European Monitoring Centre for Drugs and Drug Addiction

Ireland

Ireland Drug Report 2018

This report presents the top-level overview of the drug phenomenon in Ireland, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

THE DRUG PROBLEM IN IRELAND AT A GLANCE

Drug use

"in young adults (15-34 years) in the last year"

Cannabis

13.8 %

Other drugs

MDMA	4.4 %
Amphetamines	0.6 %
Cocaine	2.9 %

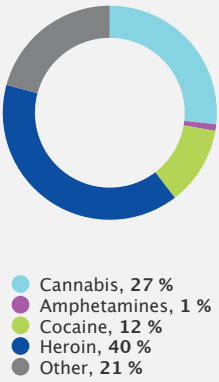
High-risk opioid users

18 988

(18 720 - 21 454)

Treatment entrants

by primary drug



Opioid substitution treatment clients

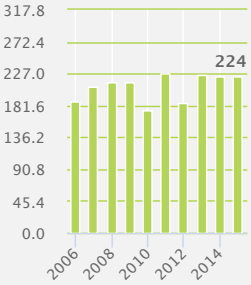
10 087

Syringes distributed

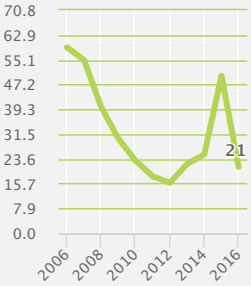
through specialised programmes

No Data

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

16 119

Top 5 drugs seized

ranked according to quantities measured in kilograms

No Data

Population

(15-64 years)

3 097 263

Source: EUROSTAT Extracted on: 18/03/2018

"NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law o?ences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin. 279,154 syringes were distributed in 2016 by pharmacy-based sites in Ireland (not including Dublin)."

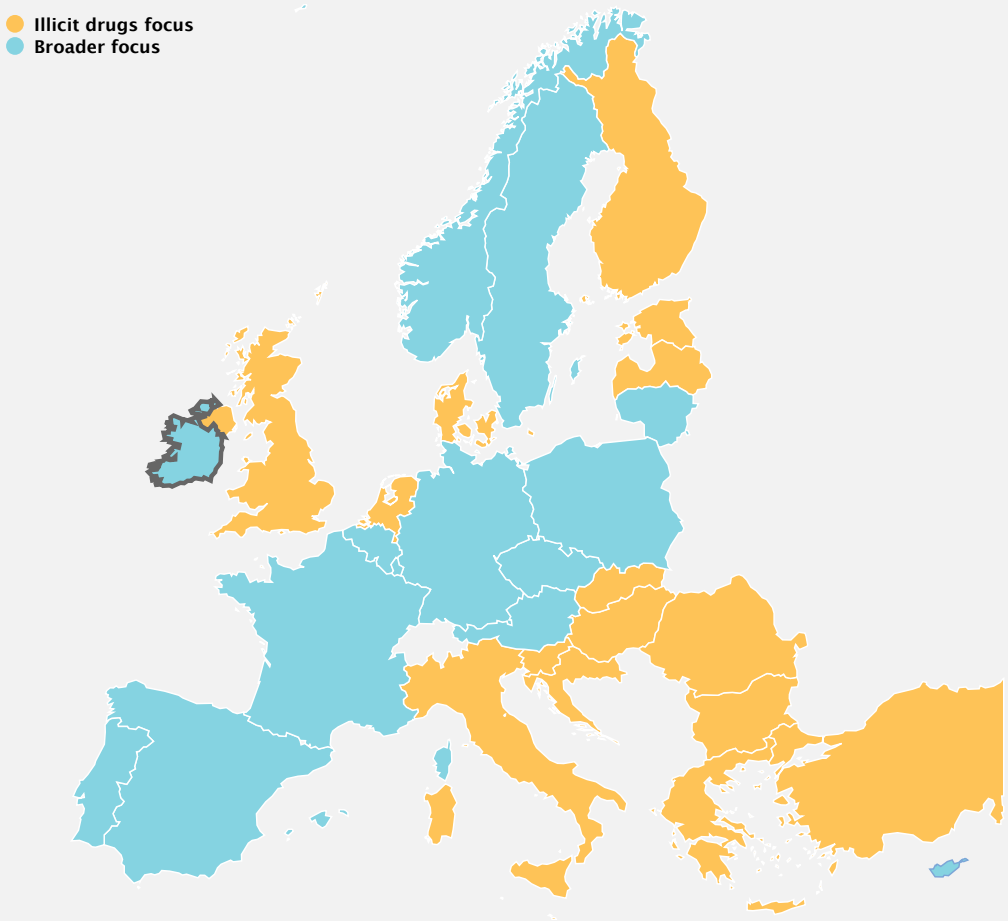
National drug strategy and coordination

National drug strategy

Ireland's national drug strategy, 'Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025', was launched in July 2017 and is the third consecutive long-term drug policy and strategy document adopted in the country. This is the first strategy to move towards an integrated approach to illicit drug and alcohol use. The strategy sets out an overarching vision for 'a healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life'. The vision is underpinned by five strategic goals that structure the approach being taken: (i) to promote and protect health and well-being; (ii) to minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery; (iii) to address the harms of drug markets and reduce access to drugs for harmful use; (iv) to support participation of individuals, families and communities; and (v) to develop sound and comprehensive evidence-informed policies and actions. Performance indicators are defined for each goal. The Department of Health has overall responsibility for implementing the strategy, which is supported by a shorter term action plan (2017-20) that contains 50 actions.

Like other European countries, Ireland evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. In 2016, an external assessment of Ireland's National Drugs Strategy (Interim) 2009-16 was completed; it considered the strategy's implementation and generated insights for the development of the current strategy. The new strategy contains a number of performance indicators associated with each goal. The detail of which objective they relate to, how they will be used and timelines for delivery are not included. More broadly, the strategy aims to operationalise a new performance measurement system by 2020.

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2016. Strategies with broader focus may include, for example, licit drugs and other addictions.

National coordination mechanisms

The Minister for Health has overall responsibility for Ireland's national drug strategy and is supported by a Minister of State with responsibility for Health Promotion and the National Drugs Strategy. The National Oversight Committee includes representatives from the statutory, community and voluntary sectors and benefits from the expertise of both a clinical and an academic representative. This

group meets quarterly. It is supported by a standing subcommittee chaired by a senior official at the Department of Health. It meets monthly and supports the implementation of the strategy, as well as promoting coordination between national, regional and local levels. The Drugs Policy Unit at the Department of Health is responsible for providing objective and informed analysis and advice to the National Oversight Committee. At a sub-national level, local and regional Drug and Alcohol Task Forces are responsible for strategic and operational coordination in the implementation of the strategy. The Health Research Board is Ireland's Reitox national focal point and manages the commissioning of research for the National Oversight Committee. Its Early Warning and Emerging Trends Committee monitors European and national data sources.

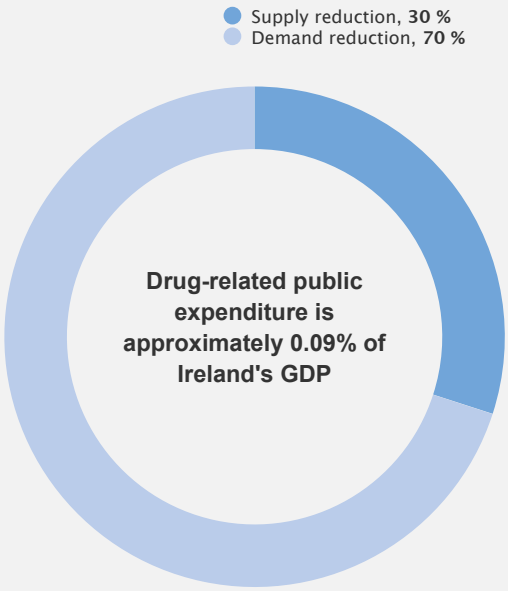
Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, most drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches. Estimates of executed labelled expenditures in Ireland are available from 2005. The priorities for drug-related public expenditure are set out in the national drugs strategy. The methods and the completeness of the expenditure estimates have varied over time. In recent years, the method of estimating drug-related public expenditure has been defined and it has become possible to compare levels of labelled drug-related public expenditure over time. In 2016, total drug-related expenditure represented 0.09 % of gross domestic product or approximately EUR 249 097.

In 2016, the planned budget allocated approximately 51 % of spending to health, 34 % to public order and safety, 8 % to recreation, culture and religion, and 7 % to social protection initiatives.

Between 2009 and 2014, drug-related expenditure in Ireland declined by 16 %. However, in 2015 and 2016, expenditure stabilised, at 0.09 % of GDP in both years.

Public expenditure related to illicit drugs in Ireland



NB: Based on estimates of Ireland's labelled and unlabelled public expenditure in 2016.

Drug laws and drug law offences

National drug laws

Possession of any controlled substance without due authorisation is an offence under the Misuse of Drugs Acts 1977-2016 (as amended). The drugs controlled under the act are listed in the schedules, together with some generic definitions of substance groups. The legislation makes a distinction between possession for personal use and possession for sale or supply.

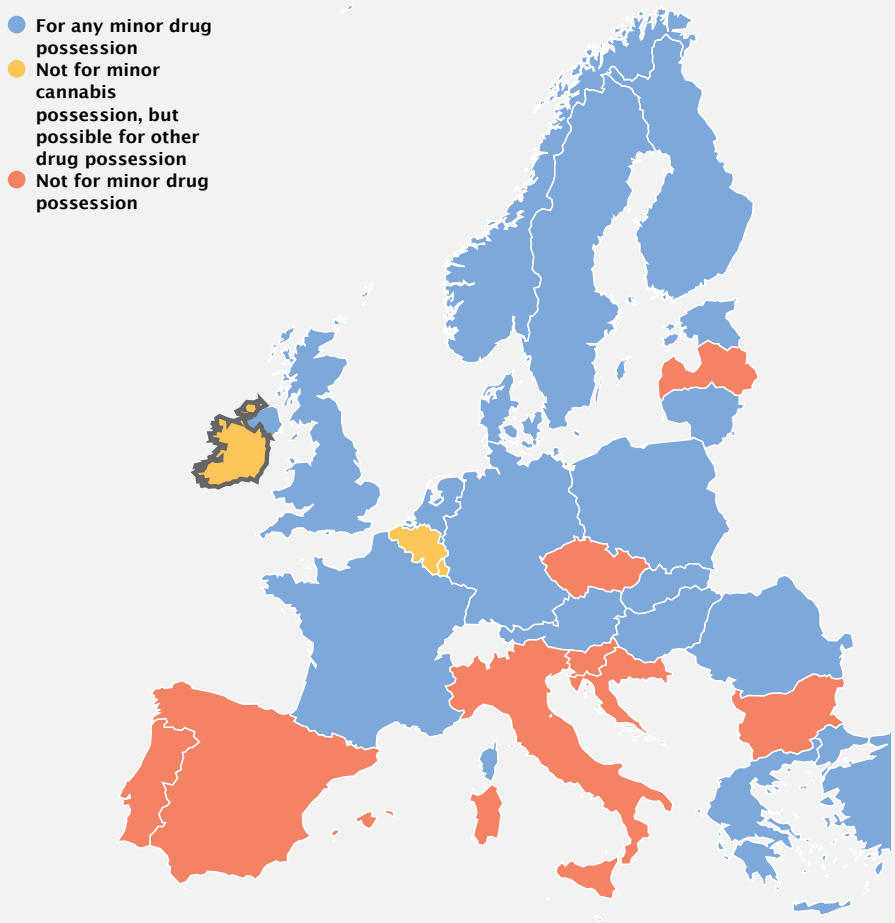
Penalties for possession for personal use depend on the type of drug (cannabis or other drugs) and on the penal proceedings, that is, whether a summary conviction or a conviction on indictment is sought. Possession of cannabis or cannabis resin for personal use is punishable by a fine on first or second conviction; however, third and subsequent offences are punishable by up to one year in prison for a summary conviction and up to three years for conviction on indictment. Possession in any other case is punishable by up to one year in prison and/or a fine on summary conviction and up to seven years' imprisonment for conviction on indictment. However, the Criminal Justice (Community Service) Act 2011 requires courts to consider imposing a community service order instead of a prison sentence in all cases where up to 12 months' imprisonment might have been deemed appropriate. The Drug Treatment Court, which is based in Dublin, has been running since 2001 and was reviewed in 2010 and 2013.

With regard to drug trafficking, different penalties can be imposed depending on the circumstances of the offender, the type of drug and the quantity involved. Possession for sale or supply can attract penalties of up to life imprisonment, with a presumptive mandatory minimum sentence of 10 years for the possession of drugs with a market value of at least EUR 13 000. In 2013, the Law Reform Commission, an independent statutory body established by the Law Reform Commission Act 1975, recommended repeal of this presumptive sentencing regime.

In response to the new psychoactive substances (NPS), which are sold in so-called 'head shops', in 2010 more than 200 individual substances were controlled under the Misuse of Drugs Act 1977; the Criminal Justice (Psychoactive Substances) Act 2010 was passed to allow the prohibition of supply-related acts involving any harmful NPS.

In 2015, the Court of Appeal effectively annulled earlier declaration orders banning numerous substances over the last two decades, so the Misuse of Drugs (Amendment) Act 2015 was introduced as emergency legislation to control those substances. Further amendments were made in 2016.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)

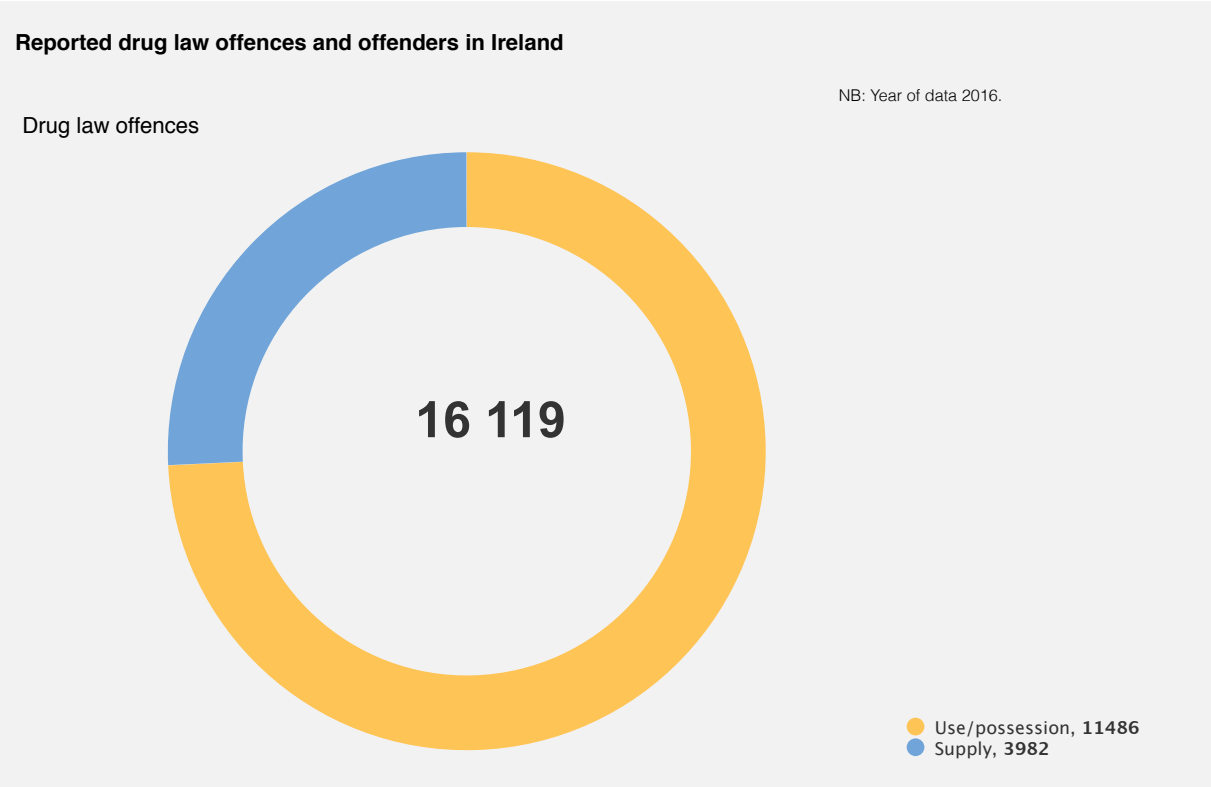


NB: Year of data 2016

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The statistical data indicate that the number of DLO incidents decreased in Ireland between 2008 and 2013, and has remained relatively stable since then. In 2016, the majority of DLO incidents were linked to use/possession.



Drug use

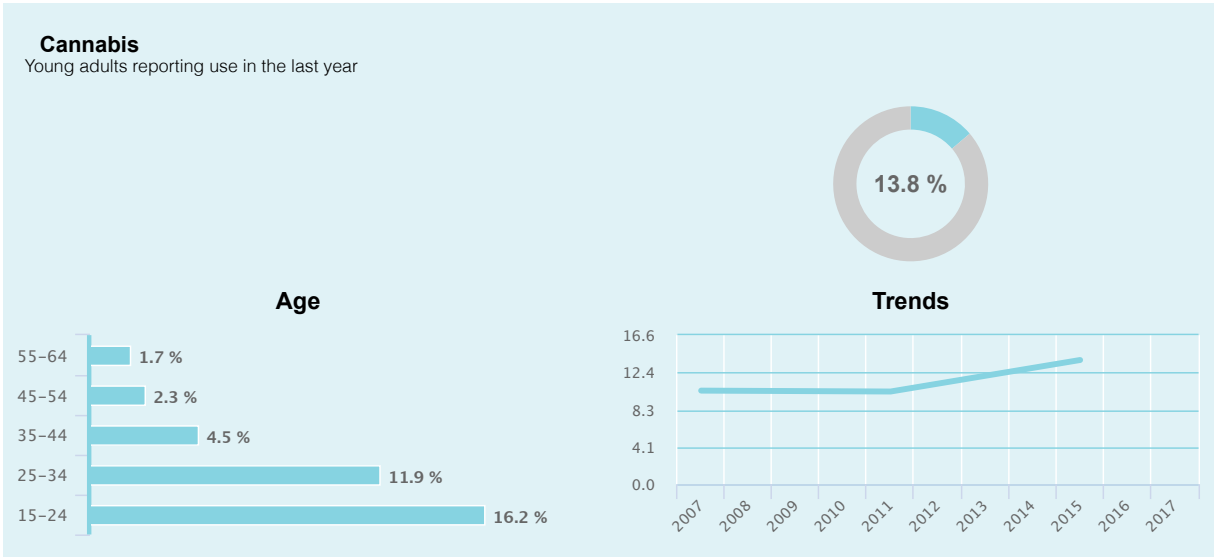
Prevalence and trends

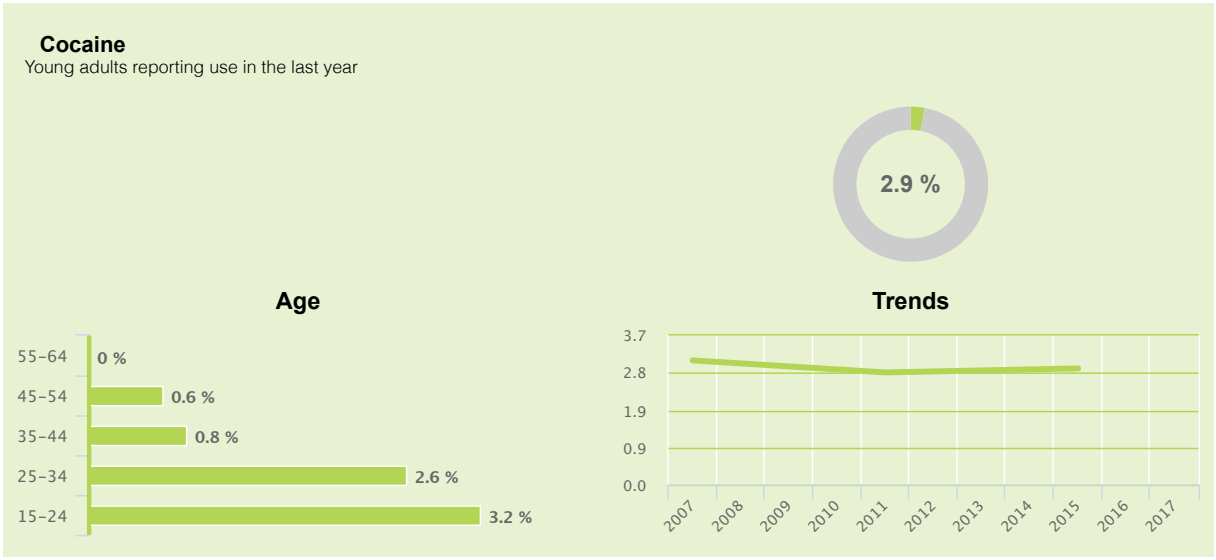
The available data suggest that drug use has become more common among the adult general population aged 15-64 years in Ireland over recent years. Fewer than 2 in 10 adults reported use of any illicit drug during their lifetime in 2002-03, but this figure increased to approximately 3 in 10 in 2014-15. Similarly, last year and last month prevalence of use of any illicit drug has increased since the 2011 survey. The most recent survey, in 2014-15, confirms that cannabis remains the most commonly used illicit drug, followed by MDMA/ecstasy and cocaine. Illicit drug use is more common among males and younger age groups. Among young adults (aged 15-34 years), the prevalence of last year cannabis use was stable between the 2006-07 and 2010-11 surveys, but it was found to have increased in the most recent study.

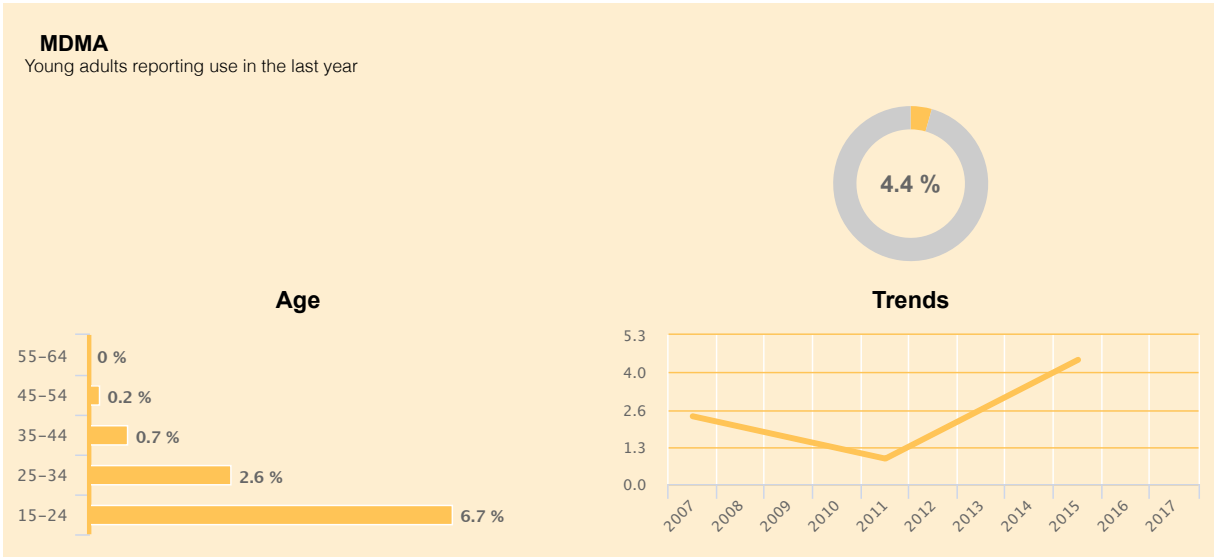
Reported last year use of MDMA decreased between 2006-07 and 2010-11 but increased substantially in 2014-15; however, cocaine use has remained stable.

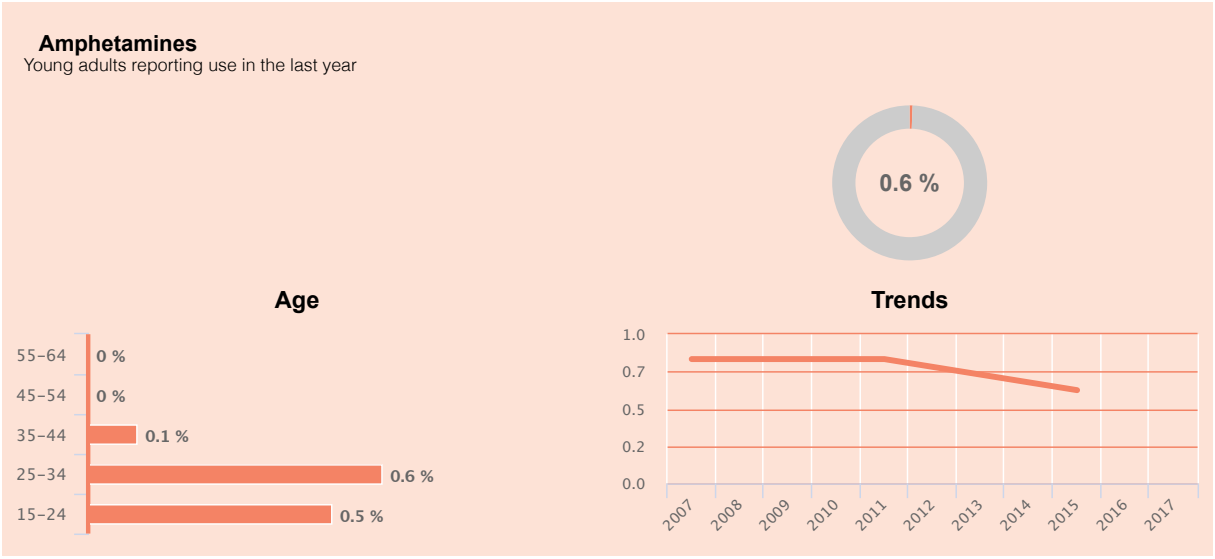
In 2014-15, the reported prevalence of lifetime use of new psychoactive substance (NPS) among the adult general population aged 15-64 years was approximately 4 %. In contrast to trends observed for other illicit substances, data from the 2014-15 study demonstrate that the prevalence of NPS use in the Irish general population has decreased since the 2010-11 survey. Among young adults, last year prevalence decreased from 6.7 % in 2010-11 to 1.6 % in 2014-15.

Estimates of last-year drug use among young adults (15-34 years) in Ireland







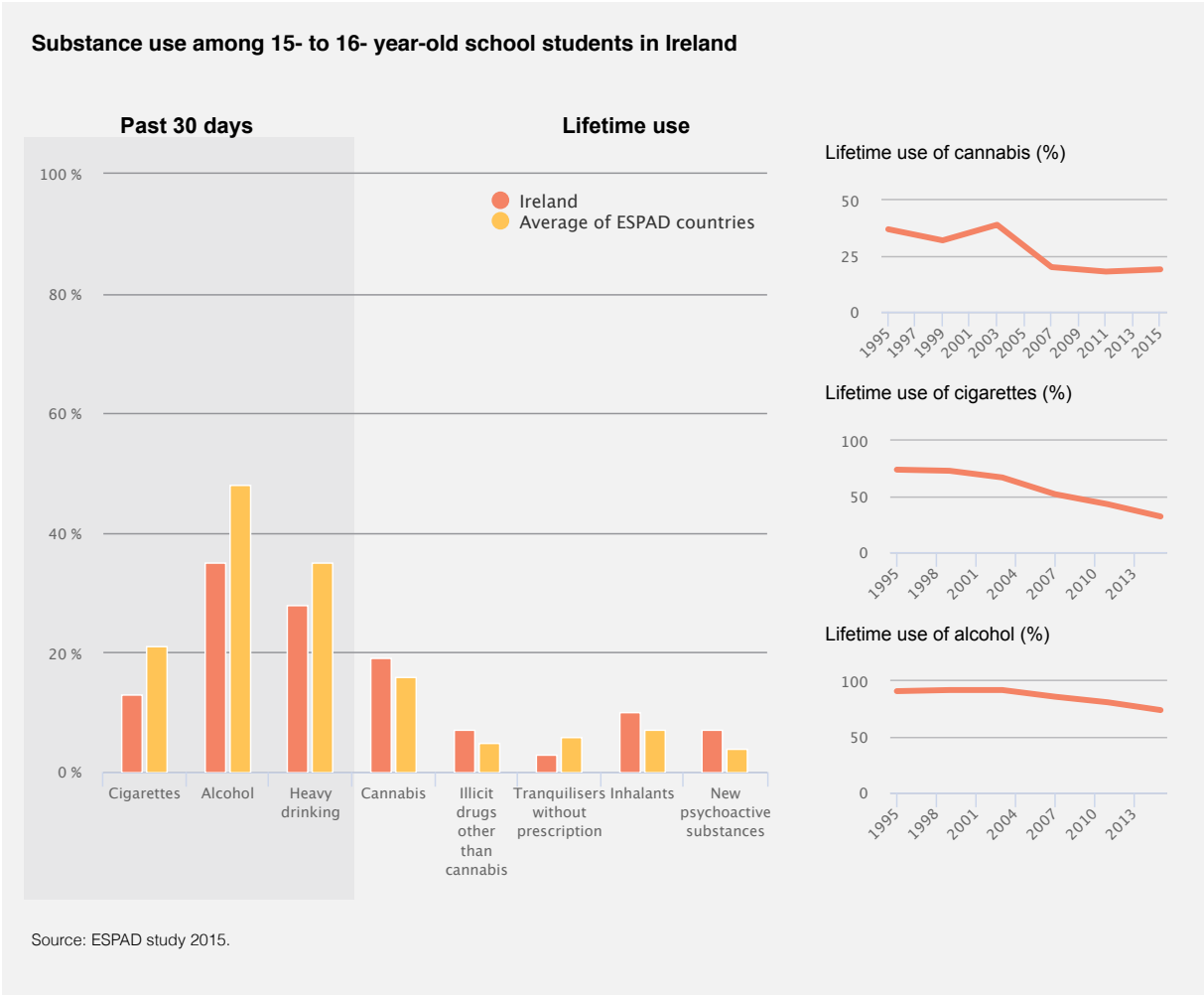


NB: Estimated last-year prevalence of drug use in 2015.

Data on drug use among 15- to 16-year-old students are reported from the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD). This study has been conducted regularly in Ireland since 1999.

For three of the eight key variables studied, Irish students reported prevalence rates that were slightly above the ESPAD average (35 countries). This was true for lifetime use of cannabis, lifetime use of inhalants and lifetime use of NPS, although the differences were not substantial.

Levels of non-prescribed use of tranquillisers or sedatives were below average, while levels of lifetime use of illicit drugs other than cannabis were similar to the overall average. The trend indicates a decrease in lifetime prevalence rates of cannabis between the 2003 and 2007 surveys, with a stabilisation in prevalence rates between 2011 and 2015.



Source: ESPAD study 2015.

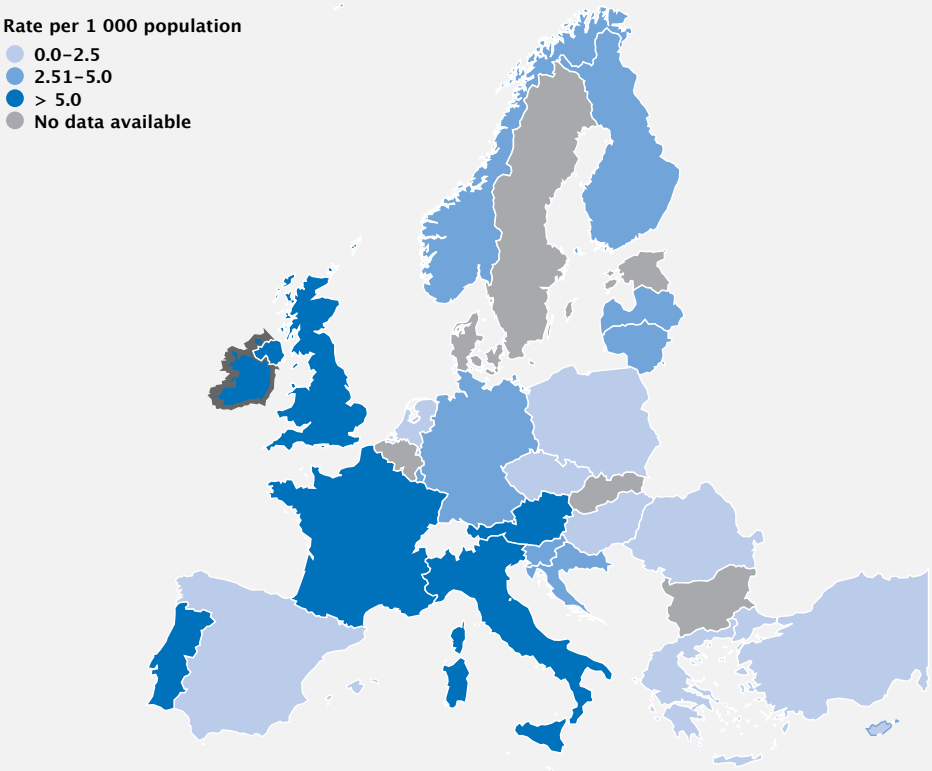
High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

The estimate of high-risk opioid use in 2014 was based on a four-source capture-recapture method and indicated that there were 18 988 opioid users (6.18 per 1 000 population aged 15-64 years) in Ireland, of whom almost two thirds lived in Dublin. In 2014, more than half of opioid users were 35 years old or older, compared with less than one third in 2006, suggesting a definite ageing of this high-risk population.

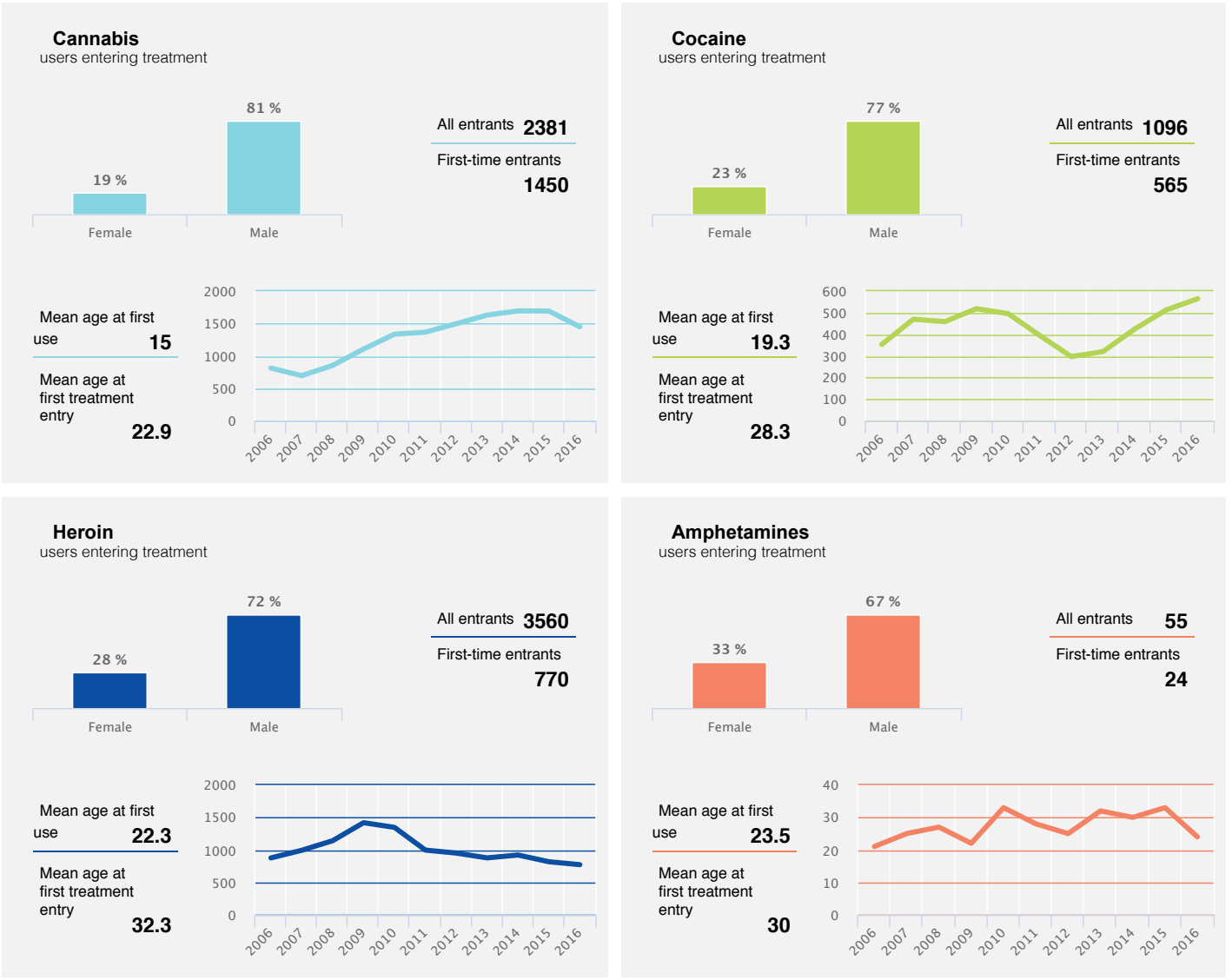
Data from the specialised drug treatment centres indicate that opioids (mainly heroin) remain the most common primary drug among those entering treatment. Between 2006 and 2010, heroin was the main drug reported by first-time entrants, but this was superseded by cannabis in 2011, and this was still the case in 2016. Numbers of first-time entrants reporting cocaine as their primary drug have been increasing since 2012. Both amphetamines and MDMA are rarely reported as the main problem drug by first-time entrants. Approximately one quarter of clients entering treatment are female; however, this proportion varies depending on primary drug and treatment programme.

National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2016, or latest available year

Characteristics and trends of drug users entering specialised drug treatment in Ireland



NB: Year of data 2016. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

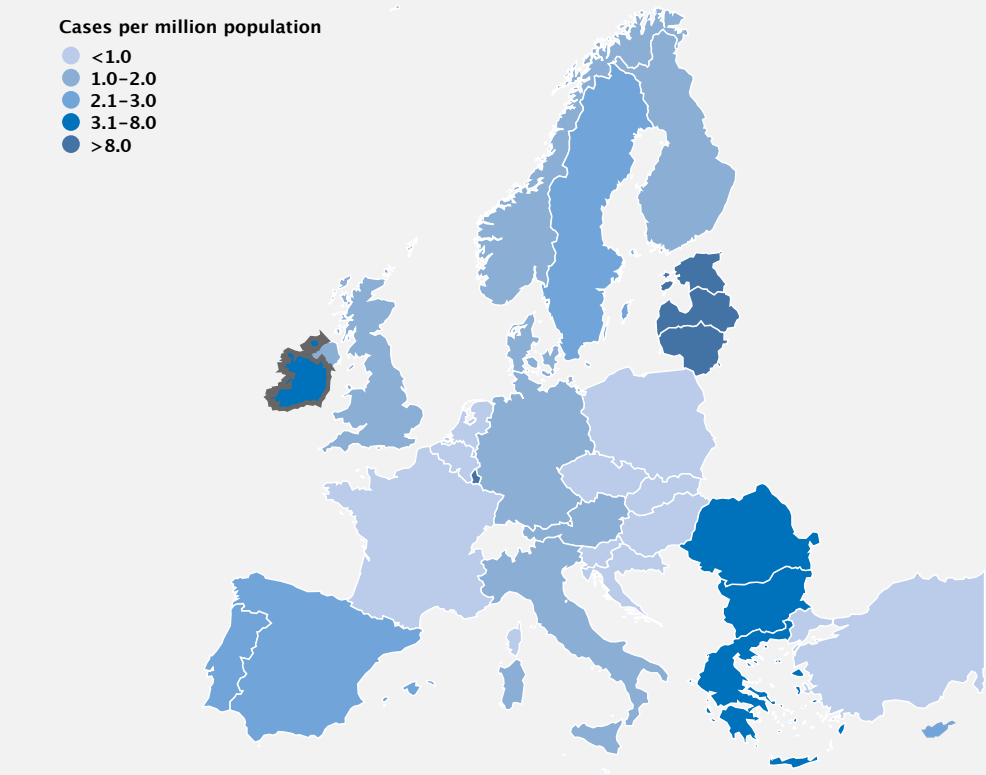
Drug-related infectious diseases

Notification data from the Health Protection Surveillance Centre indicate that the numbers of new cases of human immunodeficiency virus (HIV) infection have shown an increasing trend in the last five years, which may be partly explained by changes in reporting procedures in some areas of Ireland. In 2016, a total of 512 people were newly diagnosed with HIV infection, of whom 21 were people who inject drugs (PWID). This compares with 50 notifications reported in 2015, which was the highest number of PWID among HIV notifications reported since 2008 and was linked to an outbreak of HIV among homeless drug users in Dublin.

In 2016, more than one third of hepatitis C virus (HCV) cases were attributed to injecting drug use; however, a risk factor was reported for fewer than half of all reported cases of HCV infection. Old age (older than 34 years), gender (male) and place of residence (living in Dublin or the surrounding counties) were noticeable characteristics of PWID among HCV notifications in Ireland.

With regard to hepatitis B virus (HBV) infections, a downward trend in the number of notifications was observed between 2008 and 2014; however, recent data suggest that numbers of cases diagnosed and notified are stabilising. Risk factor data were available for 81 % of the acute cases notified and of these almost two thirds were likely to have been sexually acquired.

Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2016, or latest available year. Source: ECDC.

Drug-related emergencies

In Ireland, data on drug-related acute emergencies refer to all admissions to acute general hospitals with non-fatal overdoses and are extracted from the Hospital In-Patient Enquiry scheme. The long-term trend shows a decrease in overdose cases in the last decade (5 012 cases in 2005 and 3 956 cases in 2015). In 2015, one third of the cases were younger than 25 years and more than half of those admitted to hospital were female. More than one third of the non-fatal hospital drug-related emergencies were linked to non-opioid analgesics (mainly paracetamol), while psychotropic substances were present in one quarter of cases and benzodiazepines in less than one fifth. Alcohol was present in about 1 out of 10 cases.

Opioids were the most common illicit substances in non-fatal intoxications involving narcotics or hallucinogens (13 % of cases), followed by cocaine and cannabis.

Emergency departments in two Irish hospitals, in Dublin and Drogheda, participate in the European Drug Emergencies Network (Euro-DEN Plus) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

Drug-induced deaths and mortality

Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

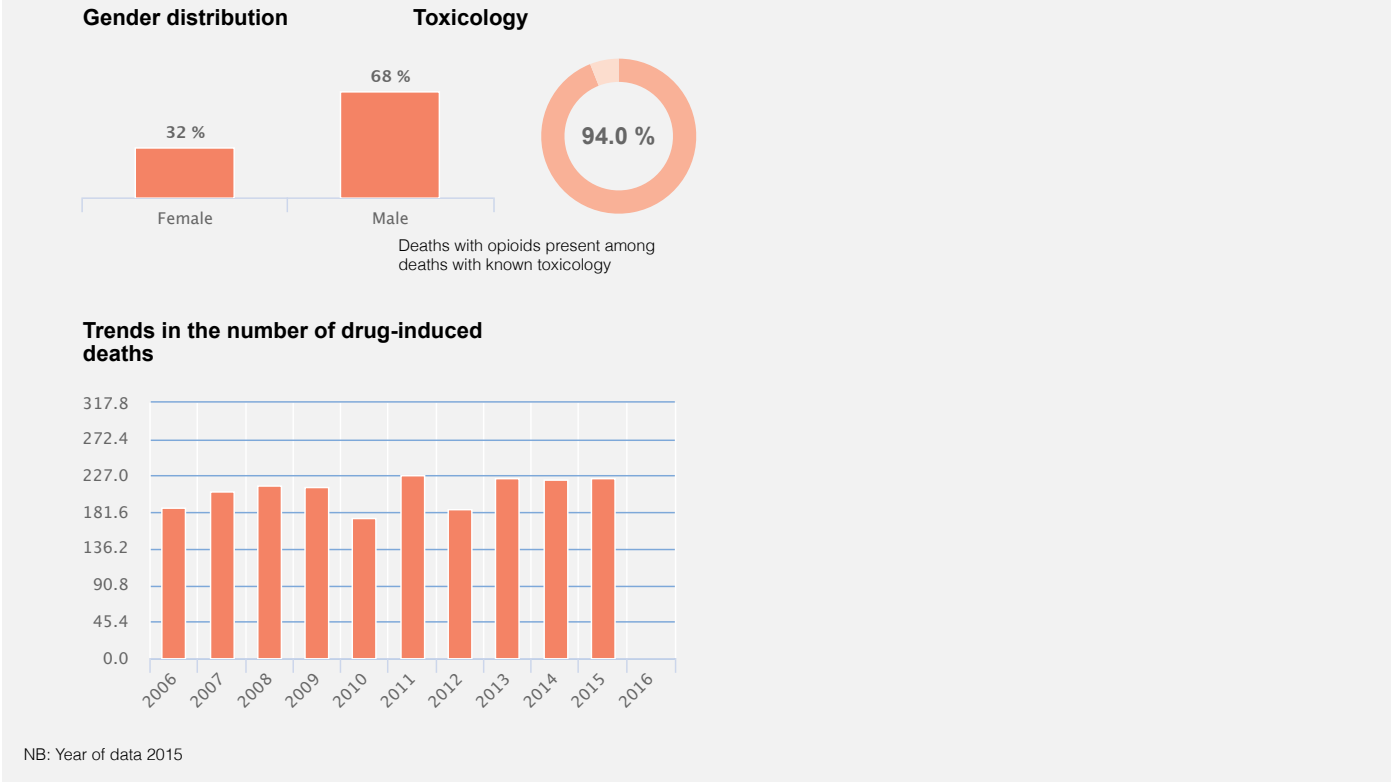
In 2015, the number of drug-induced deaths reported from a special register maintained by the Health Research Board remained stable at 224, compared with 223 deaths reported in 2014. Most those who died were male and were in their late 30s. The mean age of victims in 2015 was 39 years, the highest ever recorded, mainly due to the increase in deaths in those aged 55 years or older compared with 2014. The reason for this increase is not yet known, although more than half of deaths among those aged 55 years or older were among women.

Opioids were by far the drugs most commonly associated with drug-induced deaths, although they were frequently found together with other psychoactive substances, such as alcohol and prescription medicines.

No information regarding overall mortality among cohorts of drug users is reported.

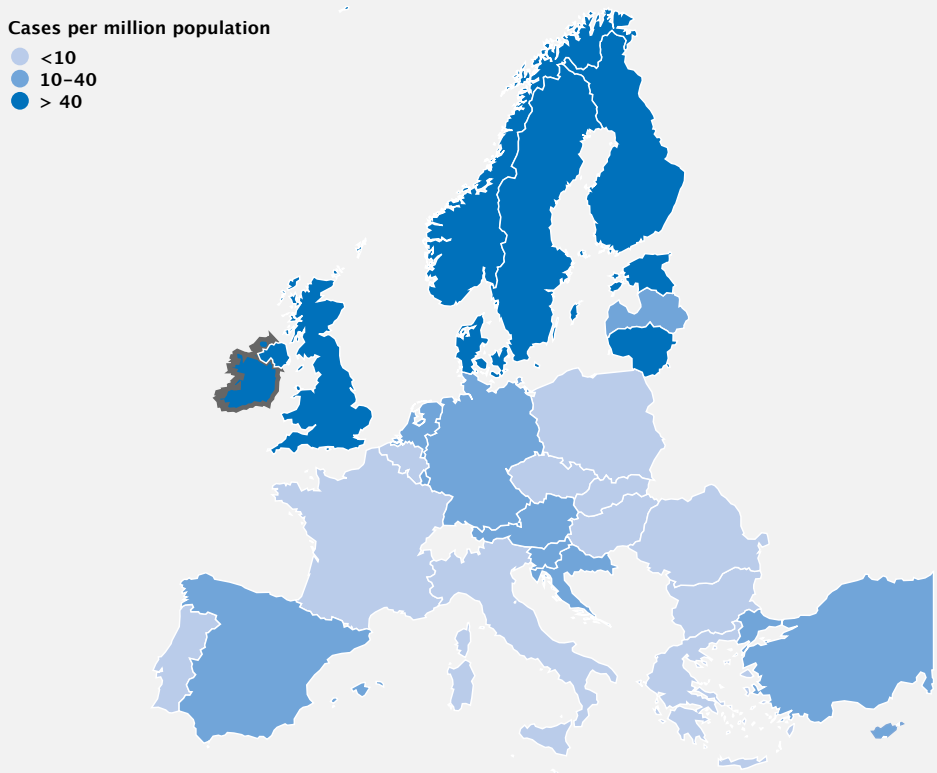
The drug-induced mortality rate among adults (aged 15-64 years) was 70 deaths per million in 2015, which is more than three times the most recent European average of 21.8 deaths per million.

Characteristics of and trends in drug-induced deaths in Ireland



NB: Year of data 2015

Drug-induced mortality rates among adults (15-64 years)



"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

Prevention

Prevention is the main focus of one of the goals of Ireland's new drug and alcohol strategy, 'Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025', which was launched in July 2017. It aims to promote and protect health and well-being by preventing early use of alcohol and other drugs among young people, influencing behaviour and challenging

social norms and attitudes, and providing targeted interventions to minimise harm to those who have already started using or at-risk groups. A number of non-governmental organisations and governmental agencies are involved, with the bulk of the funding provided by the statutory sector.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

Environmental prevention interventions in Ireland are focused on increasingly restrictive alcohol and tobacco controls, which include relatively high taxes on alcohol; drink-driving restrictions; local authority by-laws prohibiting the consumption of alcohol in public spaces; and age restrictions on the purchase and sale of alcohol. There are similar restrictions on tobacco use. From 30 September 2017, all tobacco packs manufactured for sale in Ireland must be in standardised ‘plain’ retail packaging. Local-level strategies are also being developed, which set out to change the environment in which substance use takes place, rather than focusing on ‘problem users’ per se.

Universal prevention programmes are run at both local and national levels. At local level, these include community programmes and family interventions; nationally, they include awareness campaigns, school prevention programmes, and online resources, such as the new public information site about alcohol . In the community, prevention programmes are provided in various settings, such as youth clubs and youth cafés, and by means of diversionary activities that are provided by the statutory, voluntary and community sectors.

The Social, Personal and Health Education (SPHE) programme continues to be the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. The programme is a mandatory part of the primary and post-primary (junior cycle) school curriculum, and supports the personal and social development, health and well-being of students through 10 modules, including a module on substance use. The themes and content of modules are built around helping students to understand the nature of social influences that impact on their development and decision-making, and helping them to develop adequate life skills to improve their self-esteem, develop resilience, and build meaningful and trusting relationships. Specific substance misuse prevention programmes have been integrated into the SPHE curriculum for primary and post-primary schools. From September 2017, SPHE has been incorporated into a new area of learning for junior cycle secondary-school pupils called ‘Wellbeing’, which is a compulsory element of the curriculum. Through the Wellbeing programme students learn the knowledge, attitudes and skills to enable them to protect and promote their own well-being and that of others. For the purposes of this strand of learning, well-being is described as being broader than mental and physical health; it also includes social, emotional, physical, spiritual, intellectual and environmental aspects.

Selective prevention programmes target at-risk groups and subgroups of the general population, including the children of drug users, early school leavers and those involved in antisocial behaviour. Selective prevention interventions also support the families of drugs users, and community development is acknowledged as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems. A range of selective interventions is delivered by Drug and Alcohol Task Forces who have organised, for example, local and regional awareness initiatives and community action on alcohol in socially and economically disadvantaged communities. Interventions are also funded under the Young People’s Facilities and Services Fund, which aims to prevent drug misuse through the development of youth facilities, including sport and recreational facilities. The new national drug and alcohol strategy, ‘Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025’, includes an action to develop a new scheme to improve services for young people at risk of substance misuse in socially and economically disadvantaged communities. There is also ongoing work in tackling educational disadvantage under the Delivering Equality of Opportunity in Schools programme.

Indicated prevention programmes in Ireland tend to be aimed at children and young people with behavioural problems, those who are using illicit and licit substances, and those considered to be at risk because of their family situation. Indicated prevention programmes tend to be provided as part of broader services for vulnerable children and young people. For example, the Child and Adolescent Mental Health Services teams are the first line of specialist mental health services for children and young people in Ireland. The services are provided by multidisciplinary teams, including psychiatrists, psychologists, nurses, social workers, speech and language therapists, and occupational therapists.

Harm reduction

The strategic aims and objectives of the current Irish national drug strategy include the reduction of harm related to substance use, namely by enabling people with drug misuse problems to access treatment; by reducing risk behaviours, harms to individuals, families and communities, and dependency; and by minimising the harm to those who continue to engage in drug-taking activities that put them at risk.

Harm reduction interventions

In Ireland, harm reduction services are delivered by local authorities and community-based organisations. The provision of needle and syringe programmes is a central element of harm reduction service provision. There are three models of needle and syringe programmes: fixed-site facilities, outreach syringe provision and pharmacy-based programmes.

Harm reduction facilities usually provide a range of sterile injecting equipment and materials, including different sizes and types of needles and syringes, alcohol swabs, and citric or acetic acid. Condoms, Stericups or cookers and sterile water, non-toxic foil (for smoking heroin), syringe identifiers and tourniquets are also available through the needle and syringe programmes. Pharmacies in each local and regional Drug and Alcohol Task Force area in Ireland (apart from counties Dublin, Kildare and Wicklow, which are served by a mix of fixed-site and outreach needle exchange programmes) take part in needle and syringe programmes, distributing packs containing injecting equipment for either 3 or 10 sterile injections. The extension of the pharmacy programme started in 2011 has been successful, and at the end of 2016, there were 111 pharmacies providing needle exchange, and an average of 1 614 individuals used pharmacy needle exchanges each month in 2016. The pharmacy-based programme is well accepted and now provides the most widespread type of syringe outlet in Ireland. In areas without a local clinic or mobile unit, staff complement the distribution of injecting material with ‘backpacking’, a process whereby paraphernalia are delivered by staff directly to known drug users.

A recent review of Irish needle and syringe programmes, published in 2015, identified the need to standardise the monitoring of services provided, to increase the uptake of testing for blood-borne viral infections and the uptake of vaccination, and to provide a wider range of drug use paraphernalia to clients. The evaluation of the pharmacy-based programme showed satisfactory results overall, but pointed to the need to match the contents of injecting equipment kits better to users’ needs, as well as to further reduce stigma. Further recommendations were to offer in-pharmacy testing for blood-borne viruses, or alternatively efficient referral, as well as to increase the competence of pharmacy staff in giving harm reduction advice and support. In Ireland, the hepatitis B virus (HBV) vaccine is recommended for several high-risk groups, including prisoners and people who inject drugs.

In 2015, a two-year naloxone demonstration project was initiated in Ireland. The project involved the distribution of a pre-filled syringe of naloxone on prescription and training opioid users to administer it. In 2015, approximately 600 people received training. Since the project began, five emergencies have been recorded in which naloxone given out under the project was successfully used to reverse overdoses and save lives.

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	No	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czech Republic	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

The treatment system

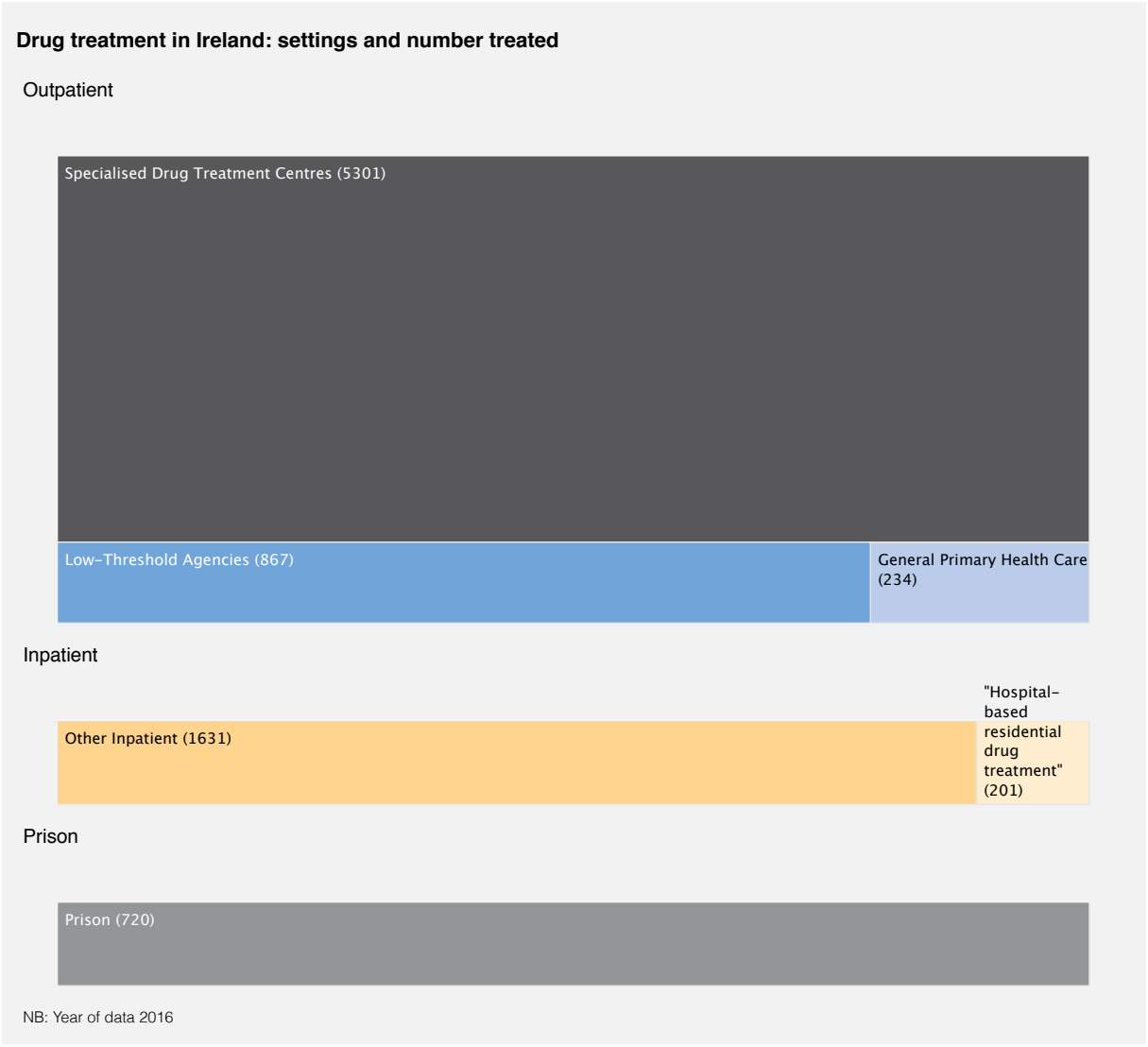
The new national drug strategy, 'Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025', was launched in July 2017 and its main aim is to minimise the harms caused by the use and misuse of substances, and to promote rehabilitation and recovery by supporting the development of a range of treatment, rehabilitation and recovery services using the four-tier model. The strategy also recognises the need for timely access to appropriate services for the client. The integrated care pathways model forms the conceptual basis for the National Drug Rehabilitation Framework.

The Health Service Executive (HSE), which manages Ireland's public health sector, is responsible for the provision of all publicly funded drug treatment. The management of all drug treatment services falls under the remit of the Primary Care Division, which oversees a number of national care groups. Drug treatment is provided through a network of HSE services (public), but also non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment.

Most drug treatment is provided through publicly funded outpatient services. These include 312 specialised drug treatment centres, 77 low-threshold agencies and 349 specialised general practitioners, which provide opioid substitution treatment (OST) in the community.

Some outpatient care is provided through mental health services and by private agencies. Inpatient treatment is provided through residential centres run by voluntary agencies or within psychiatric hospitals. There are 52 non-statutory agencies that are based on the principles of residential care or therapeutic communities and two hospital-based detoxification units.

The types of treatment and services offered vary depending on the service. Medication-assisted treatment includes methadone detoxification, methadone maintenance treatment and benzodiazepine detoxification; all of these are increasingly provided in outpatient settings. Alternative therapies, such as acupuncture, are provided through both statutory and community projects. Pregnant opioid users are entitled to immediate access to treatment. For drug users under the age of 18, special interventions, such as family therapy and specially adapted medication-free therapy, are provided. OST is provided by specialised HSE outpatient treatment clinics, by satellite clinics and through specialised general practitioners in the community, as well as in prisons.



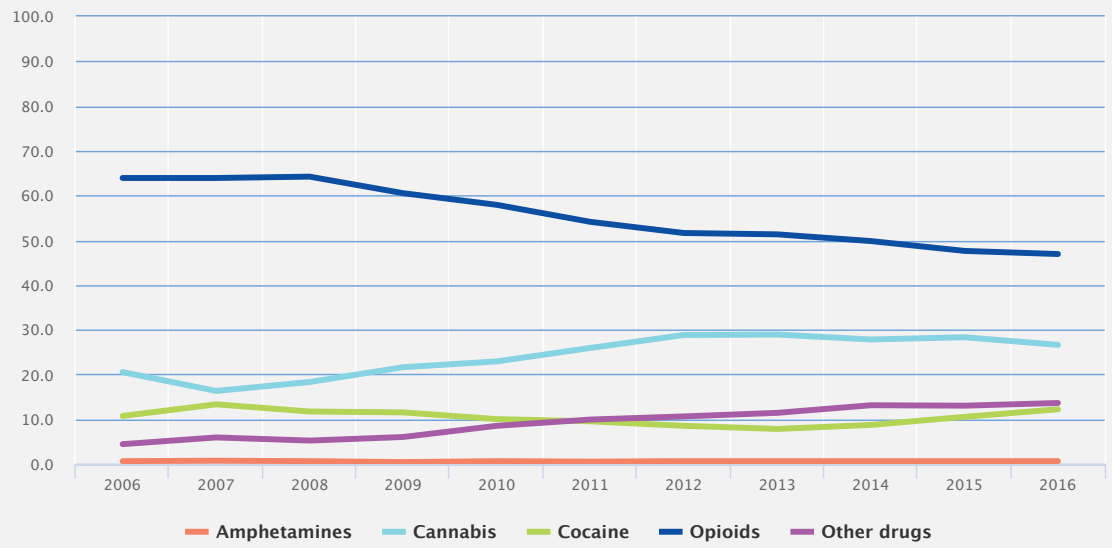
Treatment provision

In 2016, 8 954 clients entered drug treatment, 3 516 of them for the first time. Most clients entered treatment through outpatient settings.

Primary opioid users remain the largest group entering treatment in Ireland; however, as a proportion of all treatment entrants, their number has been steadily decreasing over the last few years. In contrast, the proportion of primary cannabis clients entering treatment rose between 2007 and 2013, while a decrease was observed between 2015 and 2016. In recent years, an increase in the proportion of clients entering treatment for the use of hypnotics and sedatives, mainly benzodiazepines (classified as ‘other drugs’), and cocaine has been also reported.

On 31 December 2016, 10 087 clients were receiving OST. The number of clients receiving OST has increased year on year since 2006 (apart from in 2011). Although the proportion of younger clients in OST has decreased since 2010, the proportion of clients aged 45 years or older has increased steadily.

Trends in percentage of clients entering specialised drug treatment, by primary drug, in Ireland

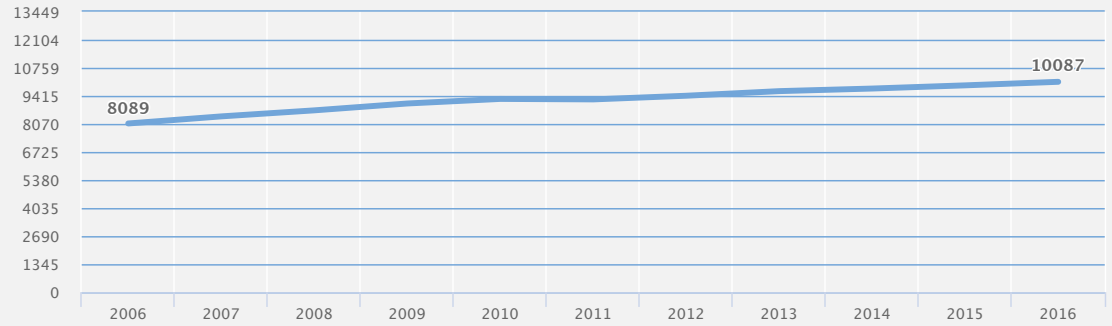


NB: Year of data 2016.

Opioid substitution treatment in Ireland: proportions of clients in OST by medication and trends of the total number of clients

Methadone, **100 %**

Trends in the number of clients in OST



NB: Year of data 2016. Numbers in treatment on the 31st December.

Drug use and responses in prison

The Irish Prison Service (IPS), which manages the prison system in the country, operates as an executive agency under the responsibility of the Ministry of Justice, Equality and Defence. It also cooperates with the Probation Service in reducing offending and improving rehabilitative outcomes.

In Ireland, prisoners are entitled to receive the same care as that available in the community. The three-year strategic plan 2016-18 committed the IPS to providing prisoners with access to the same quality and range of healthcare services available to people entitled to General Medical Scheme (GMS) health services in the community.

The latest studies conducted on drug use and drug-related problems in Irish prisons date back to 2008. A 2016 independent review of alcohol and drug treatment services for adult offenders in the community highlighted a number of recent changes in the characteristics of the drug-using prison population in Ireland, which include (i) a decline in opiate-based dependencies and an increase in dependencies linked to benzodiazepine, new psychoactive substances, opiate-based analgesics and other narcotics use, as well as polydrug use; (ii) an increasing number of offenders presenting with comorbidities, most notably mental illness combined with drug and/or alcohol dependency; (iii) the ready availability of drugs within the prison system; (iv) the presence of younger people with complex needs, for example drug dependency combined with a chaotic personal lifestyle, homelessness, mental health issues, poor literacy and communication skills deficits; (v) a cohort of offenders moving in and out of the criminal system repeatedly, posing significant challenges to effective treatment; (vi) the greater likelihood that female offenders will be chaotic substance users than their male counterparts.

Six community-based organisations provide services in prisons. The drug-related interventions available in Irish prisons include structured assessments, individual counselling, therapeutic group work, harm reduction interventions, multidisciplinary care and release-planning interventions. Drug treatment modalities include brief interventions, motivational interviewing and motivational enhancement therapy, such as the 12-step facilitation programme. The Medical Unit in Mountjoy Prison has 18 beds specifically allocated for an eight-week drug-free programme. Opioid substitution treatment is available in prison, both for maintenance and detoxification. Methadone maintenance treatment (MMT) is available in 11 of the 14 prisons. Between 2009 and 2016, more than 6 000 prisoners received drug treatment, which was mainly for opioid use. MMT was the most common treatment provided.

A 2010 study estimated that the prevalence of HIV infection among prisoners was 6 % and that the prevalence of hepatitis C virus infection was 41.5 %. Counselling services have been provided by agencies providing services to people who inject drugs. Vaccination against hepatitis B virus infection is recommended for several high-risk groups, including prisoners.

Quality assurance

One of the goals of the national drug strategy, ‘Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017-2025’, launched in 2017, is timely access to appropriate support, treatment and rehabilitation services relevant to the needs and circumstances of the person. The strategy tasks the Health Service Executive with further strengthening the implementation of the National Drug Rehabilitation Framework, to increase the quality and safety of care in the delivery of opioid substitution treatment and to improve outcomes for people with comorbid severe mental illness and substance use problems.

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using health and social care services in Ireland. In 2012, HIQA launched the National Standards for Safer Better Healthcare (NSSBHC), describing a vision for high-quality, safe healthcare and providing a framework for services to organise, manage and deliver safe and sustainable healthcare consistently. Such healthcare services place clients at the centre of all that they do while delivering care that is safe, effective and promotes better health. The NSSBHC also describe capacity and capability factors that service providers will need to support them in implementing these standards.

There are 45 standards in total, which aim to create a shared understanding of high-quality, safe and reliable healthcare among the public, service users and service providers. The 2012 NSSBHC provide an underpinning framework for continuous improvement in the quality and safety of healthcare services. For addiction services, the Quality in Alcohol and Drug Services organisational standards manual provides a set of quality standards. The manual is intended as both a guide and a review tool and is embedded within the NSSBHC; it aims to assist drug and alcohol services in the community and voluntary sector in the development of quality standards for their services. The organisational standards may also be useful to other organisations working with addiction services, such as commissioners.

The Irish College of General Practitioners is responsible for the training, accreditation and auditing of specialised general practitioners who provide methadone.

Drug-related research

Goal 5 of the new strategy, ‘Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017–2025’, is ‘to develop sound and comprehensive evidence-informed policies and actions’.

There are no objectives under this goal but its actions include (i) ‘to strengthen Ireland’s drug monitoring system’, (ii) ‘to strengthen the National Drug Treatment Reporting System by requiring all publicly funded drug and alcohol services to complete the NDTRS’; and (iii) ‘to improve knowledge of rehabilitation outcomes by undertaking a study on outcomes that takes into account the experiences of service users and their families’.

The Drugs Policy Unit (DPU), Department of Health, will be responsible for analysing the implications of research findings for policy and designing initiatives to tackle the drug problem. The DPU will provide the National Oversight Committee with advice on the commissioning of new research and the development of new data sources, having regard to current information and research deficits and advice, as well as changing patterns of drug use and emerging trends. The Health Research Board (HRB) will manage the commissioning of any research that the national committee decides needs to be undertaken to address gaps in its knowledge.

Under the new strategy, the HRB will continue to monitor the drug situation and responses for national and international purposes using EMCDDA protocols and existing data collection systems, while ensuring that Ireland can respond to new data monitoring requests arising from the National Oversight Committee and the EU. The HRB, which has managed two EMCDDA indicators, demand for drug treatment and drug-related deaths, has responsibility for two additional indicators under the new strategy. These additional indicators are prevalence and patterns of drug use among the general population, and prevalence and patterns of problem drug use.

The HRB National Drugs Library online repository contains more than 12 000 reports, articles, systematic reviews, accounts of parliamentary debates and other items. The library publishes factsheets based on data collected by the national focal point. The library also produces a series of rapid reviews in consultation with policymakers and stakeholders in the community and voluntary sectors.

Drug markets

In 2014, the first comprehensive study of illicit drug markets in Ireland was published by the National Advisory Committee on Drugs and Alcohol and the Health Research Board. This study examined the nature and organisation of Irish drug markets and analysed the different factors that influence their development, as well as the impact of law enforcement interventions. Typically, illicit drugs are trafficked into Ireland by sea (in freight transported by ferry) or by air through Dublin Airport, and they are sometimes intended for transit to the United Kingdom or other EU countries. A number of products have been intercepted in the postal system in controlled deliveries.

Crime and threat reports indicate that most of the cannabis seized in Ireland originates from Morocco; synthetic drugs are produced in the Netherlands; and heroin, originating in Afghanistan, travels to Ireland via the Balkan route. Based on police data and information, the cultivation of domestic cannabis has recently been increasing. Cannabis grow houses are generally operated by foreign national organised crime groups, which also employ foreign nationals to work as gardeners. Although synthetic drug production is generally not carried out in Ireland, evidence of small-scale production of synthetic stimulants has been reported. China is believed to be the main source of new psychoactive substances (NPS).

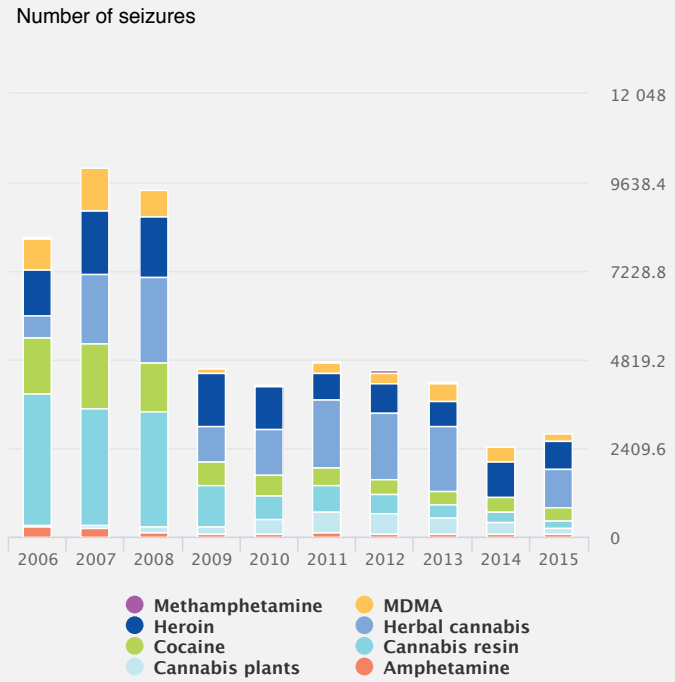
There is no large scale tableting in Ireland; however, some evidence suggests that Irish organised crime groups have participated in the tableting of pharmaceutical drugs; for example, benzodiazepines and other ‘Z-drugs’ are reportedly obtained in powder form, which is then tableted using specialised equipment.

Overall, between 2007 and 2015, a decline in the number of illicit drug seizures has been reported in Ireland. This mirrors a decrease in the number of seizures of cannabis products, which remain, however, the most commonly seized type of drug. Since 2007, the number of cocaine seizures has decreased each year. Similar reductions were evident for heroin seizures, except for two periods, between 2011 and 2012, when there was a slight increase in the number of seizures, and between 2013 and 2014, when an increase was again reported. Seizures of MDMA-type substances also decreased considerably between 2008 and 2010, followed by a period of increase between 2011 and 2013 and a reduction in the number of seizures in 2014. In recent years, following legislative changes, the number of seizures of NPS in Ireland has increased. No data was available for 2016.

The main priorities in relation to supply reduction in Ireland are drug interdiction, tackling organised crime, enhancing community policing and reducing reoffending. The new national drug strategy, focusing on building safer and more resilient communities, recognises the need to address drug-related debt intimidation at a community level. The achievement of these goals will involve the participation of a wide network of law enforcement agencies representing An Garda Síochána (Garda National Drugs and Organised Crime Bureau), the Revenue Commissioners, the Health Products Regulatory Authority, the Naval Service, the Criminal Assets Bureau and relevant community-level partners.

Ireland reports average prices for the main illicit drugs. The mean retail price of cannabis resin in 2016 was EUR 6/g; herbal cannabis, EUR 20/g; amphetamine EUR 15/g; cocaine, EUR 70/g; and heroin, EUR 140/g.

Drug seizures in Ireland: trends in number of seizures



Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	18.9	6.5	36.8
Last year prevalence of use - young adults (%)	2015	13.8	0.4	21.5
Last year prevalence of drug use - all adults (%)	2015	7.7	0.3	11.1
All treatment entrants (%)	2016	26.6	1.0	69.6
First-time treatment entrants (%)	2016	41.2	2.3	77.9
Quantity of herbal cannabis seized (kg)	n.a.	n.a.	12	110855
Number of herbal cannabis seizures	2016	n.a.	62	158810
Quantity of cannabis resin seized (kg)	n.a.	n.a.	0	324379
Number of cannabis resin seizures	2016	192	8	169538
Potency - herbal (% THC) (minimum and maximum values registered)	2016	n.a.	0	59.90
Potency - resin (% THC) (minimum and maximum values registered)	2016	n.a.	0	70.00
Price per gram - herbal (EUR) (minimum and maximum values registered)	2016	n.a.	0.60	111.10
Price per gram - resin (EUR) (minimum and maximum values registered)	2016	n.a.	0.20	38.00
Cocaine				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	2.1	0.9	4.9
Last year prevalence of use - young adults (%)	2015	2.9	0.2	4.0
Last year prevalence of drug use - all adults (%)	2015	1.5	0.1	2.3
All treatment entrants (%)	2016	12.2	0.0	36.6
First-time treatment entrants (%)	2016	16.1	0.0	35.5
Quantity of cocaine seized (kg)	n.a.	n.a.	1.00	30295
Number of cocaine seizures	2016	364	19	41531
Purity (%) (minimum and maximum values registered)	2016	n.a.	0	99.00
Price per gram (EUR) (minimum and maximum values registered)	2016	n.a.	3.00	303.00
Amphetamines				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	1.9	0.8	6.5
Last year prevalence of use - young adults (%)	2015	0.6	0.0	3.6
Last year prevalence of drug use - all adults (%)	2015	0.3	0.0	1.7
All treatment entrants (%)	2016	0.61	0.2	69.7
First-time treatment entrants (%)	2016	0.7	0.3	75.1
Quantity of amphetamine seized (kg)	n.a.	n.a.	0	3380
Number of amphetamine seizures	2016	63	3	10388
Purity - amphetamine (%) (minimum and maximum values registered)	2016	n.a.	0	100.00
Price per gram - amphetamine (EUR) (minimum and maximum values registered)	2016	n.a.	2.50	76.00
MDMA				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	3.1	0.5	5.2
Last year prevalence of use - young adults (%)	2015	4.4	0.1	7.4
Last year prevalence of drug use - all adults (%)	2015	2.1	0.1	3.6
All treatment entrants (%)	2016	0.6	0.0	1.8
First-time treatment entrants (%)	2016	1.1	0.0	1.8
Quantity of MDMA seized (tablets)	n.a.	n.a.	0	3783737
Number of MDMA seizures	2016	204	16	5259
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2016	n.a.	1.90	462.00
Purity (MDMA % per tablet) (minimum and maximum values registered)	2016	n.a.	0	88.30
Price per tablet (EUR) (minimum and maximum values registered)	2016	n.a.	1.00	26.00
Opioids				
High-risk opioid use (rate/1 000)	2014	6.1	0.3	8.1
All treatment entrants (%)	2016	46.9	4.8	93.4
First-time treatment entrants (%)	2016	26.9	1.6	87.4
Quantity of heroin seized (kg)	n.a.	n.a.	0	5585
Number of heroin seizures	2016	758	2	10620

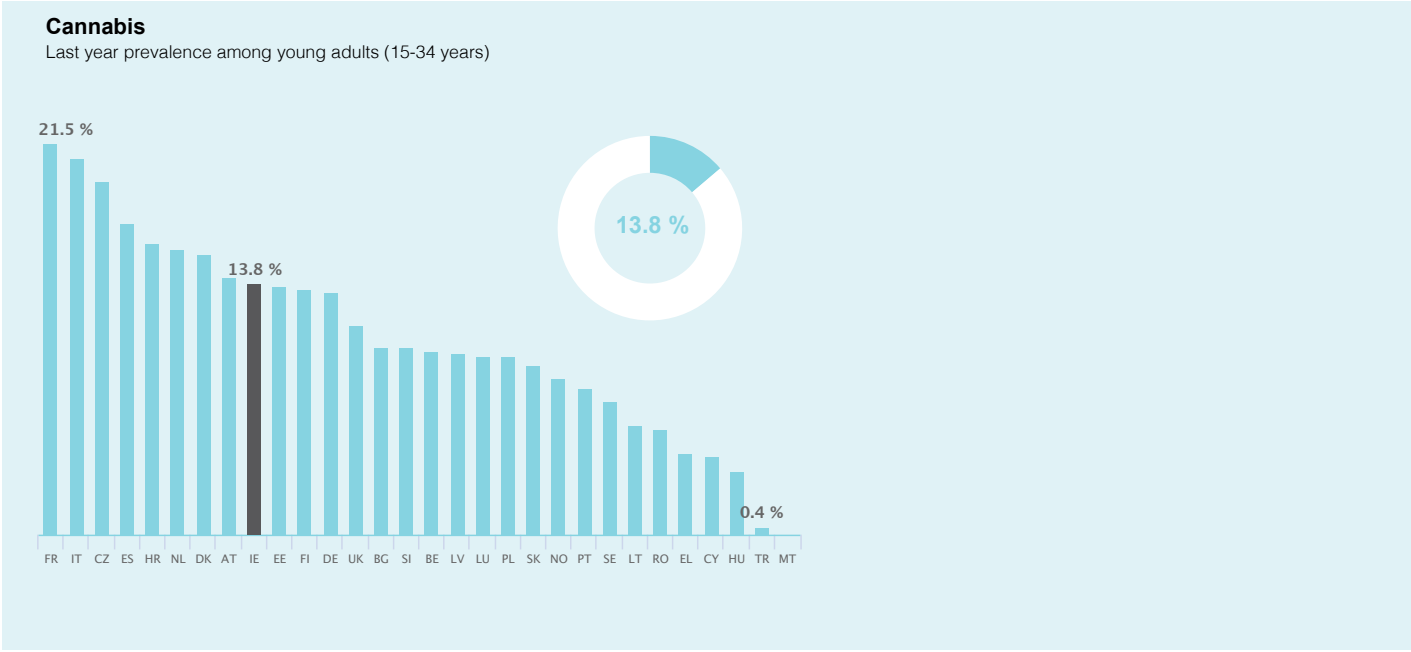
Purity - heroin (%) (minimum and maximum values registered)	2016	n.a.	0	92.00
Price per gram - heroin (EUR) (minimum and maximum values registered)	2016	n.a.	4.00	296.00
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC)	2016	4.4	0.0	33.0
HIV prevalence among PWID* (%)	2010	6	0.0	31.5
HCV prevalence among PWID* (%)	2010	41.5	14.6	82.2
Injecting drug use -- aged 15-64 (cases rate/1 000 population)	n.a.	n.a.	0.1	9.2
Drug-induced deaths -- aged 15-64 (cases/million population)	2015	70.2	1.4	132.3
Health and social responses				
Syringes distributed through specialised programmes	n.a.	n.a.	22	6469441
Clients in substitution treatment	2016	10087	229	169750
Treatment demand				
All entrants	2016	8954	265	119973
First-time entrants	2016	3516	47	39059
All clients in treatment	2016	10087	1286	243000
Drug law offences				
Number of reports of offences	2016	16119	775	405348
Offences for use/possession	2016	11486	354	392900

* PWID — People who inject drugs.

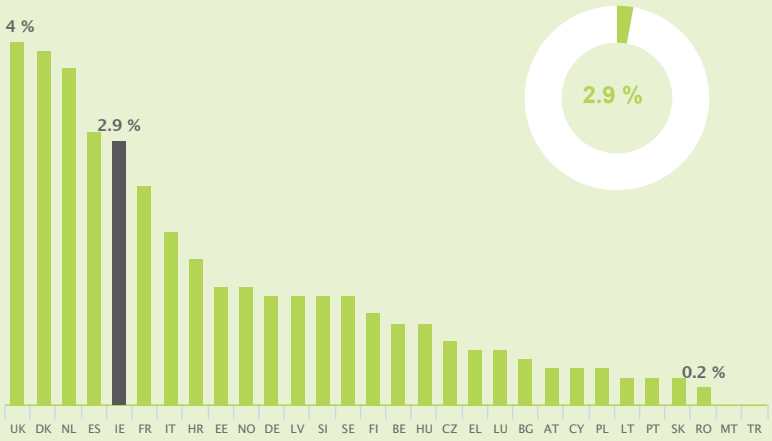
279 154 syringes were distributed in 2016 by pharmacy-based sites in Ireland (not including Dublin)

EU Dashboard

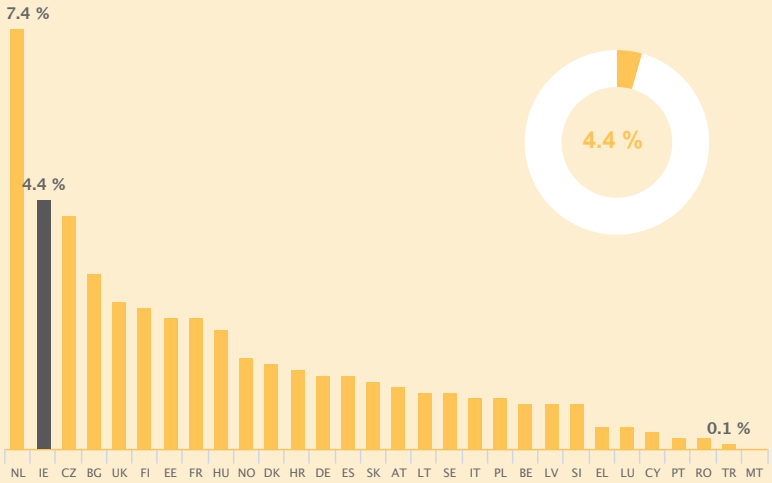
EU Dashboard



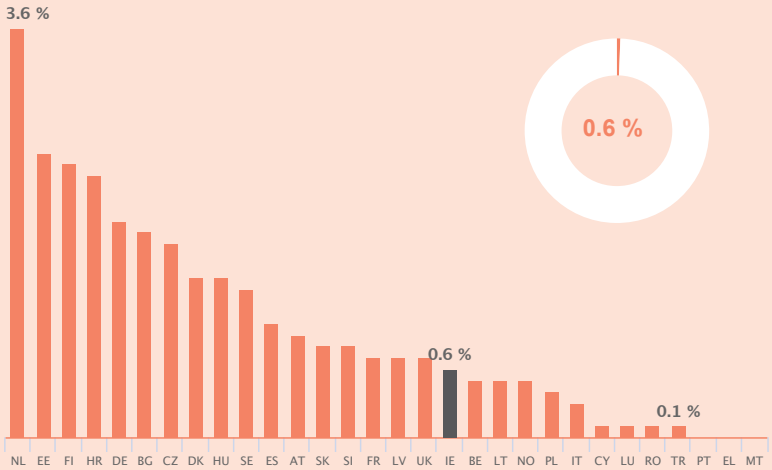
Cocaine
Last year prevalence among young adults (15-34 years)



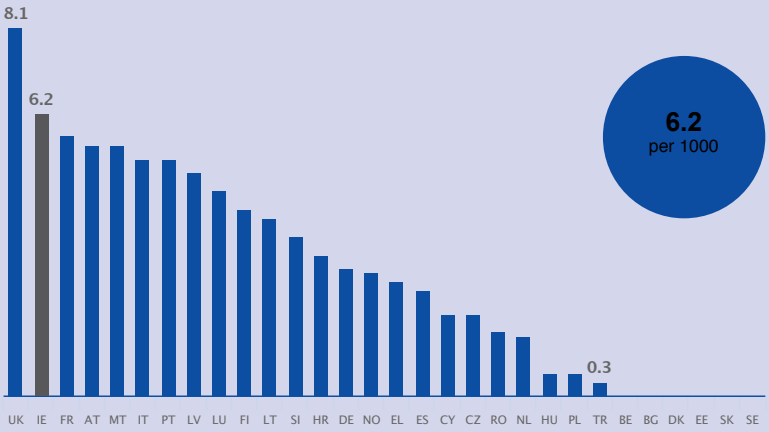
MDMA
Last year prevalence among young adults (15-34 years)



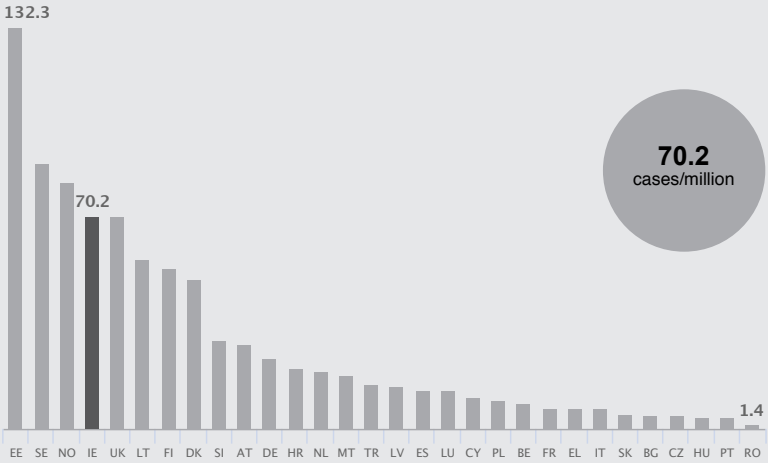
Amphetamines
Last year prevalence among young adults (15-34 years)



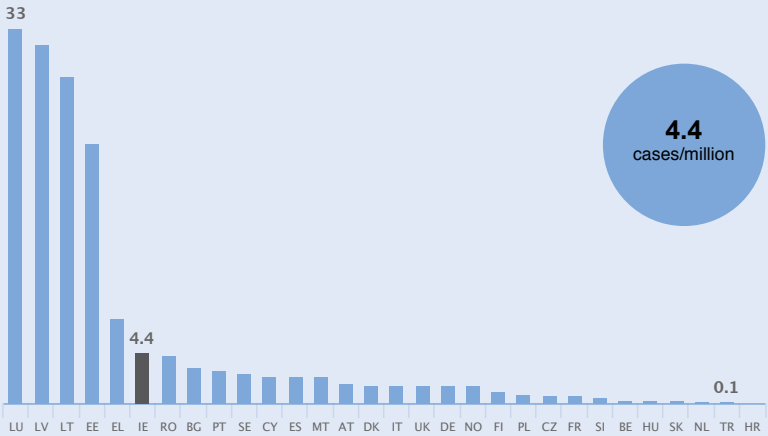
Opioids
High-risk opioid use (rate/1 000)

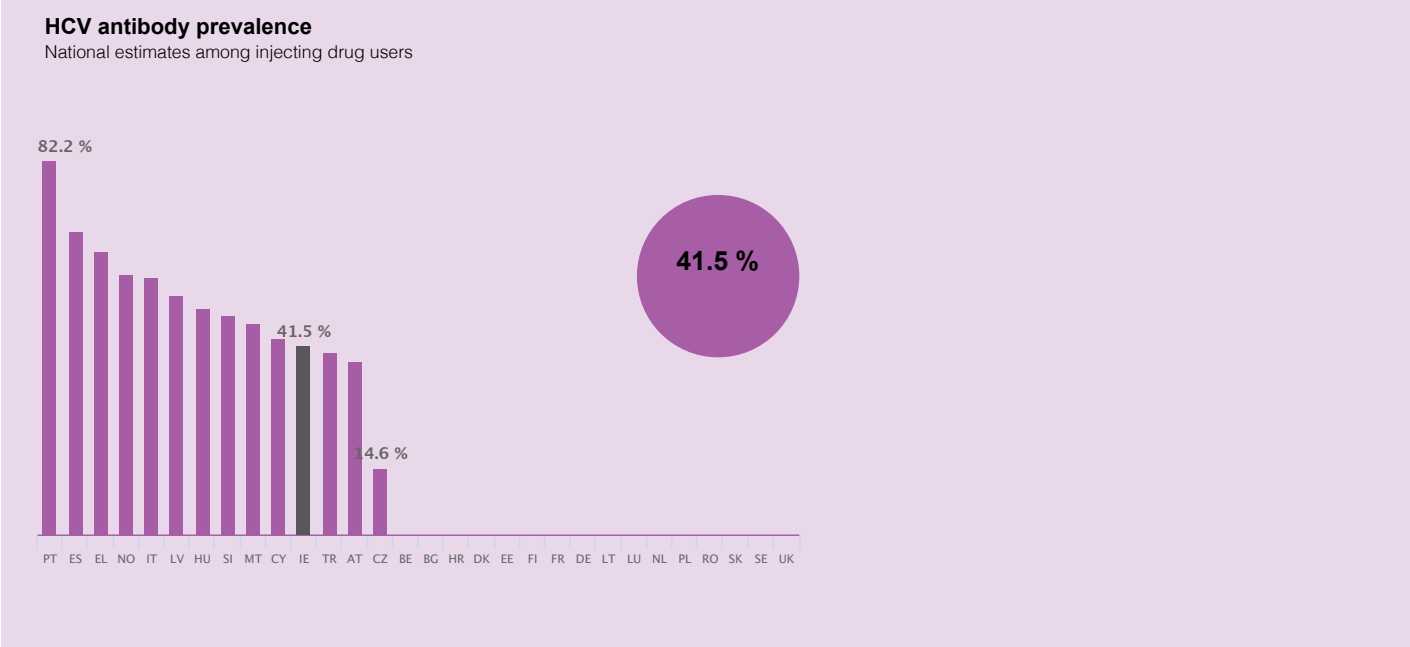


Drug-induced mortality rates
National estimates among adults (15-64 years)



HIV infections
Newly diagnosed cases attributed to injecting drug use





NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, di?erences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

About our partner in Ireland

The Irish national focal point is located in the Health Research Board (HRB). The HRB is a statutory body with a mission to improve health through research and information. The HRB is responsible for promoting, commissioning and conducting medical, epidemiological and health services research in Ireland. Within the HRB, a multidisciplinary team of researchers and information specialists work to provide objective, reliable and comparable information on the drug situation and its consequences and responses in Ireland. The HRB disseminates research findings, information and news in the drugs area through its Trends series, through the HRB National Drugs Library and through a quarterly research and policy bulletin, Drugnet Ireland. Through its research and dissemination activities, the HRB aims to inform policy and practice in relation to drug misuse.

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