Focal Point Ireland: national report for 2022 – Treatment

Ireland

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

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Table of Contents

Table of Contents **3**

List of tables and figures **4**

T0. Summary **5**

T1. National profile **6**

T1.1. Policies and coordination 6
T1.1.1. Main treatment priorities in the national drug strategy 6
T1.1.2. Governance and coordination of drug treatment implementation 7
T1.1.3. Further aspects of drug treatment governance 8

T1.2. Organisation and provision of drug treatment **8**

T1.2.1. Outpatient drug treatment system – Main providers and client utilisation 9
T1.2.3. Further aspects of outpatient drug treatment provision and utilisation 10
T1.2.4. Ownership of outpatient drug treatment facilities 10
T1.2.5. Inpatient drug treatment system – Main providers and client utilisation 11
T1.2.6. Further aspects of inpatient drug treatment provision 11
T1.2.7. Ownership of inpatient drug treatment facilities 12
T1.2.8. Further aspects of inpatient drug treatment provision and utilisation 12

T1.3. Key data **12**

T1.3.1. Summary table of key treatment related data and proportion of treatment demands by primary drug 13
T1.3.2. Distribution of primary drug in the total population in treatment 14
T1.3.3. Further methodological comments on the Key Treatment-related data 14
T1.3.4. Characteristics of clients in treatment 14
T1.3.5. Further top level treatment-related statistics 14

T1.4. Treatment modalities **14**

T1.4.2. Further aspect of available outpatient treatment services 15
T1.4.3. Availability of core interventions in inpatient drug treatment services 15
T1.4.4. Further aspect of available inpatient treatment services 16
T1.4.5. Targeted interventions for specific drug-using groups 16
T1.4.6. E-health interventions for people seeking drug treatment and support online 18
T1.4.7. Treatment outcomes and recovery from problem drug use 18
T1.4.8. Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations 18
T1.4.9. Main providers/organisations providing Opioid substitution treatment 18
T1.4.10. Number of clients in OST 19
T1.4.11 Characteristics of clients in OST 20
T1.4.12. Further aspect on organisation, access and availability of OST 20

T1.5. Quality assurance of drug treatment services **21**

T1.5.1. Quality assurance in drug treatment 21

T2. Trends 22

T2.1. Long term trends in numbers of clients entering treatment and in OST 22
T2.2. Additional trends in drug treatment 24

T3. New developments 24

T3.1. New developments 25

T4. Additional information 25

T4.1. Additional Sources of Information 25
T4.3. Psychiatric comorbidity 29

T5. Sources and methodology 29

T5.1. Sources 29

References 30

Acknowledgements 32

List of tables and figures

Table I. Network of outpatient treatment facilities (total number of units and clients) 9

Table II. Ownership of outpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all outpatient specialised drug treatment centres are public/government-owned facilities and about 20% are non-government-owned (not for profit) facilities 10

Table III. Network of inpatient treatment facilities (total number of units) 11

Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert percentage in the table. Example: about 80% of all therapeutic communities are public/government-owned facilities and about 20% are non-government owned (not for profit) facilities 12

Table VI. Availability of core interventions in outpatient drug treatment facilities 15

Table VII. Availability of core interventions in inpatient drug treatment facilities 16

Figure I. Proportion of treatment demands by primary drug 14

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2009–2021 .. 22

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2009–2021 23

Figure IV. Trends in numbers of clients in OST, 1998–2021 24

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 clients.

The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment in Ireland. 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 people with problem drug use, mainly in outpatient settings, but also in residential settings. Almost all opioid substitution treatment (OST) provided is methadone; however, since November 2017, buprenorphine-based products have been available nationally 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 OST for people with problem opioid use is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics, or 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.

In 2021, a total of 10,408 treatment entrants were reported. This is an 11.1% increase from the number of cases reported in 2020, when 9,368 were reported. The increase between 2020 and 2021 should be interpreted in the context of the impact of public health restrictions in 2020 on the provision of addiction services, as well as the reduced reporting to the Treatment Demand Indicator (TDI), due to the COVID-19 pandemic. However, the number of cases reported in 2021 did surpass the number reported in 2019 (10,267) before the COVID-19 pandemic, most likely indicating that the impact of the public health restrictions on addiction care has been allayed for 2021.

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 33.7% in 2021.

Cocaine remained the second most common problem drug reported in 2021, having surpassed cannabis in 2019. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2021, but to a lesser extent than in previous years. In 2021, the number of cocaine

cases reported (n=3,319, including powder and crack) overtook the number of heroin cases (n=3,065) reported for the first time.

Cannabis was the third 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 since then.

The majority of cases entering treatment have been treated previously. The proportion of new entrants to treatment remained relatively unchanged in 2021, at 40.4%. The proportion of new treatment entrants has fluctuated, from 39% in 2004 to a peak of 47% in 2009, but the proportion has stabilised at around two-fifths since 2013.

In 2021, cocaine was the most common drug reported by new entrants to treatment, a continuation of the trend first seen in 2020.

In 2021, more than one-half of all OST clients received OST in specialist outpatient clinics, two-fifths received it from specialist GPs, and an even smaller proportion (less than 6%) received it in prison. On 31 December 2020, 11,486 clients were registered for OST (including those receiving OST in prison).

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 Goal 2 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. Goal 2 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 Goal 2 of the national drugs strategy is “To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs” (p. 33). 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-tier, 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 OST by examining potential mechanisms to increase access through the expansion of GP prescribing and nurse-led prescribing, and through the provision of OST in community-based settings and homeless services.
- Enhancing the quality and safety of care in the delivery of OST by implementing the HSE's *Clinical Guidelines for Opioid Substitution Treatment* (Health Service Executive 2016) (Health Service Executive 2020).

Also central to these objectives are a range of actions set out to promote recovery by expanding and improving access to services for specific groups of people, including women; children and young people; groups with more complex needs; and prisoners. For example, these actions aim to:

- Expand addiction services for pregnant and postnatal women
- Respond to the needs of women who are using drugs and/or alcohol in a harmful manner by improving the range of 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, and
- Improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health National 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 of 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 – Child and Family Agency, and the Irish Prison Service (IPS).

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. The National Social Inclusion 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 Drug and Alcohol Task Forces to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance group, and it 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 service plans. 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 methadone substitution protocol 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.

While methadone is the main drug prescribed, in November 2017 there was a phased rollout of buprenorphine-based products nationally for appropriate clients (Fitzgerald 2011)(Expert Group on the Regulatory Framework 2011). Prior to 2017, such products were provided to a small number of clients and reported via other sources.

The Central Treatment List (CTL) was established under Statutory Instrument S.I. No. 225/1998, following the 1998 *Report of the Methadone Treatment Services Review Group* (Methadone Treatment Services Review Group 1998)(also see Section T5.1). The CTL is a complete register of all patients receiving OST (for treatment of opioid misuse) in Ireland and is administered by the HSE's National Drug Treatment Centre.

The HSE has published comprehensive clinical guidelines for OST in community and hospital settings (Health Service Executive 2016)(Health Service Executive 2020).

T1.2. Organisation and provision of drug treatment

The purpose of this section is to:

- describe the organisational structures and bodies that actually provide treatment within your country

- describe the provision of treatment on the basis of Outpatient and Inpatient, using the categories and data listed in the following tables. Drug treatment that does not fit within this structure may be included in the optional section
- provide a commentary on the numerical data submitted through ST24
- provide contextual information on the level of integration between the different treatment providers (e.g. umbrella organizations providing multiple services, for instance both outpatient and low threshold services);

Outpatient network

T1.2.1. Outpatient drug treatment system – Main providers and client utilisation

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also Section T1.1.2 and Section T1.4.1 of 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 TDI figures. Some addiction treatment is also provided and/or funded through the HSE's Mental Health Division and is included in TDI under the category of 'specialised drug treatment centre'. However, many outpatient mental health services do not currently provide data for the TDI.

Low-threshold services provided only 10% of outpatient treatment reported to TDI in 2021. This is because these agencies provide many additional services that do not meet the inclusion criteria for the TDI, such as needle exchange only, social support, food, etc.

Only GPs who have completed the requisite specialist training can provide OST. 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 of 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 the TDI, due to resource issues. While there have been concerted efforts by the National Drug Treatment Reporting System (NDTRS) team to improve GP data returns, the TDI still does not accurately reflect the total number of OST clients treated by GPs in the community (see Table I). In 2021, the coverage for GPs decreased slightly to 44.8%, compared with 47.0% in 2020.

Table I. Network of outpatient treatment facilities (total number of units and clients) [1]

	Total number of units	**National definition (characteristics/types of centre included within your country)**	**Total number of clients**
Specialised drug treatment centres	322	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.	7,318
Low-threshold agencies	78	Aim to prevent and reduce health-related harm associated with	888

		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.	
General primary healthcare (e.g. GPs)	377		219
General mental healthcare			
Prisons (in-reach or transferred)	30	In-reach provided by voluntary services funded by the IPS and others.	641
Other outpatient units	0		
Other outpatient units	0		

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

No new information.

T1.2.4. Ownership of outpatient drug treatment facilities

All OST 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 of 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). Please insert % in the table below. Example: about 80% of all outpatient specialised drug treatment centres are public/government-owned facilities and about 20% are non-government-owned (not for profit) facilities [2]

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

Inpatient network

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 9% of all inpatient cases reported through the TDI, but other non-statutory agencies also provide inpatient detoxification services (see Table III). The coverage of inpatient services in the TDI is high.

As of June 2020, the HSE estimated that there were 636 residential beds (for both alcohol and other drugs), which consisted of: 12 inpatient unit detoxification beds; 86 community-based residential detoxification beds; 2 adolescent residential detoxification beds; 530 residential rehabilitation beds; and 6 adolescent residential beds. This includes 21 beds for women who can be accompanied by their children (Gould). However, in 2020, in order to comply with the associated public health measures during the COVID-19 pandemic, the number of residential beds was reduced (Gould)(Bruton *et al.* 2021). This is a reduction from the total number reported for 2018 (793 beds) (Gould). There is currently no update on whether or not the number of residential beds has increased since 2020.

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 2020, 973 cases with a drug disorder were admitted to psychiatric facilities (Daly and Craig 2021). Of these cases, 434 were treated for the first time. The admission rate in 2020 was similar to the previous year, and trends over time indicate an overall increase since 2011 in the rate of first admission with a drug disorder. 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

No additional information.

Table III. Network of inpatient treatment facilities (total number of units) [3]

	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 the TDI.	86
Residential drug treatment (non-hospital based)	0		0
Therapeutic communities	0		0
Prisons			
Other inpatient units (1 – please specify here)	61	Centres where the clients may stay overnight. They include	898

		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.	
Other inpatient units (2 – please specify here)	0		0

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 of 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 mental health services treatment can be covered by private health insurance; however, again, the proportion is not known.

Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert percentage in the table. Example: about 80% of all therapeutic communities are public/government-owned facilities and about 20% are non-government owned (not for profit) facilities [4]

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

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

No additional information.

T1.3. Key data

The purpose of this section is to provide a commentary on the key estimates related to the topic. Please focus your commentary on interpretation and possible reasons for the reported data (e.g. contextual, systemic, historical or other factors but also data coverage and biases). Please note that for some questions we expect that only some key TDI data to be reported here as other TDI data are reported and commented in other workbooks (drugs, prison, harm and harm reduction, etc.). However, please make cross-references to these workbooks when it supports the understanding of the data reported here.

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

The number of cases reported in 2021 has increased compared to 2020, and it has surpassed the number of cases reported for 2019. This indicates that the impact of public health restrictions on addiction care has been allayed for 2021. Over the period of the COVID-19 pandemic, while the number of cases reported dropped, the trends remained consistent.

Opioids (mainly heroin) and cocaine are the two main drugs for which cases entered treatment in 2021. Cocaine was the second most common problem drug treated (30.2%) (see Figure I).

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped again in 2021 to 33.7%, compared with 36.5% in 2020. 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 87.3% of all cases with problem opioid use reporting heroin as their main problem drug in 2021; this is similar to figures for 2020, when 89.7% of people with problem opioid use reported heroin as their main problem drug (also see Section C T1.2.2 of the Drugs workbook).

Cocaine remained the second most common problem drug reported in 2021, having surpassed cannabis in 2019. The proportion of cases entering treatment for problem cocaine use has increased again, from 27.2% (n=2,548) in 2020 to 30.2% (n=3,139) in 2021. This is a continuation of the upward trend observed over the past number of years (see also Section B T1.2.2 of the Drugs workbook).

Cannabis remains the third most common problem drug reported (21.4%). The proportion of cases treated for problem cannabis use peaked in 2013 at 28.9%, but has shown a downward trend ever since (see also Section A T1.2.2 of the Drugs workbook).

Benzodiazepines remain the fourth most common problem drug reported; the proportion of cases treated in 2021 was 11.3%, similar to the proportion reported in 2020 (11.4%).

Amphetamines (0.2%) and ecstasy (0.1%) continued to make up a very small proportion of the main problem drugs reported in 2021, a similar trend to previous years (see also Section B 1.2.2 of the Drugs workbook).

For further information, see Section T2 of this workbook.

Table V: Summary table – clients in treatment

	Number of clients
Total clients in treatment	10,408
Total OST clients	11,486

Total clients entering treatment	Data on OST and the TDI are from different sources, are collected using different methodologies, and have duplication between them; therefore, they cannot be combined or compared meaningfully.

Source: ST24 and the TDI

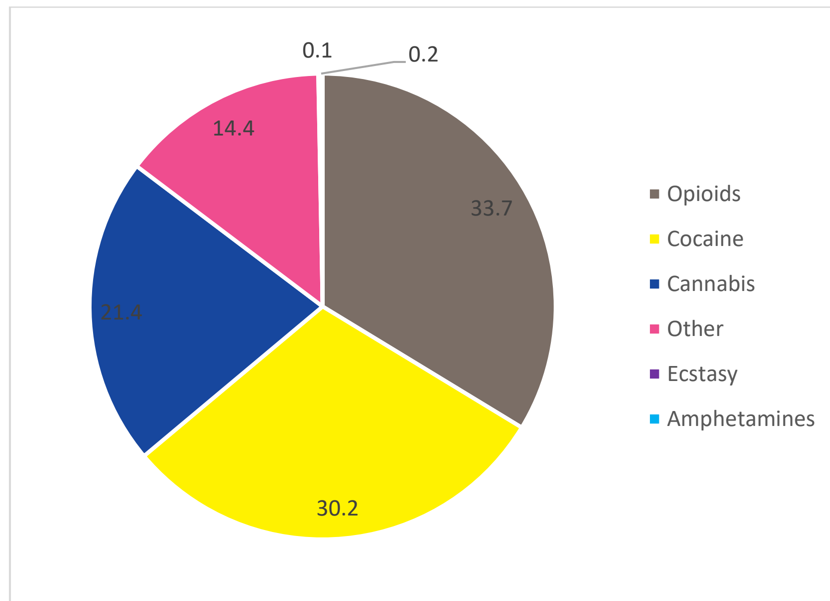

Figure I. Proportion of treatment demands by primary drug [1]

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

The purpose of this section is to:

Comment on the treatment services that are provided within Outpatient and Inpatient settings in your country. Provide an overview of Opioid Substitution Treatment (OST) in your country.

Outpatient and inpatient services

T1.4.1. Please comment on the types of outpatient drug treatment services available in your country and the scale of provision, as reported in table VI below.

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 that are not available in the service they are currently attending will be referred on to a service that 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 delivered 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 (Dail Eireann debate. Written answer 223 - Prison service [23629/22]. 2022)

Currently, as IPS medical units do not participate in the NDTRS, only data on counselling are provided to the TDI.

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

Table VI. Availability of core interventions in outpatient drug treatment facilities [5]
Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of low-threshold agencies).

	Specialised drug treatment centres	Low-threshold agencies	General primary healthcare (e.g. GPs)	General mental healthcare
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 new 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 that are not available in the service they are currently attending will be referred on to a service that 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 [6]
Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of therapeutic communities).

	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%		
OST	>75%	>75%		
Other core inpatient treatment interventions (please specify in Section T1.4.3.)	Not known	Not known		

T1.4.4. Further aspect of available inpatient treatment services

No new information.

T1.4.5. Targeted interventions for specific drug-using groups

Senior drug users (>40 years old): There are no specific services for senior drug users; they can access treatment through the normal channels.

A study examining the needs of people who use drugs (PWUD) and who were aged over 40 years was commissioned by a Drug and Alcohol Task Force Area in the greater Dublin area (Deane 2021). The findings highlighted that the participants experienced continued stigma which impacted their lives by

‘perpetuating shame and isolation’ (p. 23). Older PWUDs reported unconscious bias by some of the professionals they met. A recurring theme among community and statutory service providers was a lack of accurate information and knowledge among providers and users about the services available to older PWUD. There were also gaps in service providers’ knowledge of the roles of various professionals in the system and how referral systems worked. This prevented PWUD from accessing the right services and experiencing continuity of care, for example.

The report provided a set of recommendations covering a range of themes, including the barriers to accessing supports which may be generalisable to the rest of the country. These recommendations included: how programmes in the area could better meet the needs of older PWUD; how inter-agency and joint working practices could be improved; and what resources are required to improve the physical and mental health for this age cohort.

New psychoactive substance (NPS) users: There are no specific services for NPS users; they can access treatment through the normal channels. See Section T1.4.11 below for more information.

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

There are drug-liaison clinics in several maternity hospitals in Ireland. In 2020, 98 women from the DOVE (Danger of Viral Exposure) Service were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital 2021). Thirty-seven of the women were on OST (see also Section T1.3.6 of the Harms and harm reduction workbook).

In September 2021, a briefing paper calling for governmental support to provide gender-specific services for women experiencing homelessness and addiction, entitled *A space of her own: the need for gender specific services for women in homelessness and addiction*, was launched by a national non-government organisation (NGO)(Merchants Quay Ireland 2021).

The briefing paper draws on the findings of a number of recently published studies and other policy documents. It highlights the lack of specific services for women experiencing addiction and homelessness in Ireland. Moreover, it notes that there is a lack of gender sensitivity in the services that are available, which would better enable staff to respond to the complexities of these women’s needs and provide them with flexible pathways into the services, with speedy access, integration of services, and inclusivity.

The paper identifies five elements for progress in the area; in summary, services would respond to women’s needs by having female-friendly services with which to provide the required care to support women with complex needs with staff who are properly trained.

Underaged 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.

In 2021, an adolescent service in the in the wider Dublin area reported that of the 50 adolescents, the majority were male and mainly referred for cannabis, but many used other substances, most

commonly alcohol. Notably 8% reported using ketamine and nitrous oxide. Almost all were seen by a family therapist (Adolescent addiction service 2022).

The report authors noted that, as in previous years, most young people had established patterns of substance use prior to referral and because of this often struggle to remain drug-free (see also Section T1.4.1 of the Harms and harm reduction workbook).

Other target groups – People receiving treatment in prison: In 2022, the IPS estimated that approximately 70% of prisoners have substance misuse problems (Dail Eireann debate. Written answer 223 - Prison service [23629/22]. 2022). On committal, every person is medically assessed. Those who report problem opioid use, when confirmed by laboratory testing and where clinically appropriate, are offered a medically assisted symptomatic detoxification as per IPS policy. If a person is on OST, they can discuss stabilisation and continued maintenance. The IPS has protocols with the HSE to enable the seamless transfer of OST clients from prison back to the community.

Counselling, motivational interviewing, cognitive behaviour therapy, and other psychological supports are provided by Merchants Quay Ireland (MQI) on behalf of the IPS. MQI anticipates restarting an 8-week programme (postponed during the COVID-19 pandemic) which enables a person to undergo OST detoxification in conjunction with a daily structured programme provided by external voluntary organisations.

Not all interventions are available in open prisons, as a person needs to be drug free to secure a transfer to those facilities. Also see the Prison Workbook.

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

Online drug screening tool

Currently, there is no Internet-based drug treatment (IBDT), as defined by the EMCDDA, reported via the TDI. However, the Drug Use Disorders Identification Test (DUDIT) drug screening tool is available online for individuals over the age of 18 years. With this tool, a person answers 11 questions and is then provided with a video containing personalised feedback based on their answers. Depending on their answers, the automated feedback may advise them to contact a health professional (see http://www.drugs.ie/drugtest).

Experience of addiction professionals working virtually with clients

See the study by O'Callaghan and Lambert (2022) in Section T3.1 of this workbook on the experience of addiction professionals working virtually with clients during the COVID-19 pandemic.

T1.4.7. Treatment outcomes and recovery from problem drug use

No new information.

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

No new information.

T1.4.9. Main providers/organisations providing Opioid substitution treatment

Outpatient OST for people with problem opioid use 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 Prescribing Implementation Committee 2005)(Methadone Treatment Services Review Group 1998), 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 for people with problem opioid use who have already been stabilised on OST. Each GP qualified at this level is permitted to treat up to 15 stabilised patients. Level 2 GPs are allowed to both initiate and maintain OST. Each GP qualified at Level 2 may treat up to 35 OST patients. Practices where two Level 2 GPs are practising are permitted to treat up to 50 OST patients in total.

In 2021, according to data from the CTL, as of 31 December 2021, 55.0% of patients received OST in specialist outpatient clinics; 39.4% received OST from GPs; 5.4% received it in prison; and less than 1.0% received it in an inpatient setting (unpublished data, CTL, 2022; also see Figure IV in Section T2 of this workbook). These trends are similar to those reported for 2020.

The proportion of clients receiving OST from GPs has increased slowly but steadily over the years, from 32% in 2001 to a peak of 41% 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, including OST, from their own GP. The change may also reflect the increase in the number of specialist GPs in the community. The proportion of clients receiving treatment in specialist outpatient clinics decreased from 59% in 2008 to 52% in 2018, before rising slightly to 55% in 2021.

T1.4.10. Number of clients in OST

The number of clients registered for OST on 31 December each year is reported by the CTL, the national register of all clients on OST (see Figure IV in Section T2 of this workbook, as well as ST24.

The reporting of OST trends in this workbook and ST24 was updated in 2020 to include buprenorphine-based products. These are now included in the annual totals, and data for the period 2017 to 2019 have been revised for Figure IV (Section T2).

On 31 December 2021, 11,486 clients were registered for OST (including those receiving OST in prison)(personal communication, CTL, 2022).

There was a 3% increase in the number of people registered for OST in 2021 compared to 2020. This is likely due to the response of addiction services to the COVID-19 pandemic, as there were concerted efforts to improve access to OST by reducing waiting lists, allowing some services and GPs to increase their caseload, and increasing remote teleworking and other resources as required. This increase is not reflected in the TDI figures, in part due to public health restrictions on data collection and reduced coverage of GPs.

Almost all clients receive methadone maintenance treatment (MMT) as their opioid substitute, as historically this has been the primary drug of choice for treating opioid dependency in Ireland (Health Service Executive 2016)(Health Service Executive 2020). However, in November 2017, there was a phased national rollout of buprenorphine-based products to appropriate clients, which has now also included in the official reporting of the CTL, the national OST register. Prior to that, buprenorphine-based products were provided to a small number of clients and reported by ad hoc sources (see ST24 for more information). In 2021, 95% of those receiving OST were prescribed methadone.

T1.4.11 Characteristics of clients in OST

A 2021 study investigated NPS use, administration, adverse effects, and consumption in the previous 3 months among 213 patients attending an opioid substitution clinic (McCarron *et al*. 2021). Sixty-two per cent of participants had used NPS at least once, and 7% had used NPS in the 3 months prior. One-third of participants had injected NPS. Almost one-half of participants indicated having experienced no adverse effects, although paranoia did occur frequently. The authors noted that only 11% of participants reported ongoing NPS use, implying that making the supply of NPS illegal reduced their consumption. They also suggest that, as a high proportion of participants administered NPS intravenously, the closure of headshops was likely to have led to improved health outcomes among this group of patients.

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

Nurse prescribers for OST

The Department of Health is currently working with relevant stakeholders to consider expanding the role of nurse prescribing, to include nurse prescribing of OST **(Feighan)**. The need of nurse prescribing has been raised for a number of years (Comiskey *et al*. 2019).

An exploration of organisational change in Irish opioid community treatment services

A qualitative study was conducted to explore the factors influencing functioning and change in Irish community opioid prescribing services, from the perspective of staff working in the area (Peter *et al*. 2022). Frontline staff are essential for supporting and implementing change, but little is known about their views on 'the process and internal dynamics' of addiction services.

Only staff who had direct contact with patients were included, and efforts were made to ensure that a wide range of different professions was represented, with participants coming from 12 different clinics around Ireland. In all, 12 staff members were interviewed. Data were collected using semi-structured interviews. A content analysis approach was used, and codes were created following an iterative process with three researchers.

Results

The study found three interrelated themes:

- Meeting people where they are at. This was summarised as "How the service meets service user needs; meeting needs as a driver of organisational change; where we have come from; 'shifting the balance' and meeting service users where they're at; how the service needs to change to meet service user needs" (p. 3).
- Join up the dots. This was summarised as "Inconsistencies in how individual staff and staff groups operate; operational differences within and between services; how recruitment and retention impact on change adoption/service delivery" (p. 3).
- Get buy-in (for change initiatives). This was summarised as "Organisational attributes and attributes of change which support or inhibit change implementation; ensuring stakeholder buy-in; ensuring measurement or 'follow-through'; risk aversion and lack of resources impeding change" (p. 3).

Discussion

The study found that functioning and change in community opioid treatment services was affected by a number of internal and external interdependent factors.

One of the issues identified that was related to both domains was clinical supervision. On one hand, study participants agreed that supervision provided support to staff members, improved retention, and served as an indicator of a "healthy organisation". However, if not provided for all staff, an imbalance of supervision could actually foster a sense of alienation between team members. One positive finding was that participants felt there had been a "paradigm shift" in the services over the past years from being abstinence focused to "compassionate pragmatism", which was termed "meeting people where they are at". This change had been driven by any number of both social and institutional changes, including new policies, new staff, and new leadership. However, they pointed out the caveat of the continued presence of institutional stigma in some services. The participants noted other issues, such as no independent oversight of addiction treatment services to ensure that standards are being met, as there existed in the United Kingdom (UK). The authors commented that features of good governance are explicit in Irish policy, although not all have been fully operationalised. In particular, respondents expressed concern about differences in prescribing practices across the services, which they felt ranged from "punitive to lenient" (p. 5).

Overall, the authors noted that the factors identified by the study participants in relation to change were similar to those identified in other studies but provided particular insight into the community opioid services. The authors conclude that "effective policy implementation in Ireland remains aspirational" (p. 8), adding that this paper can help inform any future planning of addiction services but will also help to direct future research into service policy.

The authors recommended that:

- Adoption of policies which promote consistency and standardisation across addiction services, with a focus on recruiting and retaining staff
- Accreditation of services to ensure safe and consistent care by external and independent oversight
- Clinical meetings should include a representative all of staff groups to ensure greater consistency in service delivery
- Provide adequate resources for training, supervision, and support across all staff groups; and
- Provide staff with examples of new models of service delivery to enable them to better understand any potential changes, while taking into account leadership and other service attributes (p. 8).

T1.5. Quality assurance of drug treatment services

The purpose of this section is to provide information on quality system and any national treatment standards and guidelines.

T1.5.1. Quality assurance in drug treatment

No new information.

T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends in treatment data.

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

New treatment entrants (Figure II)

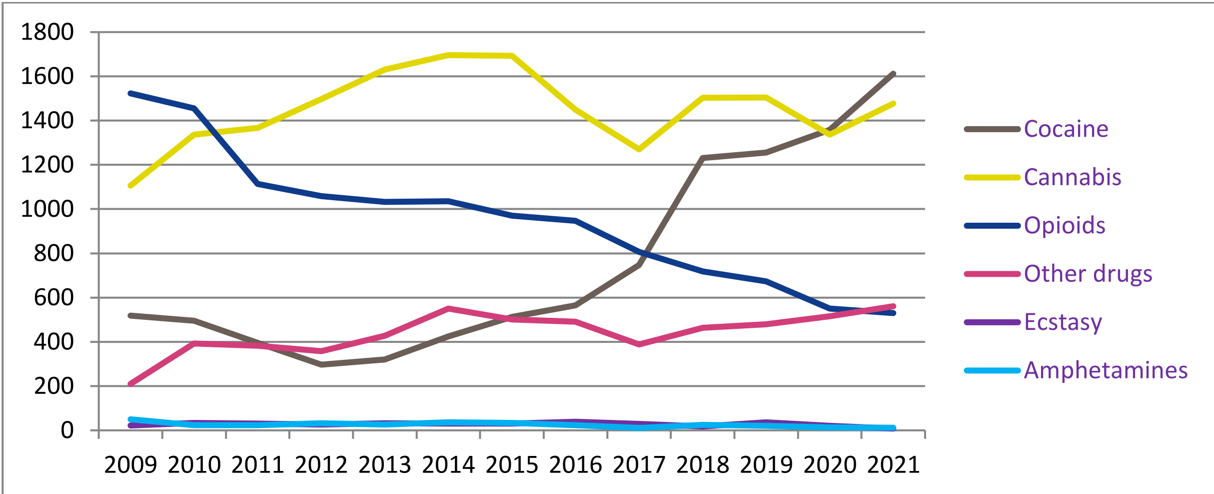

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2009–2021 [2]

The number of new cases reported in 2021 has increased compared to 2020 and has surpassed the number of cases reported for 2019, which could indicate that the impact of public health restrictions on addiction care has been allayed for 2021. Over the period of the COVID-19 pandemic, while the number of cases reported dropped, the trends remained consistent.

In 2021, there were 4,200 new treatment entrants recorded (see also the TDI). This represents an increase compared to the 3,792 new entrants reported in 2020.

Proportionally, in 2021, new treatment entrants represented 40.4% of all cases, which is similar to 2020 (40.5%). The proportion of new treatment entrants has fluctuated over the 13-year reporting period, peaking at 47.2% in 2009, but it has stabilised since 2014 at around 39%.

In 2011, cannabis surpassed opioids (mainly heroin) as the main problem drug reported by new entrants to treatment, but in 2020, the number of new entrants reporting cocaine as the main problem drug just surpassed cannabis for the first time. This trend continues for 2021, with 38.4% of new treatment entrants reporting cocaine as the main problem drug, compared with 35.2% reporting cannabis.

The number of new entrants reporting cocaine as the main problem drug has fluctuated over the 13-year reporting period, initially peaking at 19.0% in 2009, then dropping steadily until 2012, before increasing year on year to a new peak of 38.4% in 2021.

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

In 2021, 'other drugs' (mainly benzodiazepines) was the fourth largest group of main problem drugs reported by new treatment entrants, which is similar to previous years.

All treatment entrants (Figure III)

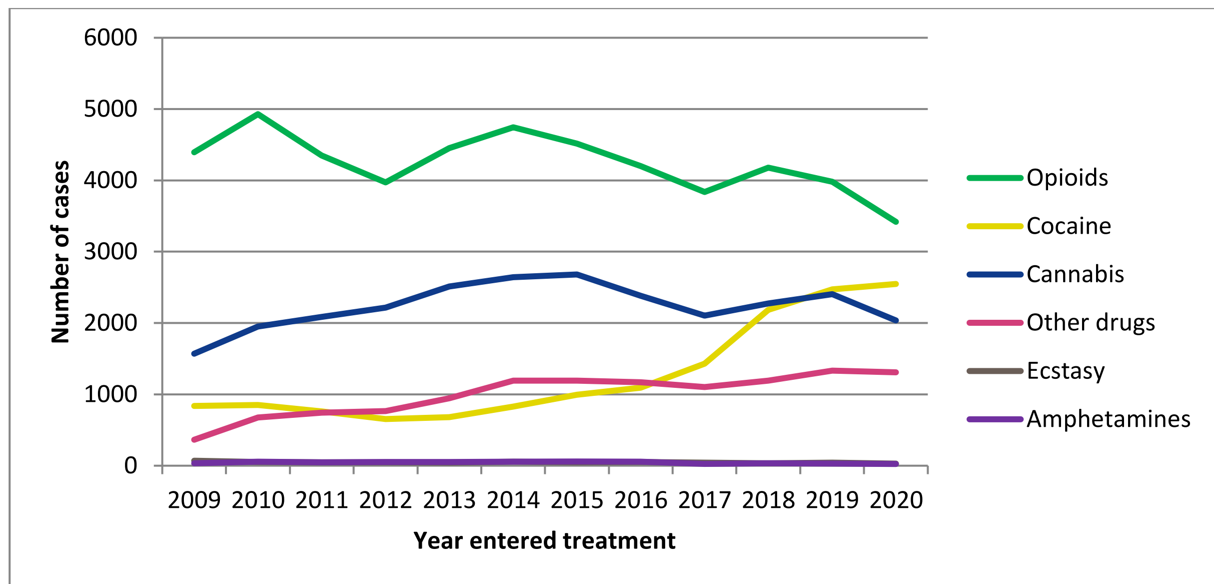

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2009–2021 [3]

The number of *all* cases reported in 2021 has increased compared to 2020, and has surpassed the number of cases reported for 2019, which could indicate that the impact of public health restrictions on addiction care has been allayed for 2021. Over the period of the COVID-19 pandemic, while the number of cases reported dropped, the trends remained consistent.

In 2021, a total of 10,408 treatment entrants was recorded in the NDTRS (see also the TDI). Of the cases recorded in 2021, the majority (55.1%) had been previously treated, which was very similar to 2020 (54.5%).

In 2021, opioids (mainly heroin) were the main problem drug used by entrants to treatment, reported by 33.7% of all entrants, compared with 36.5% in 2020. The number of cases reporting problem opioid use peaked in 2010 at 4,929 and has shown a consistent downward trend since then. In 2021, the number of cocaine cases reported (n=3,139), including powder and crack) overtook the number of heroin cases (n=3,065) reported for the first time.

In 2021, cocaine (30.2%, includes powder and crack) remained the second most common problem drug reported among all treatment entrants. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2021. 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 30.2% in 2021, compared with 27.2% in 2020. Since 2014, the average annual increase in the number of cocaine cases has been 16%. However, this has fluctuated widely, ranging from 3% between 2019 and 2020 (which may have been impacted by pandemic restrictions) to 53% between 2017 and 2018.

Cannabis (21.4%) was the third 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 since then.

Both amphetamines and, to a lesser extent, ecstasy are reported very rarely as main problem drugs by entrants to treatment in Ireland. In 2021, there were 25 amphetamines cases reported, compared with 24 in 2020, while there were only 12 ecstasy cases reported, compared with 29 in 2020. However, small numbers make interpretation difficult.

In 2020, '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 the TDI are a different selection from the data reported in the regular NDTRS bulletins (Kelleher *et al*. 2022) and interactive tables (see https://www.drugsandalcohol.ie/tables/). Therefore, figures reported through these sources will differ slightly.

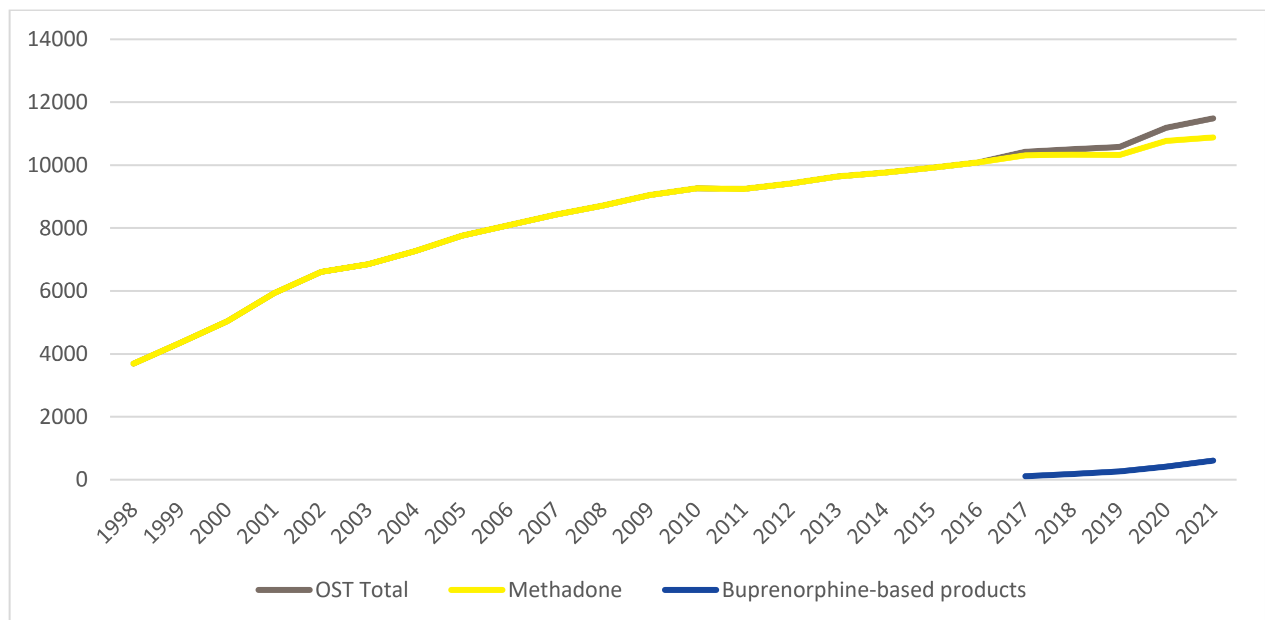

Figure IV. Trends in numbers of clients in OST, 1998–2021 [4]
Source: CTL.

T2.2. Additional trends in drug treatment

No new information.

T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug treatment in your country **since your last report**.

T1 is used to establish the baseline of the topic in your country. Please focus on any new developments here.

If information on recent notable developments have been included as part of the baseline information for your country, please make reference to that section here. It is not necessary to repeat the information.

T3.1. New developments

No new information.

T4. Additional information

The purpose of this section is to provide additional information important to drug treatment in your country that has not been provided elsewhere.

T4.1. Additional Sources of Information

No new information

T4.2. Further Aspects of Drug Treatment

Children whose parents use drugs

A recent publication from the Pompidou Group and Council of Europe highlighted the issue of children living with a parent who uses drugs (including alcohol), a cohort that is too often an invisible population (Giacomello 2022). Parental substance use can have lasting negative impacts on a child, from before birth into adulthood. The publication is intended to be a first step in highlighting this issue, to increase the available knowledge base which can then be used as a tool for services to engage with. Ireland was one of the countries that contributed to the report, and was the only country which had a specific strategy for addressing issues for children living with parental drug use (Health Service Executive and Tusla Child and Family Agency 2019). The report noted a lack of integrated data collection systems providing data on this cohort of children, but it pointed to Ireland's innovative practice where the NDTRS has been updated to enable collection of routine, aggregated data on the age and living arrangements of children of parents in treatment for drug or alcohol use (see p. 48).

Irish national drug treatment data[1] show that in 2021, 15.8% (1,697) of cases treated for drugs were residing with children aged 17 years or younger (Kelleher *et al*. 2022). Males accounted for 52.9% (898) and females 47.0% (797) of these cases (gender was not known for 5 cases or fewer).

One-quarter of cases (24.7%, 2,664) treated for drugs in 2021 had children aged 17 years or younger, but who were not currently residing with them. Three-quarters of these cases (75.3%) were males, and one-quarter were females (24.7%).

Treating alcohol withdrawal syndrome (AWS) with baclofen in opioid-dependent patients

A 2021 study investigated baclofen's effectiveness and patient acceptability in treating AWS in patients receiving OST in Ireland (Gibbons et al. 2021).

Methods

In total, 23 alcohol-dependent patients attending Dublin OST clinics were invited to take part in this proof-of-concept study. The study was non-blinded (i.e. the participants knew what drug they were taking), with no control group as the sample size was limited. The key aim of the study was to determine baclofen's acceptability. The baclofen treatment regime was administered while the patients attended a daily clinic during the 11-day detoxification period. Patients were assessed for

[1] Irish national drug treatment data differs slightly to what is reported via the TDI.

alcohol intake and had a physical assessment, including liver and cardiac function. The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) was used to monitor alcohol withdrawal symptoms during detoxification. The Treatment Satisfaction Questionnaire for Medication version 1.4 (TSQM 1.4) was undertaken once the detoxification period was completed to assess the participants' satisfaction with baclofen. Data were gathered on side effects, effectiveness, convenience, and global satisfaction with the treatment.

Data analysis

An intention-to-treat analysis was carried out to compare alcohol intake and withdrawal symptoms before and after detoxification using baclofen. An intention-to-treat analysis includes all available data from participants, as well as data from those who dropped out of the study. Appropriate statistical tests were applied to compare results among participants who completed the study and those who dropped out.

Results

Of the 23 participants invited to take part, 3 dropped out before the trial commenced, reducing the study to 14 males and 6 females. A further three participants had dropped out by Day 4 of the trial. Approximately one-half of the participants were homeless, and alcohol intake among the cohort was deemed very high. As this was an intention-to-treat study, any available data from the participants who dropped out were included in the analysis. The mean age was 37.6 years (males 38.7 years vs females 35.1 years). All participants had positive urinalysis for benzodiazepines, most (n=16/20) had abnormal liver findings, and one-half tested positive for hepatitis C. Following detoxification with baclofen, a statistically significant difference in median alcohol intake (interquartile range (IQR)) per day was observed, falling from 26.5 units (20.8–37.3) to 6.0 units (3.9–8.0), with a median reduction of 21.0 units (13.8–27.0). There was no difference observed between genders. Substantial reductions were also seen in AWS as measured by the CIWA-Ar. Female participants were more likely to experience moderate withdrawal symptoms than males at the beginning of the study. Patient satisfaction with baclofen therapy was excellent across the four domains (side effects, effectiveness, convenience, and global satisfaction) on the TSQM. Female participants scored slightly higher than males across the four scales, yet males still scored very high in relation to global satisfaction.

Discussion

The baclofen therapy for AWS saw a large decline in alcohol units consumed per day over a detoxification period of 11 days in both male and female opioid-dependent participants on OST recruited in this proof-of-concept study. Combined with the CIWA-Ar results, baclofen appeared to effectively suppress withdrawal effects. Participants considered baclofen to be effective, convenient to take, and with few side effects, and they gave very high satisfaction scores, suggesting acceptability. The authors state that this study is the first of its kind to show that a non-addictive drug (baclofen) may work in the opioid-dependent population with regard to alcohol detoxification.

However, the major weakness of the study was the positive benzodiazepine urinalysis observed in all patients, as no participant was known to have been prescribed benzodiazepines. This indicates illicit use, with the type and dose of benzodiazepines not known or regulated. Therefore, the reduction in withdrawal effects could be attributed to benzodiazepines rather than baclofen.

Another weakness was the small study numbers, which meant that a blinded controlled study could not be conducted. With no control group, a direct link to baclofen as an effective treatment of AWS

in OST patients undergoing alcohol detoxification is not possible. The authors noted that the mean alcohol consumption did not reach zero units by the end of the study. However, baclofen may be a suitable therapy for AWS in high-risk groups for relapses or developing benzodiazepine addiction, and further study is warranted.

Nitrous oxide-induced myeloneuropathy: an emerging public health issue

Two cases of nitrous oxide neurotoxicity in young men (aged 20 and 21 years) presenting at a large Dublin hospital have been reported (McCormick *et al*. 2022). Nitrous oxide neurotoxicity symptoms can vary widely, as shown by the two case studies presented in the article. Case 1 had a 2-week history of sensory changes (numbness spreading to all four limbs, unsteadiness, increased sensitivity to pain, and allodynia (hypersensitivity to touch)). Case 2 reported progressive tingling and weakness and impaired coordination. Sensation was significantly reduced. He was unsteady and unable to walk unaided.

There are no major consensus treatment guidelines available, so treatment of the neurological side effects is mostly based on case literature. Both cases in this report were treated with intramuscular vitamin B12 and oral folic acid, and both reported improvement, but not complete recovery, on follow-up (1–2 months post-discharge). This is in line with findings from other reports, with poorer outcomes found in patients who present late and who continue to use nitrous oxide.

The authors stress that it is important that professionals are aware of this important public health issue, even if relatively uncommon at the present, in the context of the risk of increased prevalence of use of nitrous oxide in the future.

In treatment data, cases of nitrous oxide are still reported very rarely. In 2021, less than five cases were reported as a main problem drug; however, eight cases were reported as additional problem drugs (unpublished data, NDTRS, 2022).

Healthcare professional well-being impacted by COVID-19 while supporting clients with addiction in Ireland

A 2022 study explored the impact that the COVID-19 pandemic had on the well-being of Irish healthcare professionals supporting clients with addiction (O'Callaghan and Lambert 2022).

In total, 15 professionals working in homelessness, addiction, public health, and emergency medicine who worked with people actively taking drugs were recruited to take part in the qualitative study using semi-structured interviews. To be included in the study, participants must also be in an active healthcare role and have experienced the drug-related death of a client (excluding bereavements within 3 months of the survey). Participants were recruited nationwide.

Four core themes were generated from the analysis: shift in priority; being left behind; managing a death; and anxious environment. Associated sub-themes provided further information and context.

Priorities that were typically client-centric shifted towards COVID-19 safeguarding and infection controls. Participants expressed feeling unprepared, confused, anxious, occupationally stressed, and internally conflicted as the new priorities challenged their existing professional values. While they understood the importance of safeguarding, participants feared there being a lack of services for their clients.

The sub-theme 'high threshold' was identified as services became more difficult to access, creating a barrier for clients. COVID-19 protocols undermined the foundation of addiction services and reduced

the number of services remaining in operation because of closures. Participants reported stress and associated emotions in response to the loss of control over client care. Three sub-themes were identified: ‘lost in transition’, ‘digital divide’, and ‘new relationship dynamics’. Addiction continued as a major public health concern during the pandemic, with those experiencing addiction becoming more vulnerable than before.

Participants were left feeling uncertain, experiencing loss of control and feelings of helplessness at their inability to provide services required by their clients. Clients’ recovery noticeably worsened, with increasing wait times leading to ‘slips’, dropping out of contact, and getting ‘lost in transition’ during their recovery period. It left the participants feeling demoralised.

Replacement of face-to-face appointments with virtual communication with clients resulted in many barriers to the recovery process due to lack of infrastructure, knowledge, access, and tools, and it abolished the sense of security and safety that in-person, private sessions provided. The pandemic changed relationship dynamics between participants and their clients, with connections becoming strained, leaving clients feeling abandoned when staff were redeployed due to the pandemic.

In the event of a client’s death, participants reported feelings of guilt, self-blame, personal responsibility, and self-questioning for these ‘preventable deaths’. Participants’ strong emotional investment in their clients coupled with COVID-19 protocols and administrative demands following the death of a client left little time for them to process the death. Certain guidelines for catering to the needs of clients were loosened due to COVID-19 protocols, leaving participants feeling exposed and anxious about legal liability should a death occur.

All participants expressed having a high level of anxiety throughout the interviews, suggesting that COVID-19 created an anxious environment for them to work in. Between self-monitoring for COVID-19, questioning their own mental health and fitness to work, and the occupational stress created by the pandemic, participants found that all corners of their lives were affected.

In the discussion, the authors highlighted areas of concern for future service delivery and opportunities to future-proof services as society moves towards hybrid models of working. The rigid protocols around service provision and the digital divide created as a result of public health measures further alienated this high-risk group, significantly impacting practitioners’ occupational well-being. They mentioned prevailing feelings of anxiety, helplessness, and concern for mortality of their clients. Nonetheless, the participants continued to support this high-risk group throughout the most difficult of circumstances.

Gambling in Ireland: profile of treated cases from a national treatment reporting system

A study, using routinely collected addiction treatment data, examined 3,000 cases of treated problem gambling in Ireland between 2008 and 2019 (Condron *et al*. 2022). This study found that while over one-half (52.7%) reported gambling as their sole problem, 47.3% of cases also reported problem substance use.

The most common problem drugs reported alongside gambling were alcohol (85.6%), followed by cannabis (32.3%), cocaine (28%), and benzodiazepines (10.9%). There were significant differences between those treated for gambling only and those treated for gambling and substance use.

Cases treated for gambling only were more likely to be in employment, have completed second- or third-level education, and be living with dependent children. They were more likely to receive outpatient treatment and be referred by GPs or health professionals. Cases treated for gambling and

additional problem drug or alcohol use were more likely to have left school early and be unemployed, and 1 in 10 were likely to be homeless. They were more likely to attend inpatient services and be referred by another drug treatment service, outreach worker, or the legal system.

The authors conclude that problem gambling affects not just those who gamble but also those around them. The potential impact of parental gambling on children is evident, with one in five cases living with dependent children. Furthermore, one-half of cases started gambling before the age of 17 years. This study provided insights into treated problem gambling nationally and its association with substance use, and it highlighted the need for a national database on gambling treatment to be established. A systematic approach to collecting and analysing data about those who seek treatment for problem gambling over time would improve understanding about why people present for treatment, improve referral pathways, and inform policy and planning.

T4.3. Psychiatric comorbidity

The development and delivery of National Clinical Programmes (NCPs) is a key deliverable of the HSE. One of the five mental health NCPs is for supporting individuals with co-existing mental health and substance use issues (Butler)(O'Sullivan 2019). The Model of Care for Dual Diagnosis (comorbid mental disorders and addiction disorders) is currently awaiting approval before being made available for public access, possibly by the end of the year. The planned tertiary level specialist Dual Diagnosis services will be established across Ireland, catering to both adults and adolescents with the first adult Dual Diagnosis team expected to commence delivering the services by the end of this year or January 2023. The Dual Diagnosis services when established will be working in partnership and in an integrated manner with both public and voluntary bodies and this is expected to include sharing of resources. The Dual Diagnosis services established primarily under the clinical governance of mental health services will be unique as these services will cater to a population group with comorbid mental disorders and addiction disorders beyond the misuse of alcohol and illicit drugs (depending on the resources being made available to the Addiction services at primary care level) (Personal Communication, Dr Narayanan Subramanian, August 2022).

T5. Sources and methodology

The purpose of this section is to collect sources and present a bibliography for the information provided above, including brief descriptions of studies and their methodology where appropriate.

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 OST for problem opioid use. When a person is considered suitable for opioid detoxification, stabilisation, or maintenance, the prescribing doctor notifies the CTL by completing an entry form. A unique number is allocated to the client, and they receive a treatment card when the methadone is dispensed in community pharmacies.

The NDTRS is a national epidemiological database that 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 seeking help for their substance misuse problems. The NDTRS is a case-based, anonymised online database. It is coordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the European Union (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 date 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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