Drug Misuse Research Division

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Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002

Contents

Introduction

The overall aim of the Irish National Alcohol Policy, launched in 1996, is to reduce the level of alcohol-related problems and to promote moderation for those who wish to drink (Health Promotion Unit 1996). Between 1989 and 2000, the per capita consumption of alcohol increased by 46 per cent, from 7.6 litres in 1989 to 11.1 litres in 2000. Ireland had the largest increase among countries in the European Union (Strategic Task Force on Alcohol 2002). The actual per capita consumption is ranked second after Luxemburg. Over the last 30 years, there was a steady increase in the incidence of deaths from conditions associated with problem alcohol use in this country. Ramstedt and Hope (2003) examined the adverse health, social and psychological effects experienced by individuals following high alcohol consumption in Ireland compared to six other European countries. Irish male respondents reported social harms associated with alcohol consumption that were higher than their European counterparts. The social harm related to alcohol consumption included negative effects on studies, home-life, and maintaining friendships. For example, 12.4 per cent of Irish men reported that alcohol consumption had affected their work or studies, compared to 4.7 per cent of European men. According to the Strategic Task Force on Alcohol Interim Report (2002), the cost of alcohol-related problems was 2.4 billion euro or 1.7 per cent of gross domestic product (GDP) in 1999. The costs included were healthcare, road accidents, alcohol-related crime and lost productivity. The healthcare cost was 220 million euro.

Alcohol-related disorders were ranked as the third most common reason for admission to Irish psychiatric hospitals in 2002 (Daly and Walsh 2003). In 2002, of all psychiatric hospital admissions, 17 per cent (1,447) were for alcohol-related disorders. Irish policy on the treatment of problem alcohol and drug use (since 1984) stipulated that the emphasis in the management of alcohol and drug-related problems should be on community-based intervention, rather than on specialist inpatient treatment (Study Group on the Development of Psychiatric Services 1984); therefore it can be assumed that alcohol-related admissions to psychiatric hospitals represent a small proportion of the overall number of individuals treated for problem alcohol use.

This study presents the numbers of individuals that sought treatment for problem alcohol use and their characteristics in the South Eastern and Southern Health Board areas from 2000 to 2002. It quantifies the substantial number of persons that were demanding treatment for problem alcohol use in community and special residential settings situated in both health board areas. The analysis of the data allows us to describe the public health importance of problem alcohol use.

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Methods

National Drug Treatment Reporting System

The National Drug Treatment Reporting System is an epidemiological database on treated drug misuse in Ireland. It was established in 1990 in the Greater Dublin Area and was extended in 1995 to cover other areas of the country. The reporting system was originally developed in line with the Pompidou Group's Definitive Protocol (Hartnoll 1994) and subsequently refined in accordance with the Treatment Demand Indicator Protocol (EMCDDA and Pompidou Group 2000). The National Drug Treatment Reporting System is co-ordinated by staff at the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children.

Compliance with the National Drug Treatment Reporting System requires that one form be completed for each person who receives treatment for problematic drug use at each treatment centre in a calendar year. Service providers at drug treatment centres throughout Ireland collect data on each individual treated for drug misuse. At national level, staff at the Drug Misuse Research Division of the Health Research Board compile anonymous, aggregated data.

For the purpose of the National Drug Treatment Reporting System, *treatment* is broadly defined as 'any activity that aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems'. Clients who attend needle-exchange services are not included in this reporting system and, until 2004, clients who reported alcohol as their main problem drug were not included. Treatment is provided in both residential and non-residential settings.

The main elements of the reporting system are:

- *All cases treated* – describes individuals who receive treatment for problematic drug use at each treatment centre in a calendar year;
    a. *Previously treated cases* – describes persons who were treated previously for problematic drug use at any treatment centre and have returned to treatment in the reporting year, and also those individuals continuing in treatment from the preceding calendar year;
    b. *New cases treated* – describes the individuals who have never been treated previously for problem drug use.

In the case of the data for 'previously treated cases' there is a possibility of duplication in the database, for example, where a person receives treatment at more than one centre.

Study methods

Since the inception of the National Drug Treatment Reporting System, persons seeking treatment for alcohol as their main problem drug have been excluded from this reporting system. Staff working in three health board areas (namely, the Southern Health Board, the South Eastern Health Board and the Mid Western Health Board) have collected data on alcohol as the main problem drug, using the National Drug Treatment Reporting System form. They also enter and analyse the data each year. In the South Eastern Health Board, the Data Co-ordinator published an overview of substance misuse each year from 2000 to 2002 (South Eastern Health Board 2001, 2002, 2003). The data collected in the Southern Health Board and South Eastern Health Board from 2000 to 2002 are reported in this analysis. The Mid Western Health Board was not requested to provide data since they only started data collection in 2002.

In the South Eastern Health Board, data are collected from both statutory and voluntary treatment services (residential and non-residential) in the area. The number of institutions participating in the reporting system increased each year, from 16 in 2000 to 29 in 2002 (South Eastern Health Board 2001, 2002, 2003). Some of the services joining the reporting system in 2001 and 2002 were new services. With the exception of St Senan's Hospital, Enniscorthy, Co Wexford, data are not collected from the inpatient psychiatric services or the acute psychiatric departments of the general hospitals for the National Drug Treatment Reporting System (South Eastern Health Board 2001, 2002, 2003; M Kidd, personal communication, 2003). The acute hospital services submit data to the National Psychiatric In-patient Reporting System, which is managed by the Mental Health Research Division of the Health Research Board.

In the Southern Health Board, data including alcohol have been collected since 1997. Data are collected from both statutory and voluntary treatment agencies (residential and non-residential) in the area. The number of centres involved was three in 1997, and has increased to 10 centres in 2002. The centres offer a mix of residential and outpatient services. Acute psychiatric hospitals are not included in these data, since they submit data to the National Psychiatric In-Patient Reporting System managed by the Mental Health Research Division of the Health Research Board (T Jackson, personal communication, 2003).

Results

South Eastern Health Board Area

The data presented in Table 1 indicate that over 70 per cent of those treated for problem substance use in the South Eastern Health Board report alcohol as their main problem drug. There has been an increase in the numbers of cases attending the treatment services between 2000 and 2002. This may be due in part to the participation of additional reporting agencies in the reporting system (see methods).

Table 1 Numbers (%) reporting problem substance use that attended treatment in the South Eastern Health Board area, 2000 to 2002

Main problem substance	2000	2001	2002
		Number (%)	
Alcohol	1010 (71.2)	1472 (76.7)	1498 (71.5)
Drug (licit or illicit)	408 (28.8)	447 (23.3)	598 (28.5)
Total	**1418**	**1919**	**2096**

The numbers seeking treatment for problem alcohol use were stable in 2001 and 2002 (Table 2 and Figure 1). Of those reporting alcohol as their main problem drug, approximately 60 per cent had never previously been treated for problem alcohol use.

Table 2 Numbers (%) reporting problem alcohol use that attended treatment in the South Eastern Health Board area, 2000 to 2002

Alcohol is main problem drug	2000	2001	2002
		Number (%)	
Newly treated cases	634 (62.8)	846 (57.5)	842 (56.2)
Previously treated cases	352 (34.9)	604 (41.0)	638 (42.6)
Treatment status not known	24 (2.4)	22 (1.5)	18 (1.2)
Total	**1010**	**1472**	**1498**

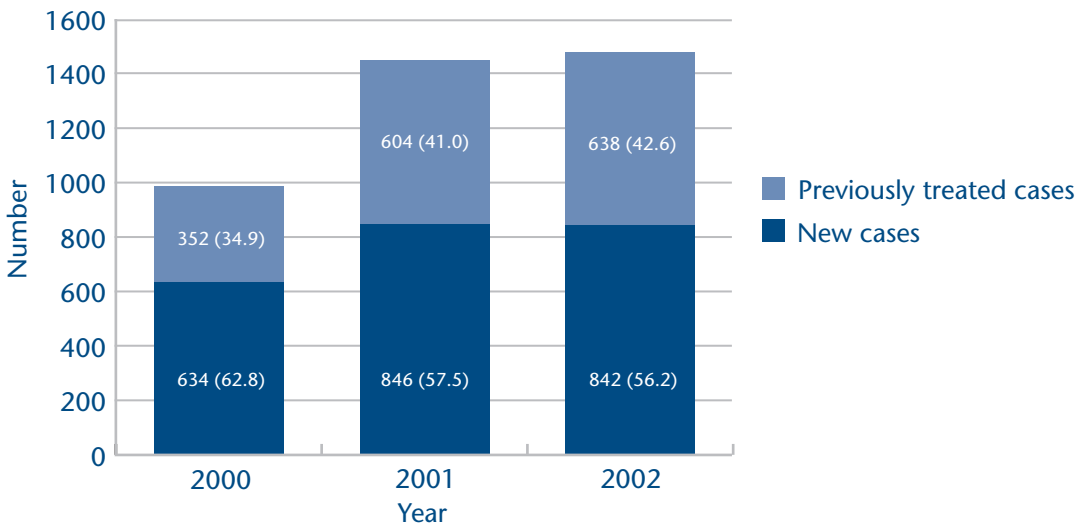

Figure 1 Numbers (%) reporting problem alcohol use, by treatment status, that attended treatment in the South Eastern Health Board area, 2000 to 2002

Table 3 and Figure 2 present a comparison between the socio-economic and demographic characteristics of new cases and previously treated cases reporting alcohol as their main problem drug in the South Eastern Health

Board area. As expected, new cases were younger than their previously treated counterparts. On average, similar proportions of new cases and previously treated cases were male. The proportion of new female cases increased by almost four per cent between 2000 and 2002 in the South Eastern Health Board area and may reflect a small increase in problem alcohol use among women. A higher proportion of new cases were employed at the time they sought treatment than their previously treated counterparts. This suggests that prolonged problem alcohol use may lead to loss of employment, or alternatively, the factors (low self esteem and inadequate problem solving skills) associated with failed treatment are similar to those associated with failure to secure or retain employment. Of note, a slightly lower proportion of new cases reported that they had left school early than did their previously treated counterparts. This is difficult to interpret and may indicate that those with fewer prospects may be more likely to develop chronic problem alcohol use than their more privileged counterparts.

Table 3 Demographic and socio-economic characteristics of those who reported alcohol as their main problem drug and attended treatment in the South Eastern Health Board area, 2000 to 2002

	2000	2001 Number (%)*	2002
Alcohol is main problem drug	**1010**	**1472**	**1498**
Median age (range 5th and 95th percentile) in years of cases			
All	45 (19-73)	43 (18-70)	45 (17-73)
New	44 (19-71)	43 (18-69)	40 (17-67)
Previously treated	43 (19-68)	43 (20-70)	44 (19-73)
Cases under 18 years old			
All	23 (2.3)	83 (5.6)	78 (5.2)
New	18 (2.8)	72 (8.5)	68 (8.1)
Previously treated	5 (1.4)	8 (1.3)	9 (1.4)
Treatment status not known	0	3	1
Male cases			
All	762 (75.4)	1094 (74.3)	1075 (71.8)
New	494 (77.9)	648 (76.6)	623 (74.0)
Previously treated	251 (71.3)	431 (71.4)	437 (68.5)
Treatment status not known	17	15	15
Cases left school early†			
All	156 (15.4)	261 (17.7)	240 (16.0)
New	93 (14.7)	126 (14.9)	112 (13.3)
Previously treated	63 (17.9)	132 (21.9)	125 (19.6)
Treatment status not known	0	3	3
Cases employed			
All	454 (45.0)	617 (41.9)	603 (40.3)
New	342 (53.9)	412 (48.7)	407 (48.3)
Previously treated	102 (29.0)	205 (33.9)	196 (30.7)
Treatment status not known	10	0	0

*Percentages based on valid cases
† Less than 15 years old

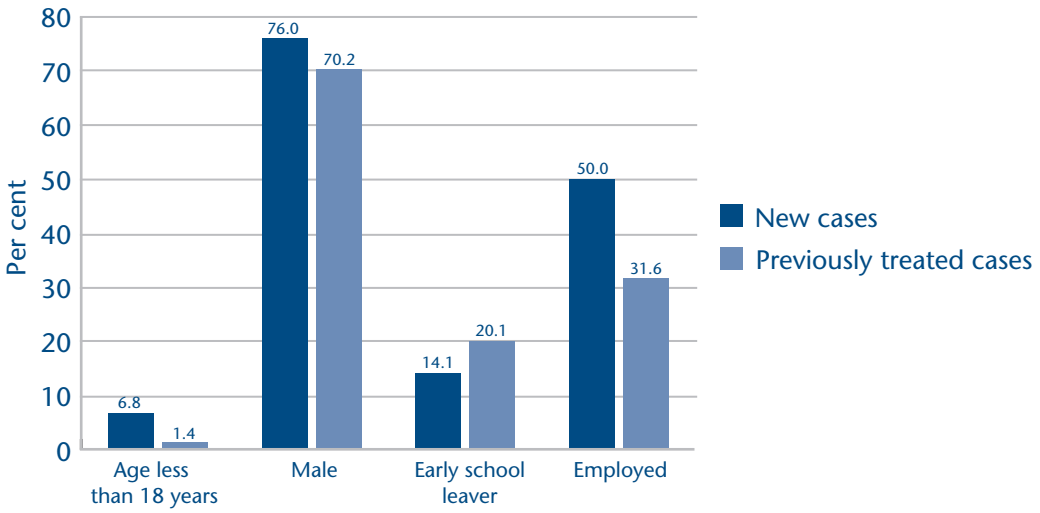

Figure 2 Socio-economic and demographic characteristics of those who reported alcohol as their main problem drug, by treatment status, and attended treatment in the South Eastern Health Board area, for combined years 2000 to 2002

Figure 3 presents the average annual incidence of treatment seeking for problem alcohol use per 10,000 of the county population within the South Eastern Health Board area between 2000 and 2002. Carlow had the highest incidence of treatment seeking for problem alcohol use while Wexford had the lowest incidence. Kilkenny, South Tipperary and Waterford had similar incidence rates. This may reflect different operational policies and different counsellor employment levels in each of the community care areas or it may be a true difference. The low incidence in Wexford could be due in part to the fact that there were fewer counsellors employed in this county compared with the others. Currently, however, all counsellor vacancies have been filled in Wexford. The boundaries for community care areas in the South Eastern Health Board area are the same as the county boundaries, with the exception of Carlow and Kilkenny, which, combined, form a community care area. The high incidence in County Carlow may be due to the fact that an Alcohol Awareness Programme is run on a regular basis. These programmes are provided for persons referred through the courts and probation services. A similar alcohol awareness programme is provided in Kilkenny. The association between problem alcohol use and deprivation will need to be examined in a later paper.

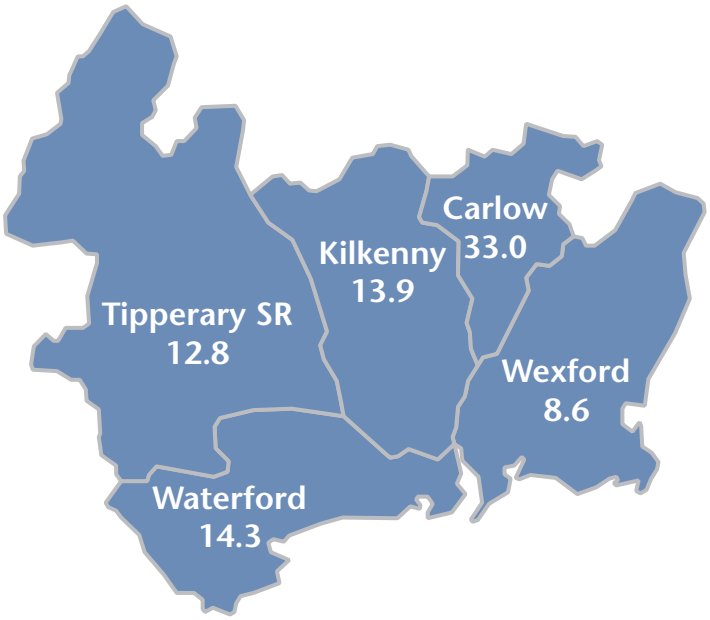

Figure 3 Average annual incidence of treatment seeking for problem alcohol use per 10,000 of the county population within the South Eastern Health Board area, 2000 to 2002 (Numerators, Central Statistics Office 2003)

In 2001 and 2002, of those reporting alcohol as their main problem drug, approximately one in every five reported using at least one other substance (Table 4). Interestingly, in 2001 and 2002, a higher proportion of new cases reported polysubstance use than did their previously treated counterparts. Table 4 and Figure 4 present the spectrum of substances used alongside alcohol. New cases were more likely to use cannabis than their previously treated counterparts. Previously treated cases were more likely to use benzodiazepines than their newly treated counterparts.

Table 4 Characteristics relating to drug use for those who reported alcohol as their main problem drug and attended treatment in the South Eastern Health Board area, 2000 to 2002

	2000	2001 Number (%)*	2002
Cases where alcohol is main problem drug			
All	1010 (100.0)	1472 (100.0)	1498 (100.0)
New	634 (62.8)	846 (57.5)	842 (56.2)
Previously treated	352 (34.9)	604 (41.0)	638 (42.6)
Treatment status not known	24	22	18
Cases used more than one substance			
All	145 (14.4)	322 (21.9)	318 (21.2)
New	75 (11.8)	210 (24.8)	196 (23.3)
Previously treated	68 (19.3)	108 (17.9)	113 (17.7)
Treatment status not known	2	4	9
Second drug used			
New cases	**75**	**210**	**196**
Cannabis	44 (58.7)	170 (81.0)	146 (74.5)
Ecstasy	18 (24.0)	15 (7.1)	30 (15.3)
Benzodiazepines	4 (5.3)	7 (3.3)	5 (2.6)
Amphetamines	3 (4.0)	2 (1.0)	5 (2.6)
Opiates	1 (1.3)	3 (1.4)	2 (1.0)
Cocaine	1 (1.3)	8 (3.8)	2 (1.0)
Volatile Inhalants	0 (0.0)	0 (0.0)	1 (0.5)
Other substances	4 (5.3)	5 (2.4)	5 (2.6)
Previously treated cases	**68**	**108**	**113**
Cannabis	33 (48.5)	74 (68.5)	74 (65.5)
Benzodiazepines	15 (22.1)	10 (9.3)	12 (10.6)
Ecstasy	10 (14.7)	10 (9.3)	13 (11.5)
Opiates	2 (2.9)	4 (3.7)	2 (1.8)
Cocaine	2 (2.9)	2 (1.9)	3 (2.7)
Amphetamines	0 (0.0)	6 (5.6)	5 (4.4)
Volatile Inhalants	0 (0.0)	0 (0.0)	0 (0.0)
Other substances	6 (8.8)	2 (1.9)	4 (3.5)

*Percentages based on valid cases

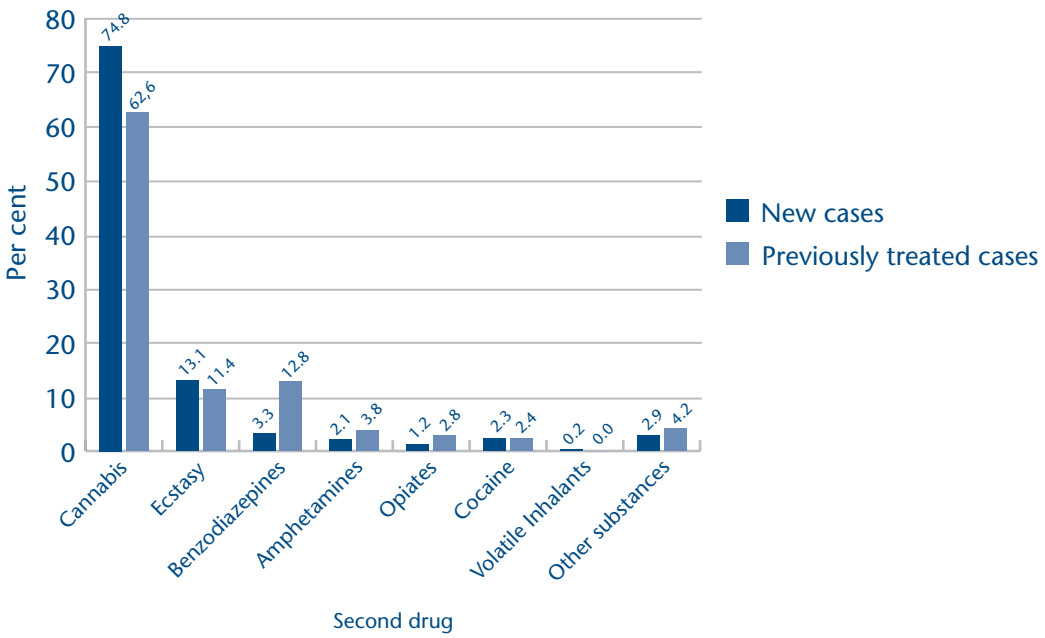

Figure 4 Reported second drug used among those who reported alcohol as their main problem drug, by treatment status, and attended treatment in the South Eastern Health Board area, 2000 to 2002

Southern Health Board Area

The data presented in Table 5 indicate that over 60 per cent of those treated for problem substance use in the Southern Health Board reported alcohol as their main problem drug. These data include information from cases attending both statutory and voluntary treatment services in the Southern Health Board area. Between 2000 and 2002, there was a steady increase in the numbers of cases attending the treatment services. This is mainly due to an increase in both the numbers of centres and numbers of staff working in these centres in recent years.

Table 5 Numbers (%) reporting problem substance use that attended treatment in the Southern Health Board area, 2000 to 2002

Main problem substance	2000	2001	2002
		Number (%)	
Alcohol	719 (67.3)	852 (61.0)	1160 (64.2)
Drug (licit or illicit)	349 (32.7)	544 (39.0)	647 (35.8)
Total	**1068**	**1396**	**1807**

The numbers seeking treatment for problem alcohol use increased over the period under review (Table 6 and Figure 5). Of those reporting alcohol as their main problem drug between 2000 and 2002, over 60 per cent were never previously treated for problem alcohol use.

Table 6 Numbers (%) reporting problem alcohol use that attended treatment in the Southern Health Board area, 2000 to 2002

Alcohol is main problem drug	2000	2001	2002
		Number (%)	
Newly treated cases	473 (65.8)	585 (68.7)	669 (57.7)
Previously treated cases	240 (33.4)	254 (29.8)	488 (42.1)
Treatment status not known	6	13	3
Total	**719**	**852**	**1160**

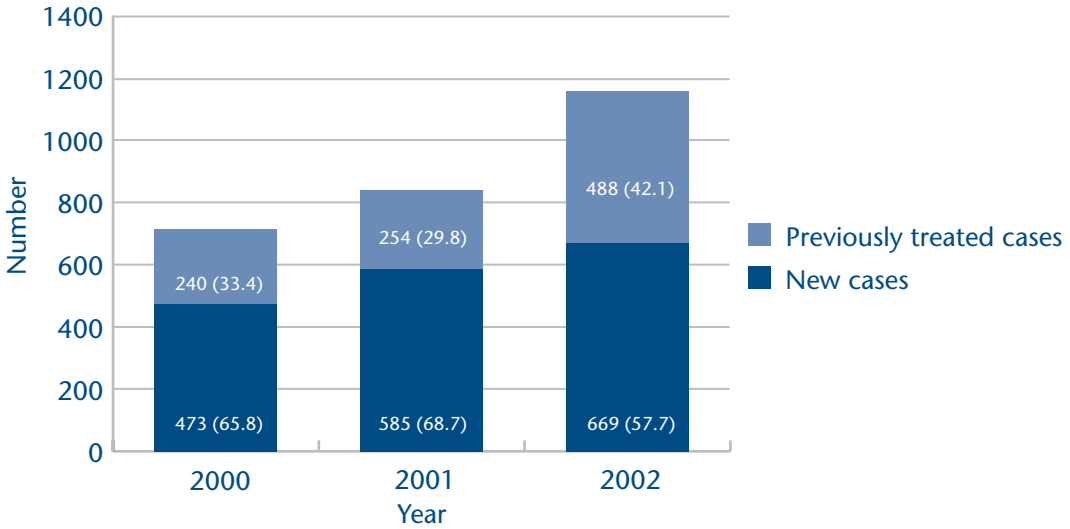

Figure 5 Numbers (%) reporting problem alcohol use, by treatment status, that attended treatment in the Southern Health Board area, 2000 to 2002

Table 7 and Figure 6 present a comparison between the socio-economic and demographic characteristics of new cases reporting alcohol as their main problem drug and previously treated cases in the Southern Health Board area. As expected, new cases were younger than their previously treated counterparts. On average, similar proportions of new cases and previously treated cases were male. The proportion of new female cases increased by seven per cent between 2000 and 2002 in the Southern Health Board area and suggests a clear increase in problem alcohol use among women. A higher proportion of new cases were employed at the time they sought treatment than their previously treated counterparts. Once again, this suggests that prolonged problem alcohol use may lead to loss of employment, or alternatively, the factors associated with failed treatment (or chronic addiction) are similar to those associated with failure to secure or retain employment. The proportion of new cases reporting that they had left school early was similar to that of their previously treated counterparts.

Table 7 Demographic and socio-economic characteristics of those who reported alcohol as their main problem drug and attended treatment in the Southern Health Board area, 2000 to 2002

	2000	2001 Number (%)*	2002
Alcohol is main problem drug	**719**	**852**	**1160**
Median age (range 5th and 95th percentile) in years of cases			
All	37 (21-58)	38 (19-57)	37 (20-58)
New	37 (20-58)	37 (19-57)	36 (19-59)
Previously treated	38 (21-58)	41 (21-58)	40 (21-57)
Cases under 18 years old			
All	8 (1.1)	22 (2.6)	24 (2.1)
New	7 (1.5)	20 (3.4)	19 (2.8)
Previously treated	1 (0.4)	1 (0.4)	4 (0.8)
Treatment status not known	0	1	1
Male cases			
All	498 (69.3)	571 (67.0)	740 (63.8)
New	338 (71.5)	397 (67.9)	432 (64.6)
Previously treated	156 (65.0)	167 (65.7)	307 (62.9)
Treatment status not known	4	7	1
Cases left school early†			
All	95 (13.2)	106 (12.4)	151 (13.0)
New	57 (12.1)	74 (12.6)	91 (13.6)
Previously treated	38 (15.8)	30 (11.8)	60 (12.3)
Treatment status not known	0	2	0
Cases employed			
All	303 (42.1)	338 (39.7)	443 (38.2)
New	228 (48.2)	246 (42.1)	275 (41.1)
Previously treated	72 (30.0)	88 (34.6)	166 (34.0)
Treatment status not known	3	4	2

*Percentages based on valid cases
† Less than 15 years old

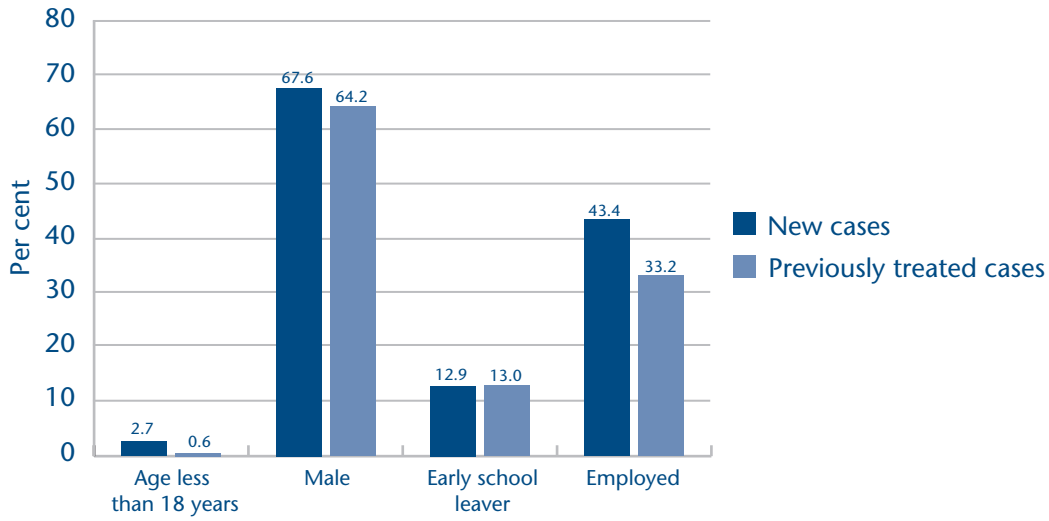

Figure 6 Socio-economic and demographic characteristics of those who reported alcohol as their main problem drug, by treatment status, and attended treatment in the Southern Health Board area, for combined years 2000 to 2002

Figure 7 presents the average annual incidence of treatment seeking for problem alcohol use per 10,000 of the county population within the Southern Health Board area reported to the addiction services between 2000 and 2002. Cork had a lower incidence rate than Kerry.

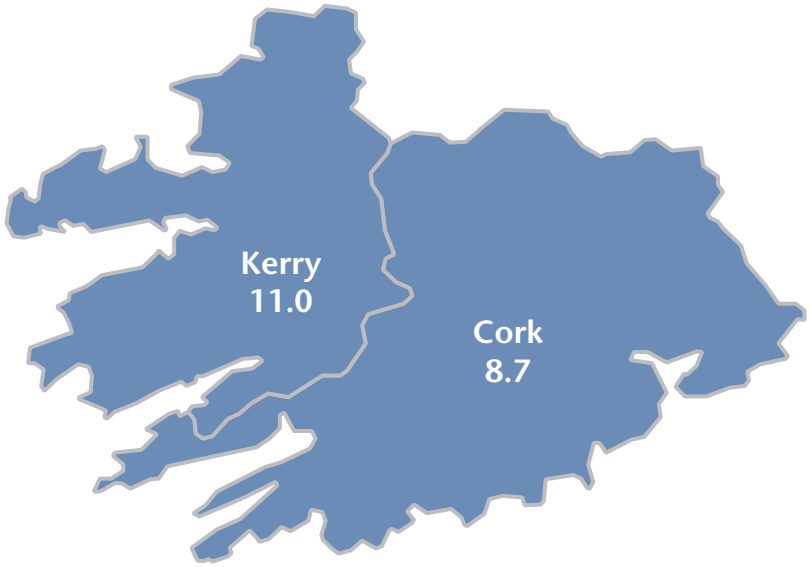

Figure 7 Average annual incidence of treatment seeking for problem alcohol use per 10,000 of the county population within the Southern Health Board area, 2000 to 2002 (Numerators, Central Statistics Office 2003)

Figure 8 presents the incidence of treatment seeking for problem alcohol use in the community care areas of the Southern Health Board. The incidence of treatment seeking for problem alcohol use was lower in the North and South Lee areas than in other areas.

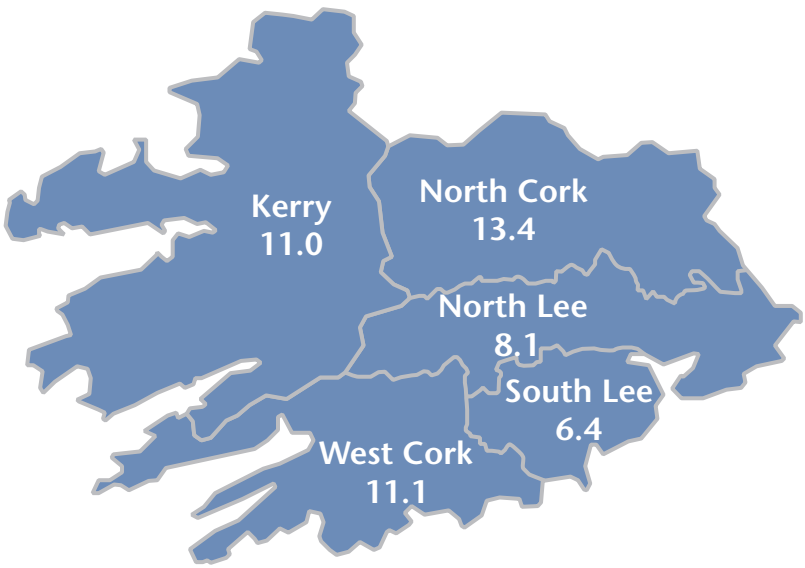

Figure 8 Average annual incidence of treatment seeking for problem alcohol use per 10,000 of the community care population within the Southern Health Board area, 2000 to 2002 (Numerators, Central Statistics Office 2003)

Of those reporting alcohol as their main problem drug, the proportion that reported using at least one other substance was similar across the time-period under review (Table 8). The proportion of new cases that reported polysubstance use was a little lower than that of their previously treated counterparts. Table 8 and Figure 9 present the spectrum of substances used alongside alcohol. Both new and previously treated cases reported that cannabis was their most commonly used second drug. Previously treated cases were more likely to use benzodiazepines than new cases. Though numbers were small, new cases were more likely to use cocaine than were previously treated cases.

Table 8 Characteristics relating to drug use for those who reported alcohol as their main problem drug and attended treatment in the Southern Health Board area, 2000 to 2002

	2000		2001		2002	
	Number (%)*					
Cases where alcohol is main problem drug						
All	719		852		1160	
New	473	(65.8)	585	(68.7)	669	(57.7)
Previously treated	240	(33.4)	254	(29.8)	488	(42.1)
Treatment status not known	6		13		3	
Cases used more than one substance						
All	172	(23.9)	170	(20.0)	229	(19.7)
New	107	(22.6)	112	(19.1)	114	(17.0)
Previously treated	65	(27.1)	54	(21.3)	114	(23.4)
Treatment status not known	0		4		1	
Second drug used						
New cases	**107**		**112**		**114**	
Cannabis	79	(73.8)	74	(66.1)	67	(58.8)
Ecstasy	11	(10.3)	13	(11.6)	20	(17.5)
Cocaine	6	(5.6)	7	(6.3)	8	(7.0)
Benzodiazepines	3	(2.8)	11	(9.8)	12	(10.5)
Amphetamines	2	(1.9)	4	(3.6)	1	(0.9)
Opiates	1	(0.9)	0	(0.0)	4	(3.5)
Volatile Inhalants	0	(0.0)	0	(0.0)	0	(0.0)
Other substances	5	(4.7)	3	(2.7)	2	(1.8)
Previously treated cases	**65**		**54**		**114**	
Cannabis	43	(66.2)	34	(63.0)	57	(50.0)
Benzodiazepines	9	(13.8)	9	(16.7)	18	(15.8)
Ecstasy	4	(6.2)	5	(9.3)	19	(16.7)
Opiates	3	(4.6)	2	(3.7)	3	(2.6)
Cocaine	1	(1.5)	1	(1.9)	5	(4.4)
Amphetamines	1	(1.5)	0	(0.0)	3	(2.6)
Volatile Inhalants	0	(0.0)	0	(0.0)	0	(0.0)
Other substances	4	(6.2)	3	(5.6)	9	(7.9)

*Percentages based on valid cases

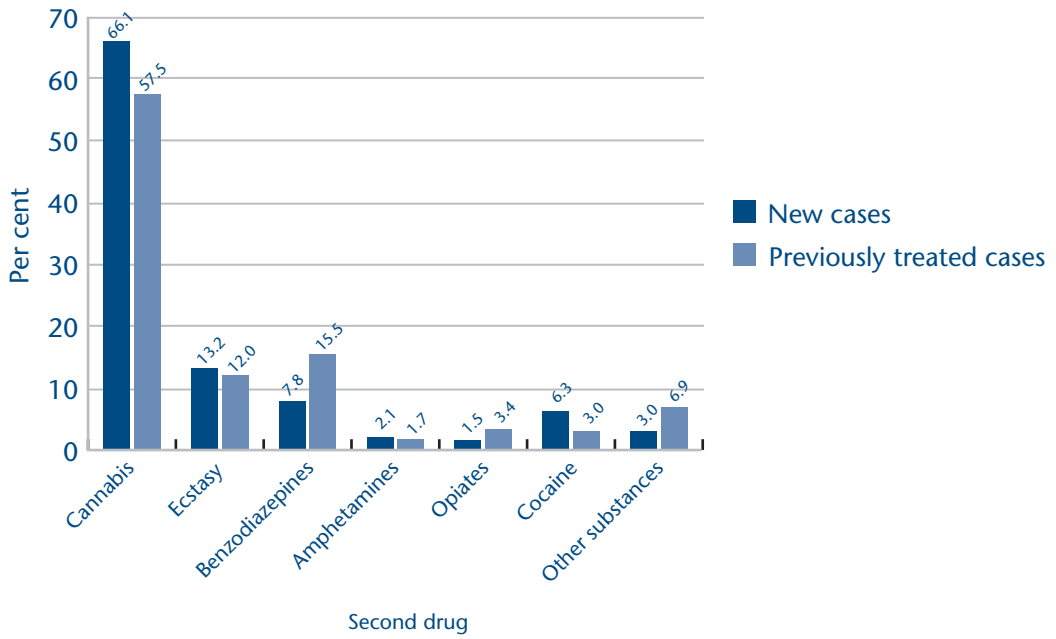

Figure 9 Reported second drug used among those who reported alcohol as their main problem drug, by treatment status, and attended treatment in the Southern Health Board area, 2000 to 2002

Comparisons between the two health board areas

In both the South Eastern Health Board and Southern Health Board areas, the number of cases reporting alcohol as their main problem substance is at least double that reporting all other drugs combined, indicating that problem alcohol use is common in these two health board areas. This raises the question: Is problem alcohol use as common elsewhere in Ireland? In both areas, 40 per cent of those reporting problem alcohol use were treated previously, indicating that this is a chronic health problem. In the two health board areas, new cases were younger and were more likely to be employed than their previously treated counterparts. This suggests that prolonged problem alcohol use may lead to loss of employment, or alternatively, the factors (low self esteem and inadequate problem solving skills) associated with failed treatment (or chronic addiction) are similar to those associated with failure to secure or retain employment. In the two health board areas, there was an increase in the proportion of new female cases seeking treatment for problem alcohol use, though the increase was higher in the Southern Health Board area.

The incidence of treatment seeking for problem alcohol use was highest in County Carlow and lowest in Counties Cork and Wexford. It is important to emphasise that the incidence of treatment seeking for problem alcohol use may be an underestimate of the total incidence of problem alcohol use in the population and may merely reflect the level of service provision in the area and participation in the reporting system. The incidence rates do not include psychiatric outpatient clinics in the community care areas in Cork and Kerry, while psychiatric outpatient clinics are included in the community care areas of the south east. The incidence rates do not include the incidence of treatment seeking for problem alcohol use in inpatient facilities in the health board areas as this is reported to the National Psychiatric In-Patient Reporting System. The associations between availability of services as well as level of deprivation and problem alcohol use could be examined in future research.

In 2001 and 2002, reported polysubstance use was similar in both areas, but in the South Eastern Health Board area a higher proportion of new cases reported polysubstance use than did their previously treated counterparts, whereas in the Southern Health Board area the opposite experience was reported. In both health board areas, cannabis was the most common second substance used among all cases. Numbers reporting ecstasy as a second problem drug increased over time among all cases. Previously treated cases were more likely to use benzodiazepines as a second drug than their newly treated counterparts in both health board areas.

Conclusions

This analysis demonstrates that it is possible to collect reliable data on problem alcohol use using existing methods. It also highlights that the exclusion of alcohol from reporting systems leads to an underestimation of problem substance use and the workload of addiction services.

At this stage it is important to clarify the respective roles of the National Psychiatric In-Patient Reporting System (NPIRS) and the National Drug Treatment Reporting System (NDTRS) in relation to data collection on treatment seeking for problem drug and alcohol use, so as to reassure managers and service providers that there is no overlap in data collection. The National Psychiatric In-Patient Reporting System is a national psychiatric database that provides detailed information on all admissions to and discharges from 52 inpatient psychiatric services in Ireland. This includes inpatient treatment for problem drug and alcohol use. The National Drug Treatment Reporting System is an epidemiological database on treated drug use in Ireland. From 2004, data on treated problem alcohol use is being collected. This reporting system collects information from outpatient services (including drug treatment centres and some psychiatric services), inpatient specialised residential centres (for the treatment of addictions), low threshold services and general practitioners. The two reporting systems have different types of service providing information and complement rather than overlap each other. A number of demographic and diagnostic variables are the same in both databases, making it feasible to do some collaborative research on inpatient and outpatient treatments.

While there should be no duplication of data collection, it is important to ensure that there is good participation of both private and public service providers, so as to ensure the data represent the total numbers seeking treatment for problem drug and alcohol use.

The benefit of information on persons with problem alcohol use is that it allows healthcare managers to describe the magnitude of the problem, the personal and drug-using characteristics of those seeking treatment, and trends in treatment seeking over time. The data presented here will also permit planners to rank alcohol alongside other public health priorities in the population and to allocate appropriate resources to its treatment.

Since the publication in 2002 of the *Interim Report* of the Strategic Task Force on Alcohol, the health impact of problem alcohol use in Ireland and potential responses have been highlighted. Data systems such as the National Drug Treatment Reporting System and the National Psychiatric In-Patient Reporting System have the potential to play an important part in measuring trends in problem alcohol and drug use.

There is a momentum gathering that responses to alcohol and illicit drug use should be integrated. This is also an issue that is being discussed by the ten Regional Drug Task Forces, which have been set up over the last year (J Barry, personal communication, 2004). These data identify a clear overlap between problem alcohol and drug use and point to the need for an integrated approach to the management of substance misuse. It is unclear at this stage where alcohol treatment services and alcohol prevention services will reside, vis-à-vis drug services, in the restructured health services.

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