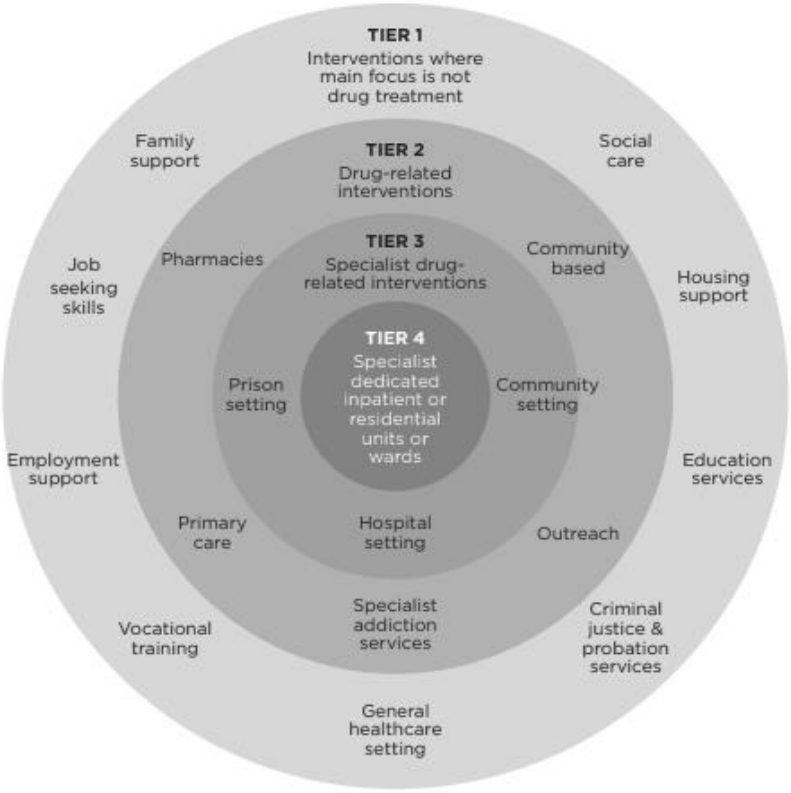
1.1 The Importance of Drug Treatment Services

Drug treatment services can significantly reduce the negative impact of drug use and dependence. With treatment, people can recover, with recurrence rates similar to other chronic diseases. (Office of the Surgeon General, 2016). Treatment services are also cost effective in terms of reducing healthcare costs, criminal justice costs, and the social and economic costs of drug related harm. Studies have shown that the cost of providing evidence-based treatment far outweighs the cost of untreated drug dependence (United Nations Office on Drugs and Crime, 2021). Ettner et al (2005), in a study of 43 substance treatment providers in California, found that every dollar spent on substance abuse treatment saves $4 in healthcare costs and $7 in law enforcement and other criminal justice costs. Davies et al (2009), in a study of 1800 people receiving treatment in England, estimated that healthcare costs reduce by 31% when drug users are in treatment. They estimated a cost-benefit ratio of 2.5:1, suggesting that every £1 invested results in £2.50 in terms of benefits to society.

1.2 Drug Treatment in Ireland

Drug treatment services in Ireland are provided by both statutory and non-statutory services in a range of settings, including hospital, residential centres, outpatient clinics, General Practice and community-based services. They aim to provide person-centred care, promoting rehabilitation and recovery. The types of treatment available include medication, psychiatric treatment, counselling and brief interventions, specific therapy (e.g. family, complementary) and life skills training. Services are organised in terms of a ‘Four Tier Model of Care’ with clients offered the least intense level of care according to need (Department of Health, 2017).

Figure 1.1: The Four-Tier Model of Care



Source: Doyle, and Ivanovic, (2010)

1.3 Drug Treatment Monitoring

As part of the National Drug and Alcohol Strategy (Department of Health, 2017, action 5.1.47), all publically funded services are required to record all treated cases on the National Drug Treatment Reporting System (NDTRS). This is a database of treated drug and alcohol use in Ireland. It is coordinated by the Health Research Board (HRB) on behalf of the Department of Health. The NDTRS data is collected in line with the EMCDDA's standardised questionnaire on drug treatment and as such enables Ireland to meet its reporting requirements to Europe, but also ensures that it comparable with treatment data from other member states. The NDTRS collects data on types of substances used, consumption behaviour, and sociodemographic characteristics. As such, the NDTRS provides a valuable source of information in terms of planning and

developing services. It permits an assessment of demand for treatment services and is also an indirect indicator of drug and alcohol misuse (Bellerose et al, 2011).

Although the NDTRS does provide a comprehensive overview of drug treatment patterns in Ireland, there is an issue that some service providers may not complete the NDTRS for patients receiving Opioid Agonist Treatment (OAT). This is because there is a mandatory legal requirement for those receiving OAT to be recorded on a Central Treatment List. This is a separate register held by the National Drug Treatment Centre on behalf of the HSE as required by Statutory Instrument No. 522/2017 of the Misuse of Drugs Regulations (Irish Statute Book, 2017). The NDTRS may also not be completed for patients receiving OAT where this is not explicitly stated in a Service Level Agreement. As such, to accurately reflect treatment demand, there is a need to utilise both datasets.

1.4 Aims and Objectives

This Insights Report will provide an overview of drug treatment patterns in Ireland from 2014-2021 by supplementing data recorded on the NDTRS with that recorded on the Central Treatment List. Research has identified higher drug use among those people experiencing homelessness and among the Irish Traveller population (O'Reilly et al, 2015, Carew et al, 2013). There is a dearth of information available on drug use among non-Irish populations; therefore the report will disaggregate results where possible for these population sub-groups. The specific objectives are to examine:

1. Overall patterns from 2014-2021
2. Patterns by type of service provider
3. Patterns by main drug treated
4. Patterns for homeless people
5. Patterns for Travellers and other ethnic groups

2. METHOD

2.1 Introduction

NDTRS data was combined with opioid treatment data from the Central Treatment List. The data was used to show patterns of drug treatment from 2014 to 2021.

2.2 National Drug Treatment Reporting System (NDTRS) Data

Drug treatment data from 2014-2021 was obtained from the HRB's published reports on drug treatment patterns (Kelleher et al, 2021, 2022). This contains case data for overall treatment patterns by service provider and drug type. It also disaggregates data for new users and previously treated users. In addition, the following data was also requested from the HRB:

1. OAT (treatment cases commencing methadone or buprenorphine OAT) and non-OAT (e.g. brief intervention, counselling) opioid treatment. This classification does not distinguish between OAT only and OAT in combination with other treatment types.
2. Treatment for powder cocaine, crack cocaine and freebase cocaine from 2014-2021.
3. Treatment patterns for the Traveller population and non-Irish ethnic groups.
4. Treatment patterns for cases experiencing homelessness.

Although the NDTRS does record cases where alcohol was the main problem drug, these were excluded from the current analysis. However, the data does include those that listed alcohol as a secondary reason for treatment. As there is currently no unique health identifier, the NDTRS data is for episodes of treatment, rather than the individual person treated. Treatment refers to activities that aim to ameliorate the medical, social or psychological impact of substance misuse (Bellerose et al, 2011).

2.3 Central Treatment List Data (CTL)

Treatment cases for OAT from 2014-2021 (methadone or buprenorphine containing products) was provided by the National Drug Treatment Centre. This was provided for total patients (during and at end of period) and new first time patients. Data was also disaggregated for:

1. Name of treatment facility (enabling classification by inpatient and outpatient)
2. GP treatment (level 1 and 2)
3. Pharmacy
4. Prisons
5. Homelessness

CTL data could not be disaggregated by ethnicity.

2.4 Combining Data

OAT data from the HRB was deleted and replaced with OAT data from the Central Treatment List. OAT (CTL) and non-OAT (NDTRS) were summed to give a combined total for Opioid treatment. It was assumed that those receiving non-OAT (NDTRS) were not also receiving OAT (CTL). To disaggregate data by service provider type, CTL data for individual facilities were reclassified as inpatient or outpatient. In addition, CTL data was reconfigured to disaggregate by new and previously treated cases (previously treated cases based on subtracting new cases from the total treated during period). CTL data could not be disaggregated by ethnicity. Opioid treatment for Travellers and other ethnic groups was therefore based only on NDTRS data. For all other drugs, data from the NDTRS was utilised. It is acknowledged that by combining data sources, there is an increased margin of error.

2.5 Impact of COVID-19

In 2020, treatment services were affected by the COVID-19 pandemic. Temporary closures of services and measures introduced to comply with COVID-19 may have had an impact on treatment figures. It is therefore important to interpret 2020 data in the context of COVID-19.

3. DRUG TREATMENT PATTERNS 2014-2021

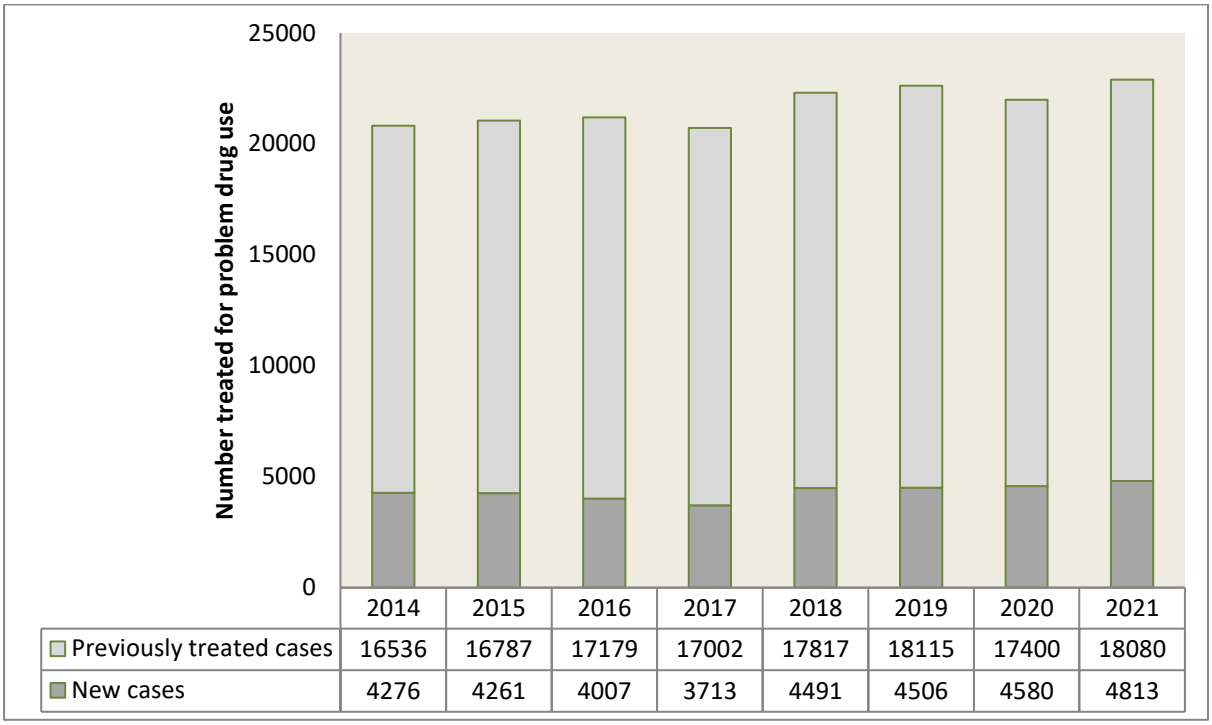
3.1 Introduction

The following represents drug treatment patterns from 2014-2021 using combined data from NDTRS and CTL. NDTRS data is utilised for all treatment except OAT. For OAT, the NDTRS data is replaced with data from CTL.

3.2 Overall Patterns

The total number of those receiving treatment in 2021 was up to 23,332 (21% new cases). This represents a 10% increase since 2014. In 2020, the total number treated had declined by 4% compared to 2019. However, the numbers treated in 2021 have increased by 4% since 2020. Figure 3.1 shows the percentage of new cases has remained relatively stable since 2014, with only small fluctuations taking place (e.g. the proportion of new cases increased from 20.1% in 2014 to 20.6% in 2021). Previously treated cases have fluctuated, but in 2021 the percentage of previous cases was similar to that in 2014. Based on these patterns it is forecast that by 2026 new cases could increase by 8% (5183 cases; CI =4354-6011) and previously treated cases could increase by 5% (18,998 cases; CI = 18,553-19,443).

Figure 3.1: Number Receiving Treatment for problem Drug Use 2014-2021 (combining NDTRS* and CTL data)



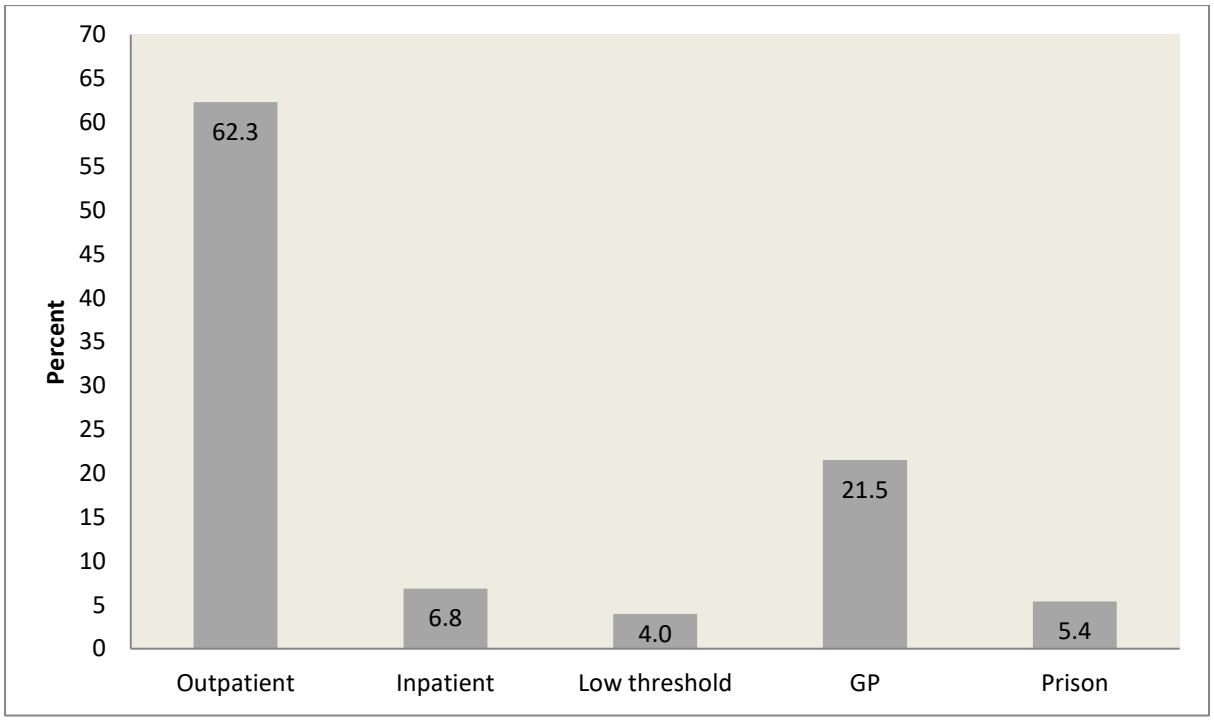
	2014	2015	2016	2017	2018	2019	2020	2021
Previously treated cases	16536	16787	17179	17002	17817	18115	17400	18080
New cases	4276	4261	4007	3713	4491	4506	4580	4813

Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

3.3 Type of Service Provider

Figure 3.2 shows that in this analysis the main service provider for treatment cases were outpatient services (62%) and community GPs (22%). Compared to the NDTRS (Kelleher et al, 2021), the combined data shows a greater proportion of cases treated by GPs (22% compared to 1%) and a lower proportion of cases treated at outpatients (63% compared to 70%). In addition, low threshold cases are only represented on the NDTRS database. Low threshold services typically do not require abstinence from substance use to access and aim to remove barriers to access (Islam et al, 2013).

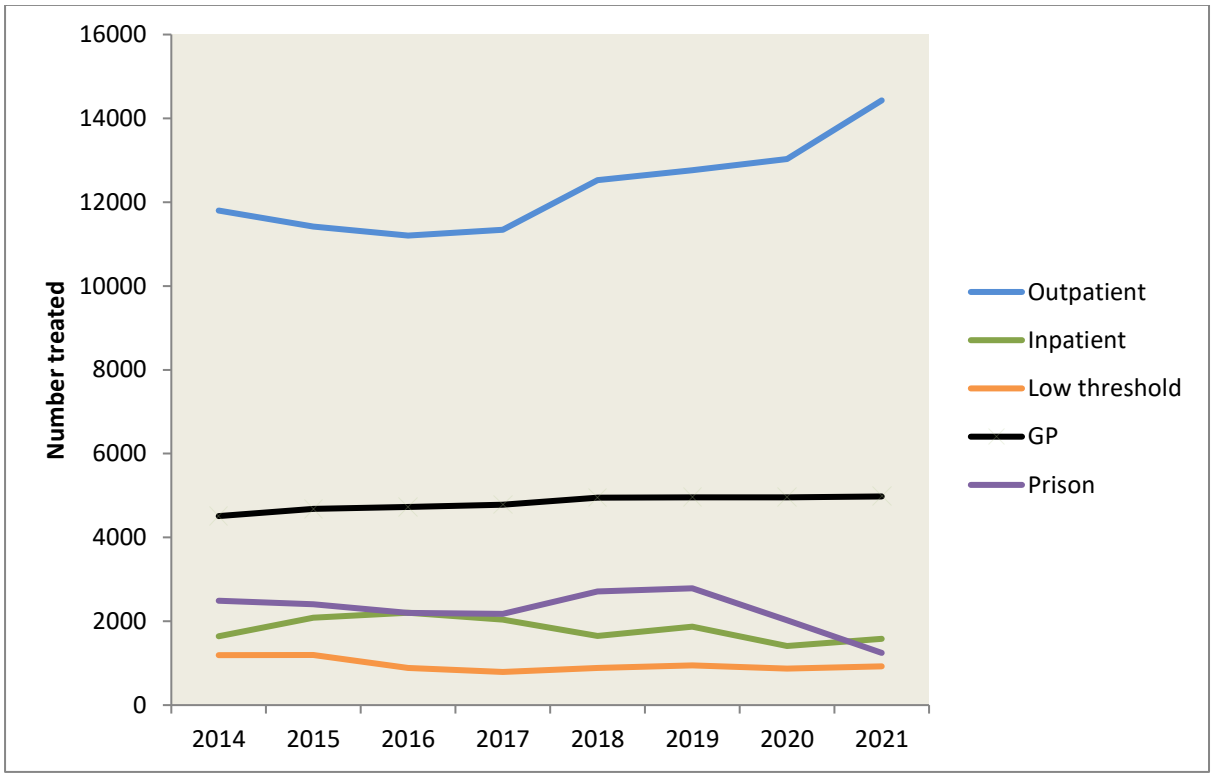
Figure 3.2: Proportion Treated by Main Service Provider (2021)



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

Figure 3.3 shows the type of treatment by service provider from 2014-2021. Compared to 2014, it can be seen that in 2021, increases have been experienced by outpatient (22%) and GP (10%), while there has been a decrease for low threshold (23%), prison (50%), and inpatient treatment services (4%). The numbers receiving prison treatment have fluctuated, but experienced a sharp decline in 2020 and 2021, while the number receiving low threshold treatment has experienced an overall decline throughout the 2014-2021 period.

Figure 3.3: Treatment by Main Service Provider 2014-2021



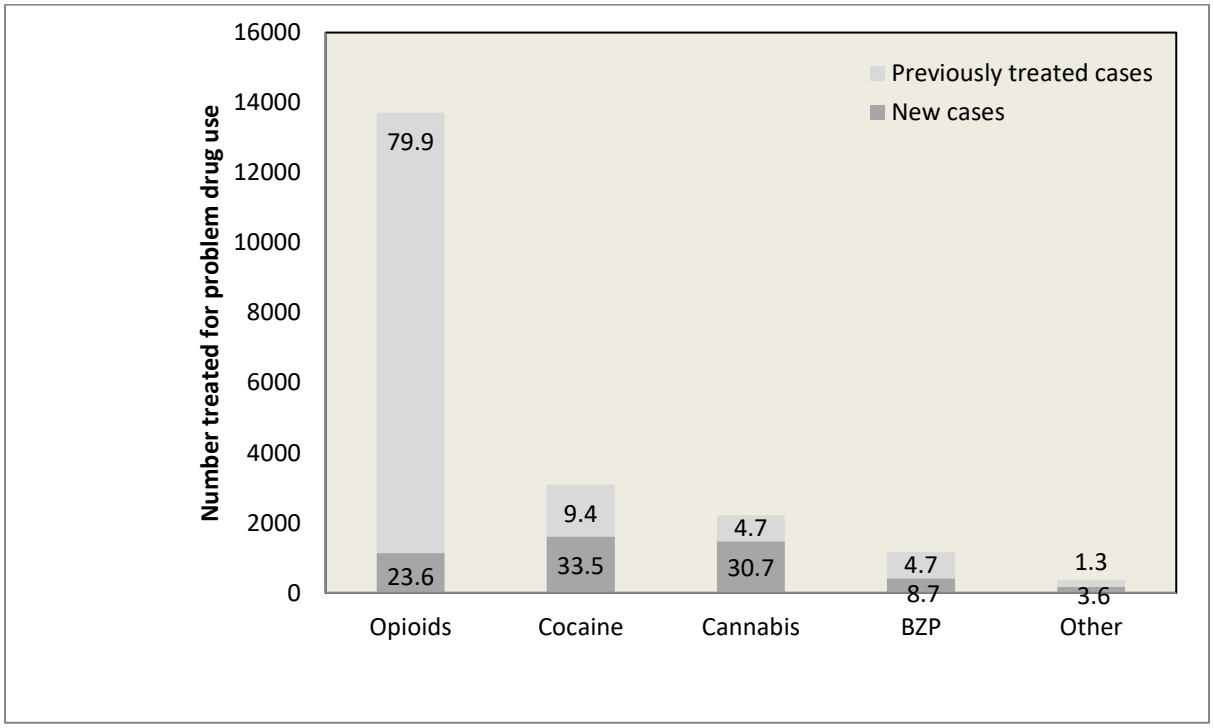
Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

3.4 Main Problem Drug

Figure 3.4 shows that the main problem drug treated in 2021 was Opioids (66%), followed by Cocaine (16%), Cannabis (11%), Benzodiazepines (BZP, 6%), and other drugs (2%). Other main problem drugs included Z drugs, amphetamines, novel psychoactive substances, MDMA, and volatile inhalants. The largest proportion of new cases were for cocaine (34%; of which 83% were cocaine hydrochloride and 17% freebase cocaine), Cannabis (31%) and Opioids (24%), whereas Opioid cases represented the largest proportion of previously treated cases (80%). The majority of Opioid (91%) and BZP (61%) cases were previously treated cases whereas the majority of Cocaine (50%) and Cannabis (64%) cases were new cases. A total of 83% of those being treated for opioid misuse in 2021 received Opioid Agonist treatment

(OAT) with 17% receiving other forms of treatment (e.g. counselling, motivational interviewing).

Figure 3.4: Main Problem Drug Treated with Proportion of New and Previously Treated Cases (2021)

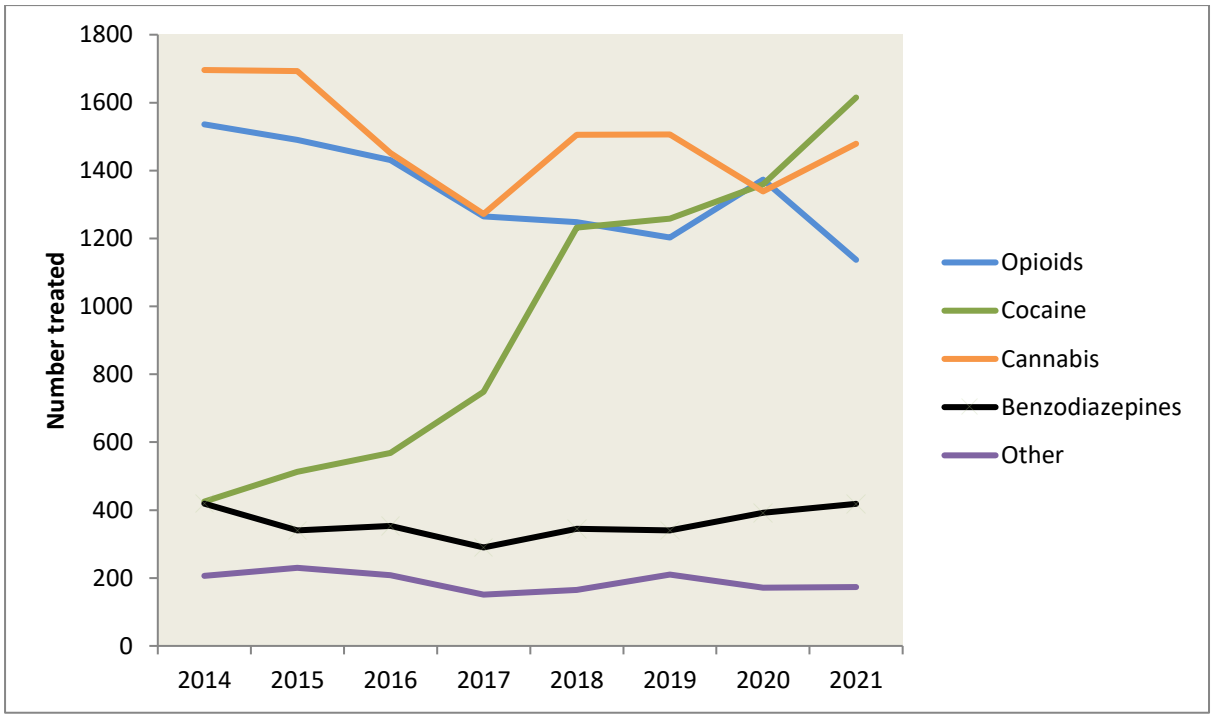


Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

Figure 3.5 shows patterns of new drug treatment cases between 2014 and 2021. For the main problem drugs, it can be seen that with the exception of cocaine, the overall number of new cases treated has declined since 2014; although there have been some fluctuations. During this period, new cases for cannabis and opioid treatment were markedly higher than for BZP and other drugs. New cases for problem cocaine use have sharply increased with the numbers treated tripling between 2014 and 2021. Cocaine hydrochloride has increased by 307%, while freebase cocaine has increased by 296%. Cocaine has increased from having the third highest number of new cases

treated in 2014 to having the highest number of new cases in 2021. Based on this pattern, it is forecast that 2503 (CI = 2242-2763) new cases could be treated for problem cocaine use by 2026 (an increase of 55% compared to 2021). Cannabis by contrast has decreased from having the highest number of new cases receiving treatment in 2014 to having the third highest in 2021 (13% decline). By 2026, based on this pattern, it is forecast that the number treated could reduce to 1215 (CI = 921-1509), a decrease of 22% compared to 2021. The number of new treatment cases for opioid treatment has experienced a decline, but did increase in 2020 (when opioid dependent people were prioritised into treatment during the COVID-19 pandemic), giving an overall 26% decline from 2014-2021. Based on this pattern, it is forecast that there could be 951 (CI = 798-1110) new opioid cases treated in 2026 (a 20% decrease compared to 2021). BZP and other drugs have experienced a gradual decline up to 2017, followed by a gradual increase thereafter. This has resulted in a marginal increase during the period for BZP (0.2%) and a decline of 16% for other drugs. It is forecast that there could be 431 new cases treated for BZP (CI = 249-614) in 2026 (an increase of 3% compared to 2021) and 134 treated for other drugs (CI = 90-178) in 2026 (a decrease of 29% compared to 2020).

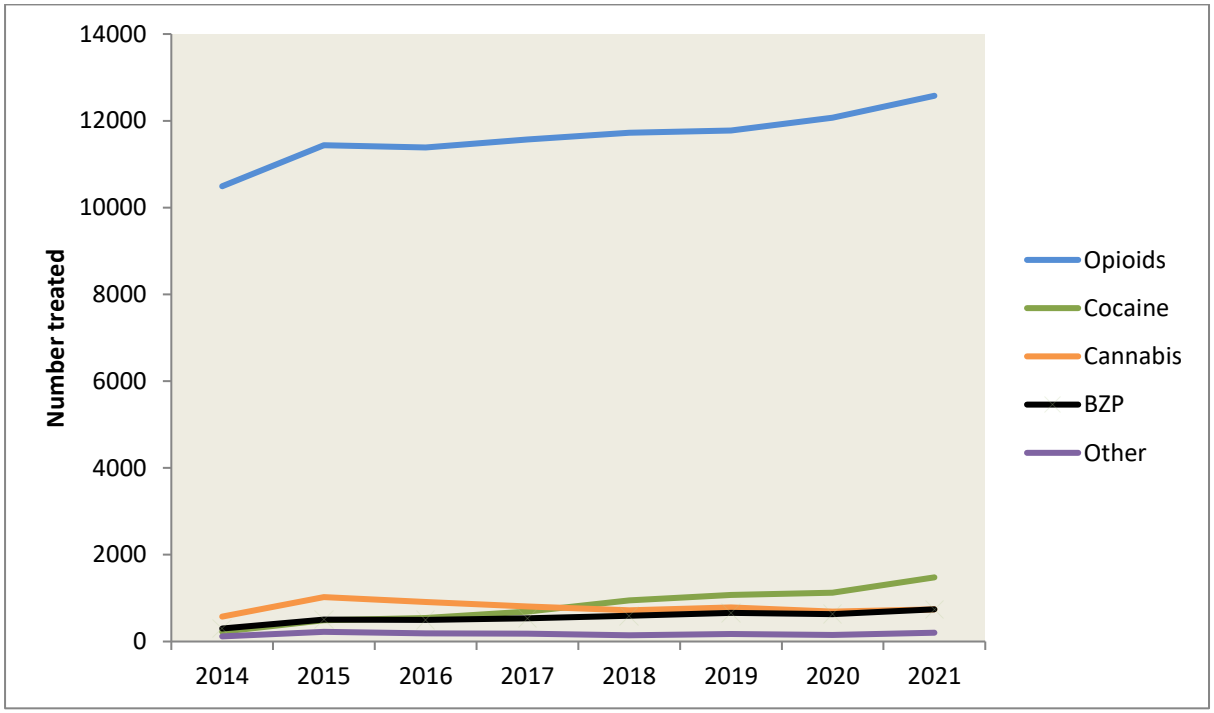
Figure 3.5: Main Problem Drug Treated for New Treatment Cases (2014-2021)



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

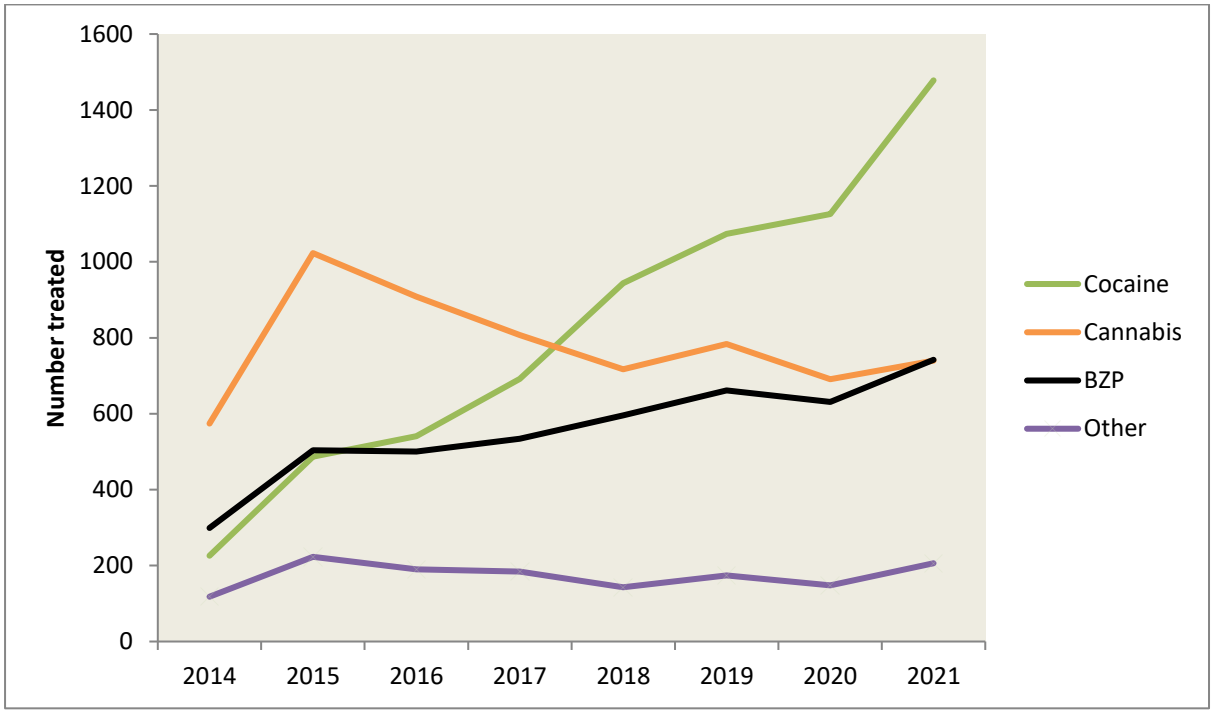
Figure 3.6 and 3.7 show patterns of previously treated cases from 2014-2021. During this period, the number treated for opioids is approximately 10-15 times greater than treatment for any other drug type and has increased by 20% from 2014. If this pattern continues it is forecast that there could be 13,589 previously treated cases by 2026 (an increase of 8% from 2021). In examining patterns of treatment for drugs other than opioids (figure 3.7), it can be seen that as with new cases, there has been a sharp increase in previously treated cocaine cases (49% from 2014-2021). Previously treated cases for cannabis have fluctuated and are 29% higher in 2021 compared to 2014. Those previously treated for BZP have sharply increased and in 2021 were 149% higher than 2014. Treatment for other drugs have increased (75%) but have shown sharp fluctuations. If this pattern continues, it is forecast that in 2026 there could be 2201 (CI = 2076-2325) previously treated cases for cocaine, 674 (CI = 61-1286) for cannabis, 923 for BZP (CI = 789-1057) and 144 (CI = 24-270) for other drugs.

Figure 3.6 Main Problem Drug Treated for Previously Treated Cases (2014-2021)



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

Figure 3.7: Main Problem Drug Treated (excluding opioids) for Previously Treated Cases (2014-2021)



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

3.5 Ethnicity

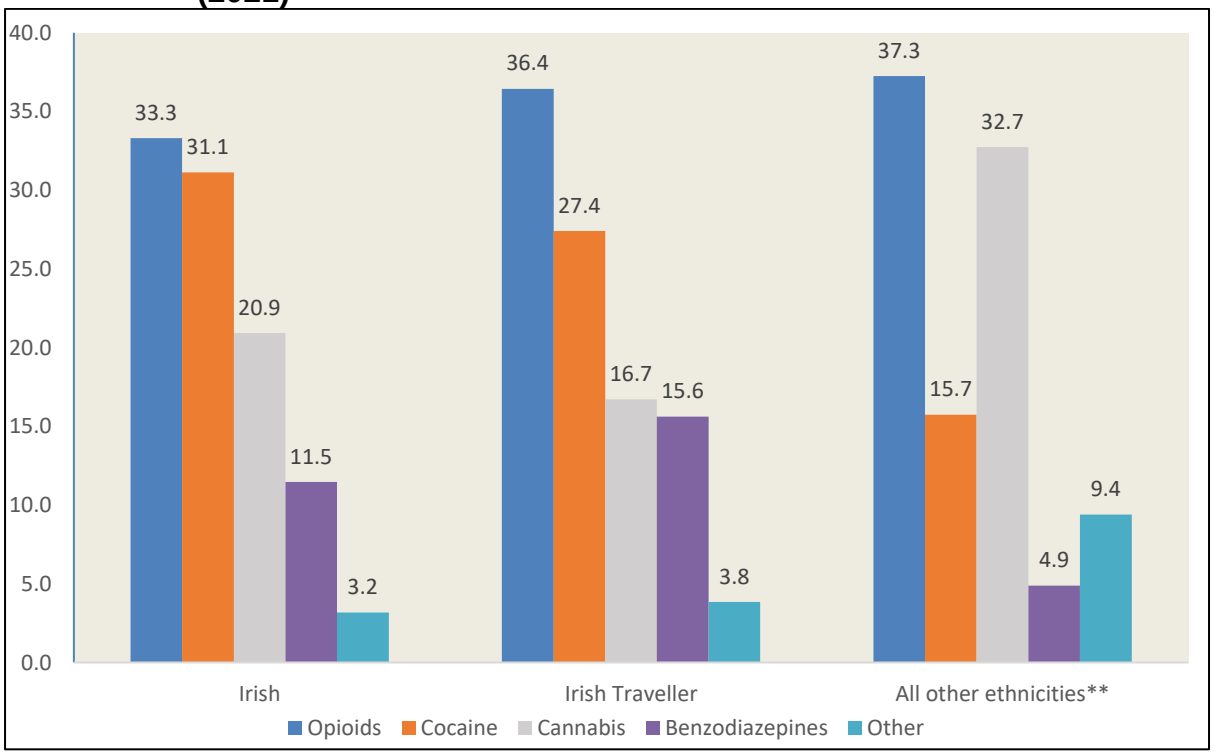
Information on self-reported ethnicity is included on the NDTRS database, but not on the CTL database. As such, the data presented for ethnicity is solely from cases in the NDTRS database. In 2021 Irish ethnicity represented 91% (n = 9774) of cases treated. The remaining treated cases were Irish Travellers (3%, n = 365), other ethnicities (5%, n = 553) and unknown or not stated ethnicity (1%, n = 82). There has been little overall change in this pattern since 2014. The overall number of Irish receiving treatment increased by 8.1% between 2014 and 2021, with Travellers increasing by 14.8%, while all other ethnicities have increased by 28.3%.

Figure 3.8 shows the proportion of each ethnicity treated in 2021 for each problem drug (excluding unknown and not stated). It can be seen that a lower proportion of

Irish are treated for opioids (33% compared to 36-37%) while a larger proportion of Irish are treated for cocaine (31% compared to 15-27%). A larger proportion of other ethnicities are treated for cannabis (33% compared to 17-21%) and other substances (9% compared to 3-4%), while a larger proportion of Traveller cases are treated for BZP (16% compared to 5-12%).

Differences between Irish Travelers and Irish are significant for BZP ($z = -2.4361$, $p < 0.05$). Differences between other ethnicities and Irish are significant for Cocaine ($z = 7.6664$, $p < 0.05$), cannabis ($z = -6.5693$, $p < 0$ .05), BZP ($z = 4.7883$, $p < 0.05$), and other drugs ($z = -7.7516$, $p < 0.05$). Differences between Irish Travellers and other ethnicities are significant for cocaine ($z = 4.2947$, $p < 0.05$), cannabis ($z = -5.3909$, $p < 0.05$), BZP ($z = 5.5204$, $p < .05$), and other drugs ($z = -3.196$, $p < 0.05$).

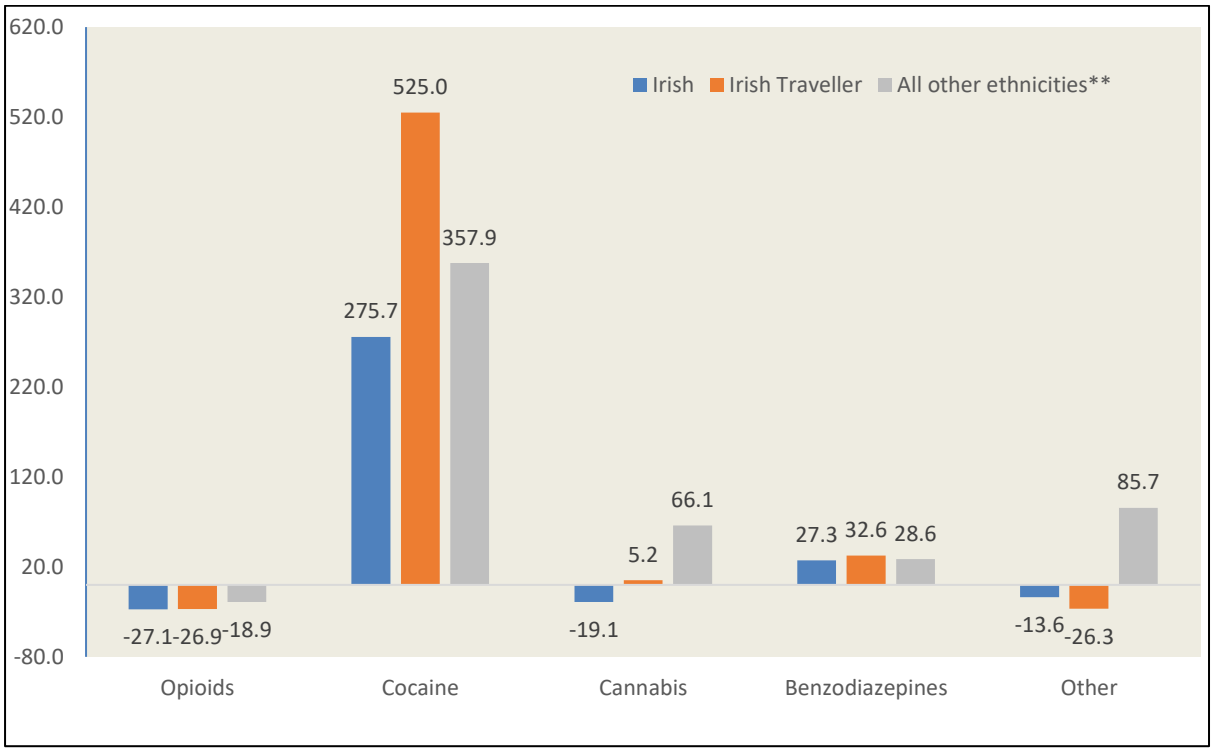
Figure 3.8: Proportion of each ethnic group treated by main problem drug (2021)*



*excludes cases where ethnicity is unknown or not stated (1%)
** Includes 'Any other white background,' 'Black African,' 'Any other black background,' 'Asian Chinese,' 'Any other Asian Background,' 'Other including mixed background,' and' Roma'. Source: NDTRS

Figure 3.9 shows changes in treated cases from 2014-2021 for each problem drug by ethnicity. Whilst all ethnic groups have experienced a similar decline in cases treated for opioids (19-27%), there are differences in terms of other drugs treated. Travellers (525%) and all other ethnicities (358%) have experienced larger increases in cases treated for cocaine than Irish (278%). For cannabis, Irish cases have declined (19%), while Travellers have increased by 5% and other ethnicities have increased by 66%. BZP treatment has increased for all ethnicities (27-33%). Treatment cases for all other drugs have experienced a decline for Irish (14%) and Travellers (26%), while other ethnicities have increased by 86%.

Figure 3.9: Percentage Change in Cases treated 2014-2021 by Ethnicity for Main Problem Drug*

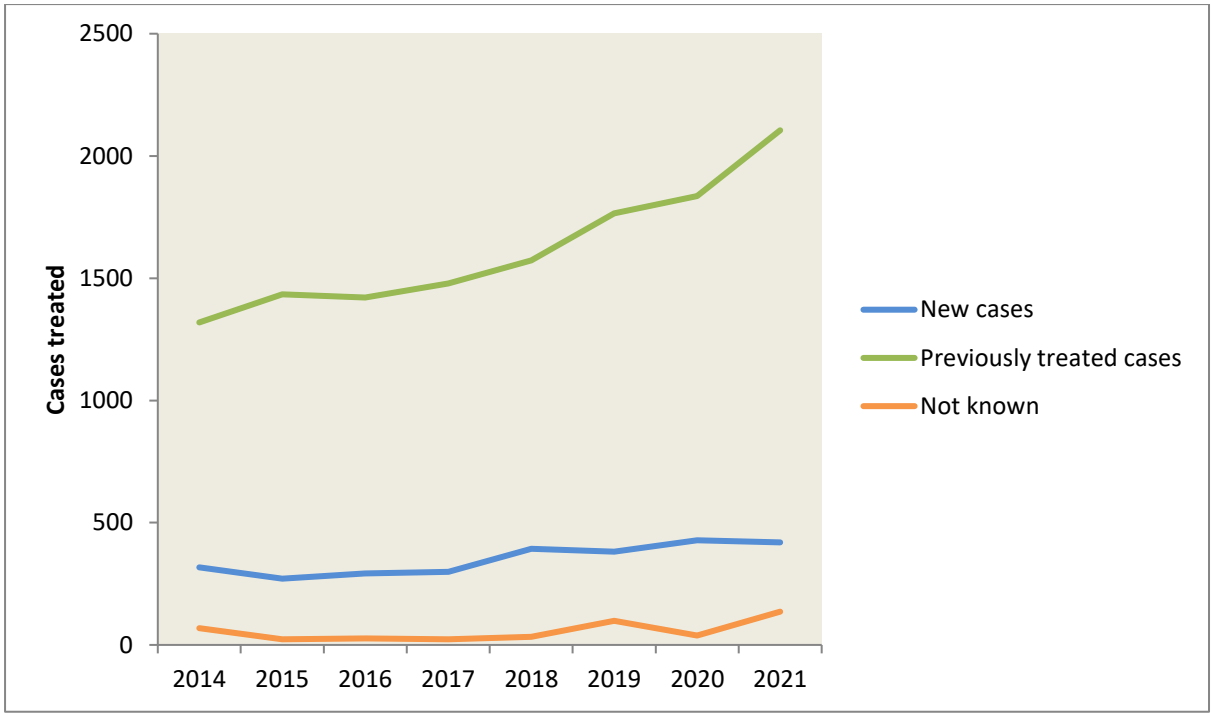


*excludes cases where ethnicity is unknown or not stated (1%)
** Includes 'Any other white background,' 'Black African,' 'Any other black background,' 'Asian Chinese,' 'Any other Asian Background,' 'Other including mixed background,' and' Roma'
Source: NDTRS

3.6 People Experiencing Homelessness

In 2021 there were 2661 cases experiencing homelessness receiving treatment for problem drug use. This represents 11% of all treated cases. The majority of these (79%) were previously treated cases, while 16% were new cases, and for 5% it was unknown if they had been treated before. Figure 3.10 shows patterns of new and previously treated cases experiencing homelessness from 2014-2021. During this period, there has been a 57% increase in cases experiencing homelessness that were treated. New cases have increased by 33% while previously treated cases have increased by 60%. Based on these patterns it is forecast that by 2026 new cases will increase by 39% (582 cases; CI = 474-690) and previously treated cases will increase by 24% (2603 cases; CI = 2277-2929).

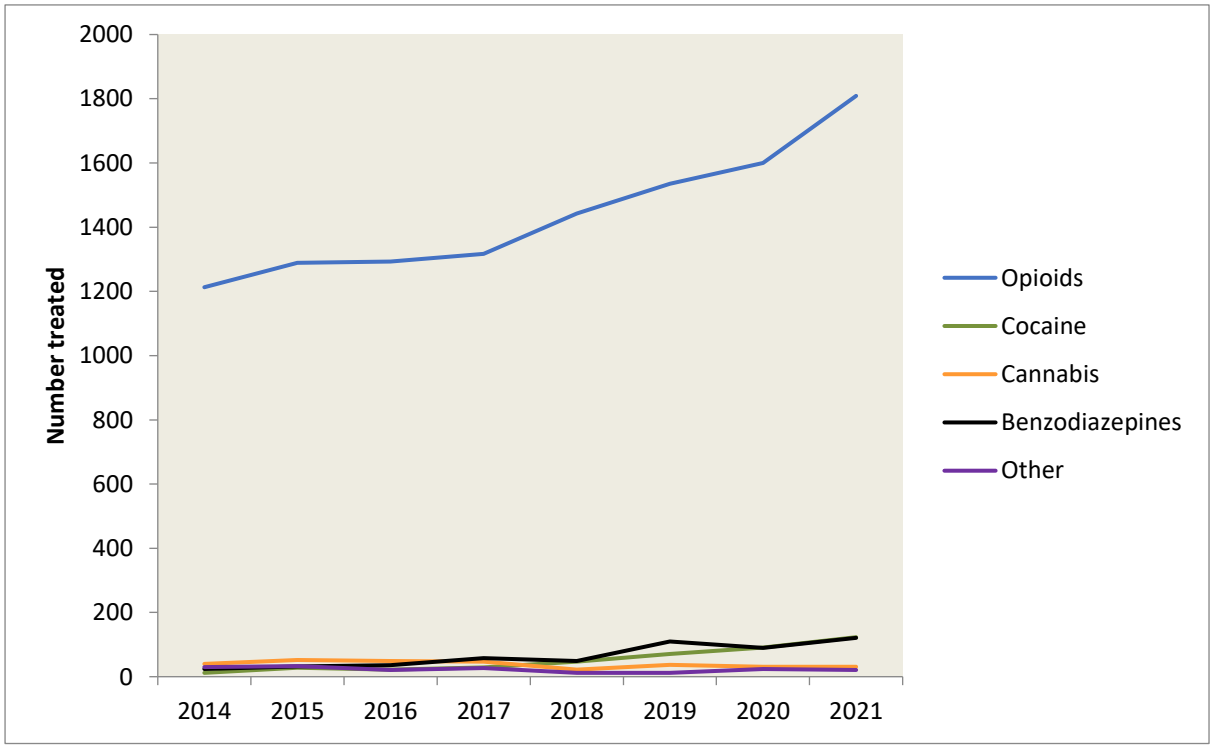
Figure 3.10: Number of Cases Experiencing Homelessness Receiving Treatment for Problem Drug Use 2014-2021



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

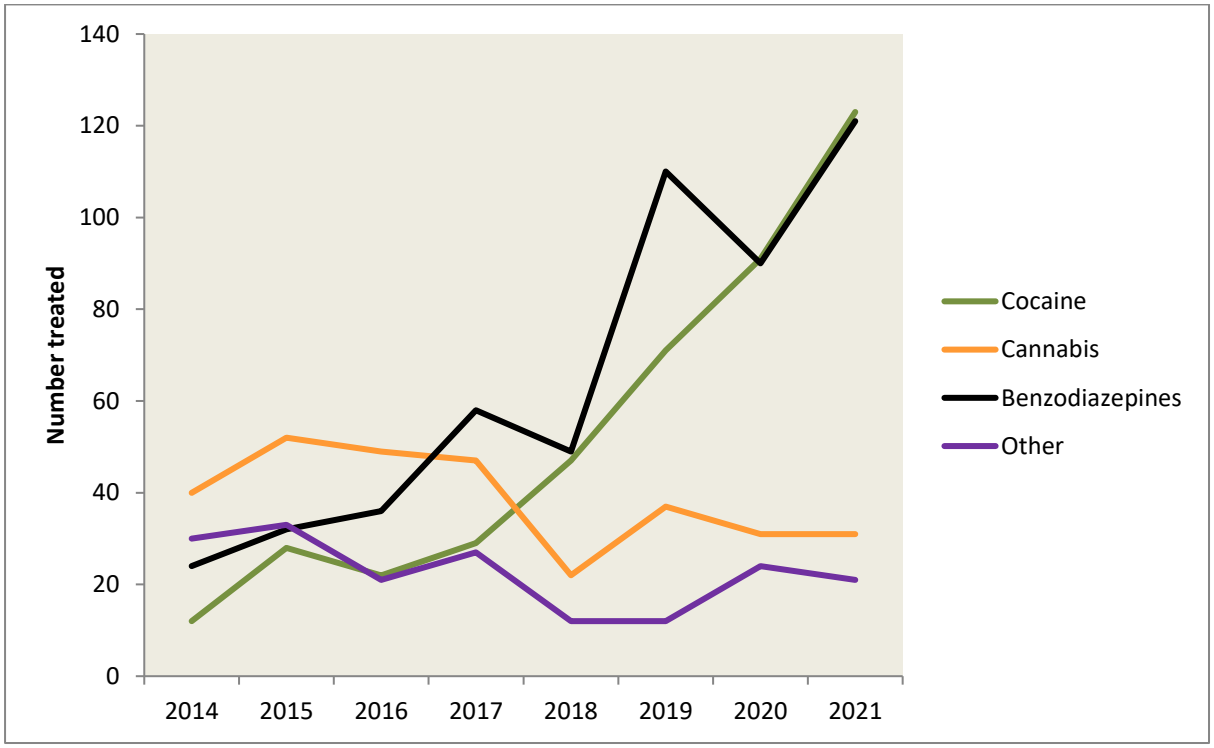
Figures 3.11 and 3.12 show the main problem drugs treated for cases experiencing homelessness and patterns of treatment by drug type from 2014-2021. During this period, the number treated for opioids was 15-30 times greater than any other drug type. In 2021, 86% of treatment was for opioids. The other main types of drug treated in 2021 were cocaine (6%) and BZP (6%). The number treated for opioids, cocaine, and BZP increased from 2014-2021, while 'other drugs' and cannabis experienced a decrease. The magnitude of changes in treatment during the period can be seen in Figure 3.13. This shows that cocaine treatment increased by 925%, with a 404% increase in BZP treatment, and a 49% increase in opioid treatment. 'Other' drugs and cannabis experienced a decrease in treatment (30% and 23% respectively).

Figure 3.11: Main Problem Drug Treated for Cases Experiencing Homelessness (2014-2021, all cases)



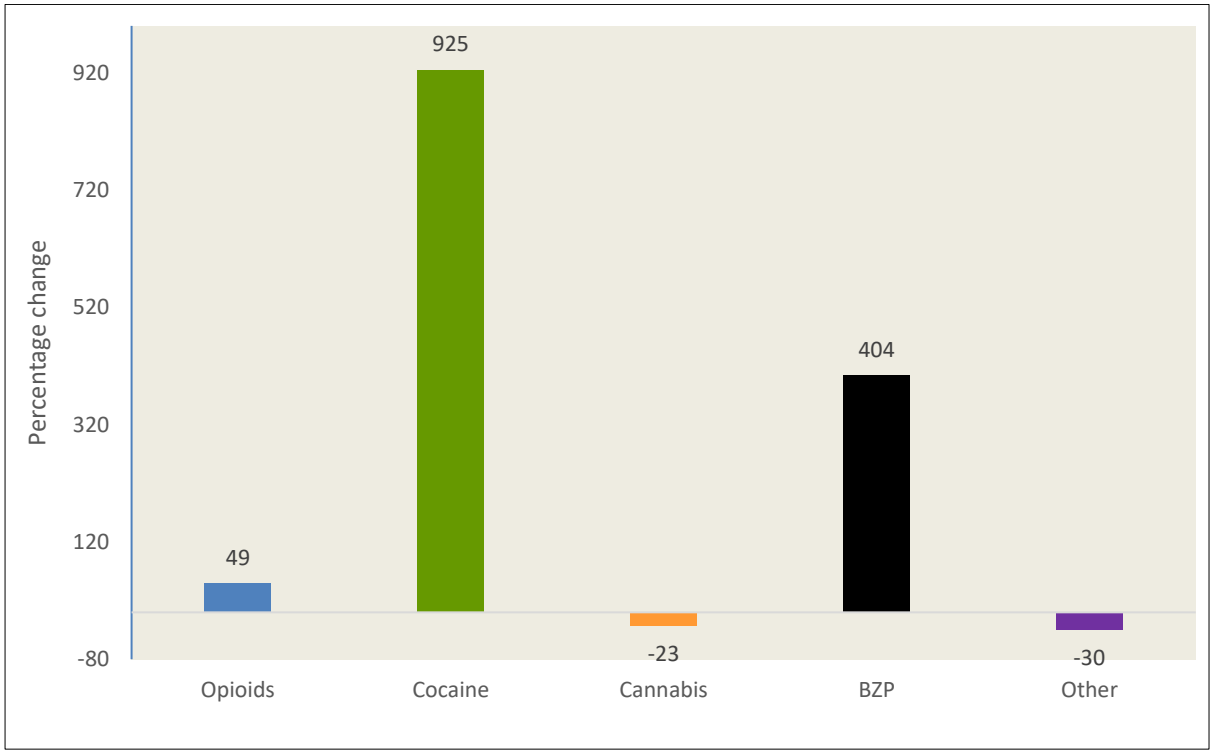
Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

Figure 3.12: Main Problem Drug Treated for Cases that are Experiencing Homelessness (excluding opioids, 2014-2021, all cases)



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

Figure 3.13: Percentage Change in Cases Experiencing Homelessness Treated 2014-2021 by Main Problem Drug



Source: NDTRS, CTL; *NDTRS treatment data for opioids replaced with CTL opioid treatment data

4. DISCUSSION

4.1 Introduction

This report provides a comprehensive overview of treatment patterns for different types of treatment from 2014-2021. By combining the two main available data sources, it enables a more accurate assessment of current and future patterns of drug treatment demand in Ireland, and an insight into patterns of drug use in Ireland. Key issues emerging from the analysis will now be outlined.

4.2 Overall Patterns and Trends

In 2021 there were up to 23,332 cases receiving treatment for problem drug use. This is higher than that previously published by the NDTRS (Kelleher et al, 2022). It is important to note that the NDTRS remit is to publish entries to treatment in a calendar year as per EMCDDA guidelines and it does not include continuous care cases. Therefore, these combined database results provide a more comprehensive reflection of demand for treatment services and the work conducted in treatment services. They also help to rationalise the current resource requirements to provide treatment services. By utilising CTL data, a large number of people receiving OAT are included that are not recorded in previously published data. This issue of underreporting is recognised by the HRB (Kelleher et al, 2022). The National Drugs Strategy (Department of Health, 2017) sets a requirement for all publically funded services to record all treated cases on the NDTRS (action 5.1.47). However, there is also a mandatary legal requirement for service providers to send data for those receiving OAT to the CTL. Rather than returning OAT data to two different databases, it appears that some service providers are just sending to the CTL. For ongoing monitoring purposes, it would be beneficial if data collection could be streamlined so that service providers only have to send returns once for each person receiving treatment. It also needs to be integrated to permit analysis on an ongoing basis, with such data utilised whenever treatment data is published.

In terms of trends in treatment since 2014, it can be seen that although there have been some fluctuations, the total number of cases receiving treatment has gradually risen, with a 14% increase in 2021 compared to 2014. This overall treatment pattern is mainly attributable to opioid treatment, which has experienced a steady pattern of growth in previously treated cases while new cases have declined. As opioid treatment is 10-15 times greater than any other drug, this overall pattern masks sharp increases in the treatment of other drugs such as cocaine. The overall number receiving treatment dropped in 2020, which is likely to be attributable to the impact of COVID-19. Since 2014, the overall prevalence of illegal drug use has also remained relatively stable (Mongan et al, 2021). Based on current patterns of treatment, it is forecast that there could be 24,181 cases treated in 2026 (a 3.6% increase compared to 2021; although it must be noted that new cases of cocaine are forecast to increase by 55% - see section 4.4). Between 2014 and 2020, investment in HSE Addiction Services has increased by 23% (HRB, 2022b). Thus with the 14% increase in overall numbers, more resources have been given to develop services to meet this demand in addition to the changing treatment needs of those requiring treatment (such as a rise in treatment for those with problem cocaine use) and a continued reorientation of services towards the Four Tier Model of Care outlined in the National Drug and Alcohol Strategy (Department of Health, 2017). Future investment will be required to meet such demands on treatment services.

In addition, it is also worth pointing out that there may be a significant number of people that experience problem drug use that are currently not receiving treatment. Although prevalence estimates for problematic opioid use (Hanrahan, et al, 2022) suggest that HSE services are treating a significant proportion of opioid dependent substance users, this may not necessarily be the case for people dependent on other substances. Studies have found that only 10-14% of problem drug users receive treatment (Grant et al, 2016, Office of the Surgeon General, United Nations Office on Drugs and Crime, 2021). It is likely that a similar pattern is experienced in Ireland. If untreated problem drug users can be encouraged to use services, additional treatment expansion may be required to meet demand. Studies have shown that the cost of providing evidence-based treatment far outweighs the cost of untreated drug dependence (United Nations Office on Drugs and Crime, 2021). The Office of the Surgeon General (2016)

emphasises the importance of screening for Substance Use Disorder in general health care settings, as many people may be unaware that they have a problem that requires treatment. The feasibility of developing a system of screening for problem drug use in a range of health care settings should be explored. This should consider utilising existing approaches employed by the HSE, such as SAOR (Screening and Brief Intervention for Problem Alcohol and Substance Use; O Shea et al, 2017). In addition, initiatives developing as part of the National Drug and Alcohol Strategy (such as the Health Diversion programme for those people caught in possession of drugs for personal use) may also impact on treatment services, as this cohort may not have been identified previously.

4.3 Type of Service Provider

The National Drug and Alcohol Strategy aims to promote treatment as close to a person's home and at a lower level of complexity that best suits their needs (Department of Health, 2017). This is reflected in treatment patterns, with over 8 out of 10 people treated in non-acute facilities such as outpatient services and GPs. This pattern is not as evident in the NDTRS previously published data (Kelleher et al, 2022) which does not fully demonstrate the role of GPs in OAT, given the fact that continuous care treatment is not included. As such, the degree to which government policy objectives are being achieved is not as clear if we solely rely on the NDTRS. This again shows the importance of streamlining data collection and integration of data sources. GPs play a key role in drug treatment, given the level of physical and psychological morbidity that can develop in this population. In particular, they help ensure that large numbers of opioid dependent persons can be treated in their own local area (HSE, 2010). GPs that have completed specialist training (provided by the Irish College of General Practitioners (ICGP)) can initiate OAT (level 2 GPs) or continue OAT to those that have stabilised (level 1 GPs) (HRB, 2022a).

Another issue that warrants consideration is the 55% decline in treatment of cases in prison since 2019. It is not clear why this decline has been experienced and future treatment patterns among the prison population should be monitored. However, this decline in treatment numbers does coincide with the COVID-19 pandemic period, which experienced an overall decline in crime (An Garda Síochána, 2020) and a 38%

decline in the prison population (Irish Prison Service, 2022). This may partly explain the pattern.

4.4 Main Problem Drug Treated

4.4.1 Overall Patterns

Although people receive treatment for a variety of drugs, in nine out of ten cases treatment is for problem use of opioids, cocaine or cannabis. Treatment for problem opioid use far outweighs treatment for other drugs, and this overall pattern has remained relatively stable with a 10% increase from 2014-2021. In 2021, for this analysis there were twice as many cases treated for opioids than any other drug. The numbers reported in this analysis for opioid treatment better reflect the current demands on treatment services. This can be utilised to help determine current and future resource requirements for treatment services. When comparing new and previously treated cases, there was a number of notable variations in treatment patterns of type of drug used.

4.4.2 New Cases

While new treatment cases of opioids and cannabis have started to decline, cocaine has experienced almost a fourfold increase since 2014, and in 2021, was the most frequently treated problem drug for new cases. This is a worrying pattern with forecasts suggesting that if this continues, there could be an additional 55% increase new cocaine treatment cases in Ireland by 2026. A report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the United Nations (UN) states that new treatment patterns are the most representative of the underlying untreated population (Donmall, 2006). As such the findings suggest that cocaine use is dramatically rising among the population in Ireland, which 'mirrors' patterns throughout Europe.

The EMCDDA suggest that cocaine use and availability is increasing in Europe, with 15% of all first time treatment demand in 2020 being cocaine related (EMCDDA 2022a). Cocaine hydrochloride (coke) is the main type of cocaine used in Ireland and new treatment cases have increased by 239%, but freebase cocaine (crack) use has also increased by 300%, albeit from a much lower base. The EMCDDA note that crack

use (although uncommon) may be increasing throughout Europe, which is concerning due to the health and social problems associated with its use. This mainly affects marginalised groups, many of whom also experience other substance use problems. The EMCDDA (2022a) state that monitoring systems should have the capacity to track cocaine and crack cocaine in particular (EMCDDA, 2022a). This highlights the importance of developing monitoring systems such as drug checking, syringe analysis, and wastewater analysis. Steenbeek et al (2022) for example, in a 13-country study (which included Ireland), have demonstrated the utility of wastewater analysis to monitor crack cocaine use. In terms of treatment, the EMCDDA (2022a) note that crack treatment is challenging, due to the mental and physical health problems and aggressive behaviour associated with its use. This may require investment in specific treatment services for crack related problems. This issue has been recognised by the HSE, and funding has been allocated to cocaine treatment for 2022. A total of four main cocaine treatment initiatives throughout Ireland have been funded in 2022. As part of the pilot, these programmes will be evaluated. Based on the outcome of the evaluation, consideration should be given to progressing this treatment model.

In terms of the main other new treated cases, opioid treatment has declined by 26% since 2014 and cannabis treatment by 13%. This downward pattern is promising, yet at the same time it is worth pointing out that in 2021 similar numbers were treated for these drugs as cocaine. Both opioids and cannabis remain a significant public health concern and patterns should be closely monitored. For example, across Europe opioids were found in up to three quarters of overdoses (EMCDDA, 2022a) while cannabis was a key drug present in drug related emergency department presentations and new drug treatments. The 2019-20 drug prevalence survey (Mongan et al, 2021) found that cannabis was the most popular illegal drug in Ireland, estimating that there are 45,000 people with Cannabis Use Disorder (with the highest prevalence among 15-34 year olds), which suggests that demands for treatment services will continue and treatment services should adapt to cater for this ongoing problem. Mental health adverse consequences are well-recognised complications of cannabis dependence, particularly with the higher potency cannabis now available (Hines et al, 2020).

4.4.3 Previously Treated Cases

The number of previously treated cases for opioids is 10-15 times greater than any other drug treated, and has increased by 20% since 2014. Once somebody becomes dependent on opioids, long term treatment is usually required, which can be lifelong (WHO, 2009). Unpublished data from CTL indicate that in 2021, 40% of those on Opioid Agonist treatment have been receiving treatment for ten or more years. The WHO note that such long-term treatment is a cost effective way of prolonging and improving quality of life that supports long-term recovery. Nevertheless, it must be recognised that long-term treatment for Opioid Use Disorder represents a significant level of service provision. This issue is also compounded by the fact that as opioid users age, they also experience co-morbid physical and psychiatric health problems requiring treatment (Naji et al, 2017, Mayock et al, 2018). Due to the long-term nature of treatment, it would be important that in addition to recording the number of people receiving treatment, that outcomes such as the achievement of recovery goals are recorded and monitored to help ensure that services continue to meet needs. In addition, although Opioid Agonist Treatment continues to be the 'gold standard' for treatment for Opioid Use Disorder (National Academies of Sciences, Engineering, and Medicine, 2019, McNicholas et al, 2021), it would be important that the potential for complete abstinence from drugs is considered for each of those receiving treatment. Herlinger and Lingford-Hughes (2021) for example note that opioid dependent users that present to drug treatment services want to get off drugs as opposed to wanting to be prescribed methadone for years. They note that while abstinence may not be a realistic goal for some, it should be one of a range of treatment options available. HSE Clinical Guidelines for Opioid Substitution treatment (HSE, 2016) include a detoxification period of treatment. However, there is some evidence which shows dissatisfaction with this phase of treatment. Mayock et al (2018) in a qualitative study of people receiving long-term methadone maintenance treatment found that several participants did not feel they could discuss a detoxification plan with physicians, and that detoxification was discouraged. This study was undertaken in 2018, and this issue may have subsequently been addressed. During COVID-19, the Guidelines were adapted, which included the introduction of a shorter health assessment, and the need to support patients to make fully informed treatment choices between methadone and buprenorphine. Although these changes have been reviewed by an expert panel

(Durand et al, 2022), it would be important to determine their impact in terms of achieving better outcomes. In addition, the issue of detoxification and achieving abstinence needs to be considered in the context of the development of a recovery plan (to enhance 'recovery capital') once abstinence has been achieved.

Although treatment for Opioids represents the vast majority of previously treated cases, it must also be noted the number of previously treated cases for cocaine, BZP, and cannabis, all of which have increased since 2014, warrant consideration. Previously treated cocaine cases mirror the sharp rise in new cases. There is no approved medication for Cocaine Use Disorder. As such, people presenting for treatment are given a range of psychosocial treatments (e.g. cognitive behavioural treatment, motivational interviewing), and there is no 'best practice' approach. High dropout rates for psychosocial approaches have been found (Kampman, 2019), which may explain the rising pattern of previously treated cases. A systematic review of 157 treatment programmes recommended the use of contingency management (Bentzley et al, 2021). This approach gives people vouchers for goods and services if goals are achieved. It would be useful to review existing HSE cocaine treatment programmes (including new initiatives recently introduced to address crack cocaine) to establish which are the most effective in an Irish context and to determine whether there is a need to develop and pilot new programmes such as contingency management.

Previously treated cases for BZP addiction has also been increasing, although the numbers are lower than for cocaine and opioids. BZP are a group of drugs used to treat conditions such as insomnia and anxiety. These are prescription only medications, but they can also be obtained illegally. Duffin et al (2020) note (using EMCDDA Trendspotter methodology) that the use of 'street tablets' (prescription medication not acquired directly from a medical professional) has increased in recent years. Benzodiazepines are often used in combination with other drugs such as opioids (EMCDDA, 2018). In 2017, 86% of poisoning deaths in Ireland where heroin was implicated also involved other drugs, which were mainly benzodiazepines (HRB, 2019). The increase in treatment for BZP may be linked to patterns of opioid use and treatment. However, it is important also to determine whether prescription BZP is also contributing to the increase in treatment patterns. The HSE does have prescribing

guidelines, (HSE, 2021) and it would be important to determine whether these are being adhered to and whether they are helping to prevent BZP addiction and dependence. This was outside the scope of the current study. One Irish study has shown that prescribing to young people is often not in adherence to the guidelines (Murphy et al, 2015). In addition, BZP overprescribing for Travellers was recognised in a study of Traveller organisations in 2011 (Pavee Point, 2011), and it would be important to determine whether this pattern has continued to date. The feasibility of disaggregating available datasets to investigate prescribed BZP should be explored. The Medical Council (2021) have established a multidisciplinary group to examine patient safety concerns around the prescribing practices of benzodiazepines, pregabalin and Z drugs, and a position paper is expected early in 2023.

Although previously treated cases for cannabis have fluctuated, they are currently exhibiting a downward pattern, which is promising. However, as with new cases, it would be important that these patterns are closely monitored, particularly in terms of age and gender.

4.5 Ethnicity

Having treatment data disaggregated by ethnicity is important, as knowledge of variations in patterns has implications in terms of the need for targeted treatment interventions. An ethnic identifier has been included on the NDTRS since 2007. However, it is disappointing that ethnicity is not recorded on the CTL database. A review of Irish health and social care datasets has shown that only 14% collected information on ethnicity (Hannigan et al, 2020). However, the HSE Intercultural Health Strategy (HSE, 2019) stresses the importance of disaggregating data by ethnicity. In addition, the National Traveller Health Action Plan (Department of Health (2022) has included the implementation of an ethnic identifier on all health datasets as one of its strategic actions. As such, an ethnic identifier should be introduced to the CTL database as a matter of urgency. Despite not being able to produce combined database results, the analysis of ethnicity using the NDTRS database reveals a number of variations by ethnic group.

The NDTRS database shows that Irish ethnicity represents 91% of cases treated. Although the Central Statistics Office (CSO) ethnicity categories are slightly different[1] (CSO, 2017), this is similar to the overall population (91.7%). By contrast, both Irish Travellers and other ethnicities are over-represented. Travellers comprise 0.7% of the population, yet 3% of treatment episodes are for Irish Travellers (five times greater). Similarly, other ethnicities represent 3.6% of the national population and 5.1% of treatment episodes (1.4 times greater). This pattern has remained relatively consistent from 2014-2021. A study undertaken by Carew et al (2013) found that the proportion of Travellers treated was three times greater than the national population. Our study shows that this proportion has increased. It is also worth noting that these figures may also under-report minority ethnic groups experiencing problems with drugs. Carew et al (2013) and Pavee Point (Cafferty and Collins, 2011) state that Travellers may not be willing to disclose their identity due to issues such as a lack of trust. Pavee Point (Cafferty and Collins, 2011) also note that studies have shown that minority ethnic groups have difficulty accessing supports that are designed to meet the needs of the dominant population. These patterns do suggest that there needs to be treatment programmes targeted to meet the needs of specific ethnic groups. Pavee Point (Cafferty and Collins, 2011) have produced good practice guidelines for drug and alcohol services working with Travellers. The Pompidou Group (2022) have also produced a guide for health professionals that work with refugees, migrants, and internally displaced people. It is suggested that both these guidelines are utilised to develop updated guidelines for the treatment of all ethnic and minority groups including Travellers, refugees, migrants and internally displaced persons. This should be undertaken in partnership with non-statutory organisations that work directly with Travellers and other ethnic groups. Services should then review and audit their performance based on metrics from these updated guidelines. Consideration should be given to adopting these as key performance indicators (KPIs) for services.

When examining the type of treatment by ethnicity, it can be seen that a greater proportion of Travellers are treated for opioids and BZP, while a greater proportion of Irish are treated for cocaine and a greater proportion of other ethnicities are treated for cannabis. The main changes over time of note are the increase in treatment for

[1] Since 2022, ethnic categories in the NDTRS are the same as those used in the last CSO census

cocaine among all ethnic groups (particularly for Travellers), and the increased treatment of other ethnicities for cannabis, and other drugs. These patterns again suggest that treatment programmes may need to be targeted to meet the needs of specific ethnic groups. The need for targeted programmes is recognised by Claffey et al (2017) who recommend cultural and gender sensitive OAT guidelines for Travellers.

4.6 People Experiencing Homelessness

Monitoring drug treatment patterns by homeless people is very important because use of drugs and alcohol has been found to be the main cause of death among homeless people in Dublin (Ivers et al, 2019). The study has shown that in 2021 homeless cases comprised 11% of people receiving treatment, with a 57% increase in homeless people receiving treatment since 2014. This represents a sizeable proportion of treatment provision, with 2661 treatment episodes in 2021, which is forecast to increase to 3185 by 2026 (39% increase for new cases and 24% for previous cases). It is worth noting that our forecasts may underestimate the number requiring treatment, as it does not take into consideration the rising number of homeless people (increasing in 2021 by 30%; Department of Housing, 2022). These findings demonstrate the importance of ensuring that treatment services are able to meet the needs of homeless people, which have been shown to be complex (Miler, et al 2021). Consideration should be given to developing specific targeted treatment programmes for homeless people. This has also been recommended by the EMCDDA (Pleace and Lloyd, 2020, EMCDDA, 2022b). A number of these have been developed in other countries (Magwood et al, 2020, Miler et al, 2021) which should be reviewed to determine if similar services could be developed in Ireland.

In terms of the main problem drugs treated for homeless cases, patterns are similar to overall treatment patterns, although there are some differences. For example, a greater proportion of homeless people receive treatment for opioids (86% compared to 66%). Studies have shown homeless people are more likely to inject opioids (Han et al, 2022). This finding demonstrates the importance of the HSE's Naloxone Programme, which provides Naloxone and training for homeless service providers to help reduce the impact of opioid overdoses (Evans et al, 2021). In addition, although only a small proportion of homeless people are treated for cocaine and BZP (6% for

each class of drugs), the increase in treatment since 2014 is alarming, with treatment increasing at a greater rate than the overall drug treatment population. If specific treatment programmes for homeless people are developed, then it would be important to provide treatment for a range of drugs in addition to opioids.

4.7 Study Limitations

The study represents treatment data from two separate databases of drug treatment. Differences between the databases in terms of how the data is categorised may contribute to inaccuracies when combining data. For example, on the NDTRS, if someone starts treatment in a given year and continues treatment into the following year, their treatment entry is reported for the original year. NDTRS data on cases continuing treatment across years was not included in this study. By contrast, they would be recorded for the following year on the CTL database. This would particularly affect data for long-term treatment such as OAT.

As the study utilised episode of care data, it is not possible to determine the number of people that received treatment, or whether the same person had more than one treatment or type of treatment in a given year. In addition, it is not possible to crosscheck the databases for double counting. This would require the development of a unique patient identifier. This issue warrants consideration as part of a process to streamline the recording of drug treatment in the future.

5. CONCLUSIONS AND RECOMMENDATIONS

By combining available data sources (CTL and NDTRS) this Insights Report provides a comprehensive assessment of treatment patterns in Ireland from 2014 to 2021. This can be utilised to help plan and resource services. The report has raised a number of important issues, both in terms of data collection and the future development of services.

The following recommendations are made:

1. Drug treatment data collection should to be streamlined so that treatment providers only have to send returns once for each person receiving treatment. The introduction of the long awaited Individual Health Identifier could be of benefit in this regard.

2. A process for integrating drug treatment data to facilitate ongoing analysis and the production of annual results for all available data sources should be developed by collaboration between the HSE Addiction Services and HRB.

3. An ethnic identifier should be introduced to the Central Treatment List database as a matter of urgency. This should employ the same categories for ethnicity as used by the Central Statistics Office.

4. The feasibility of developing a system of screening for problem drug use in a range of health care settings should be further developed to engage those who require treatment in appropriate care. This should utilise existing approaches employed by the HSE such as SAOR (Screening and Brief Intervention for Problem Alcohol and Substance Use).

5. HSE Clinical Guidelines for Opioid Substitution Treatment should be updated incorporating modifications introduced during the COVID-19 pandemic that have proven beneficial.

6. Following the evaluation of HSE pilot cocaine treatment programmes, those treatment models that have been successful in addressing harms need to be embedded in treatment services.

7. The feasibility of disaggregating available datasets to investigate drug treatment patterns for prescribed and non- prescribed benzodiazepine (BZP) use should be explored.

8. Targeted drug treatment programmes aimed at specific marginalised groups need to be considered to help engage them in appropriate care. This should include the development of good practice guidelines for drug and alcohol services working with ethnic groups and utilise resources available from elsewhere in Europe.

9. KPI's should be reviewed (based on good practice guidelines) for drug and alcohol services that monitor performance in terms of meeting the needs of ethnic groups.

10. Consideration should be given to developing specific treatment programmes for those who are homeless and using substances in problematic ways. Existing programmes in existence internationally should be reviewed to determine if similar services could be developed in Ireland. These should provide treatment for a range of drugs in addition to opioids.

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