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AND ILLICIT TRAFFICKING IN DRUGS
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The Dublin/London Drug Research Project

Final Report

by

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## 1. SUMMARY OF MAIN FINDINGS

The principal objectives of this project were to

- develop a first treatment demand indicator and
- establish a reporting system of information on the socio-economic characteristics of drug misusers in Dublin and London, through the collection of similar core data in each city.

Both these objectives were achieved.

**Profile of the study population**

- The sex ratio was similar in both cities, but in London drug misusers were slightly older than in Dublin;
- Almost one quarter of the London population comprised non white nationals, whereas the proportion in Dublin was negligible;
- Eight in ten of the Dublin client group were unemployed compared to six in ten in London;
- Fewer drug misusers in Dublin than in London were making their first treatment demand;
- The primary drug of misuse in both cities was an opiate or opioid, predominantly heroin;
- Dublin drug users were more likely to have ever injected their drugs and ever shared injecting equipment than their London counterparts.

**First treatment demand**

- Thirty three percent of London drug users were making their first treatment demand compared to 15% in Dublin;
- In both cities clients were more likely to be under 25
- years and misusing a non opiate/opioid drug than those who had previously received treatment;
- In both cities a significant minority of drug clients had been 10 or more years on their primary drug before making their first treatment demand.

**Socio-economic characteristics**

- The treated populations in the two cities were alike in terms of the sex ratio - two males to every female;
- In both London and Dublin most clients were living with their parental families;
- A higher proportion of women than men in both cities lived with a partner who was also a drug misuser;
- In London a higher percentage was in regular work than in Dublin;
- Dublin clients were more likely to be injecting their drugs than London users.

## 2. INTRODUCTION

This project was undertaken as a direct consequence of the European Commission's current policy on the fight against drug misuse. The broad objectives of the study are to develop a first treatment demand indicator - seen as one of the best indicators of treated drug misuse - and to explore the feasibility of establishing a reporting system of information on the socio-economic characteristics of drug misusers in defined catchment areas. These objectives have been tested through the implementation of drug reporting systems in Dublin and London which collected similar core data on clients attending specified treatment centres in both cities.

This report will outline relevant features in the background to the project, describe the methodology used to achieve the stated objectives, present the main findings and discuss their implications. The report will conclude with comment on the current extent and future potential for European co-operation in the collection of agreed core data at city or national level. The availability of such data could in turn prove invaluable for researchers and decision makers regarding future research priorities in Europe.

## 3. BACKGROUND

With the increase in recent times in the availability and consumption of illicit drugs Western European countries have responded to this now almost endemic threat to their societies in a variety of ways. Such responses include the expanded provision of treatment facilities, the development of educational/preventative programmes and, in general, the implementation of more repressive legislation against drug trafficking, drug misusers and the possession of illegal drugs.

There has been both a national and international dimension to 'solving' the drug problem. The World Health Organisation (WHO) was one of the international agencies to the forefront in making recommendations. In 1973 a report[1] on a study undertaken for the regional office for Europe of the WHO stated that

> "although each country has a drug problem which is in some ways unique, there are common concerns which to-day cross all boundaries. Each country seems to experience a problem which is a variation on common themes - the growing involvement of young people in drug taking, the explosive spread of the habit which suggests analogy with contagious disease, the introduction of new substances and increasing evidence of multiple drug abuse, uncertainty as to the adequacy of traditional treatment facilities and a shared feeling of the inadequacy of existing data".

The report went on to suggest that international co-operation in meeting these challenges could be aided by an agreed terminology and made reference to an earlier WHO report[2] which had placed particular emphasis on the need for policies to be based on data. Data and their collection in this context were seen as providing a rational response to specific interconnected realities of the drug situation rather than directing random shots in the dark at the problem.[3] Some of the characteristics of useful data included:

- data gathered within a framework of well thought out hypotheses;
- data seen in the context of other work whether in the same or in other countries. This involves the need for definitions on which comparative studies can be based;
- data which serve the planners' purpose must avoid the over complex;

– data are much more likely to serve and illuminate the needs of decision making if research worker and decision maker enjoy a continuous dialogue.

The structure of the Pompidou Group meant that the epidemiology working group was directly accountable to a formal committee of senior government officials from the participating countries, who were in turn working within broad guide lines agreed by the Ministers of the countries concerned. This ensured that there was a channel for the flow of information between researchers and policy makers.

One particular piece of research carried out by the epidemiology group of the Pompidou Group "The Multi-city Study of Drug Misuse"[4] provides the background to this current project and so will be briefly described here. Between 1982 and 1986 experts from seven European cities, Amsterdam, Dublin, Hamburg, London, Paris, Rome and Stockholm met to consider guidelines given at the 6th Ministerial conference of the Pompidou Group (November 1981) that

> "the development of administrative monitoring systems for the assessment of public health and social problems related to drug abuse should be given priority".

Following discussion within the epidemiology group it was decided to carry out a comparative study of drug misuse in seven European cities which would have the following specific objectives:

1. To review and summarise available data on drug misuse in each city regarding the history of drug misuse, the legislative policy, the demographic profile of the city, survey findings on drug misuse, treatment and social care systems, the law enforcement system and details of drug monitoring systems that existed. These data were considered necessary background information which would highlight the different socio-cultural backgrounds of the participating cities and their response to what was

then seen as an epidemic of drug misuse, in particular of opiates, which affected most European cities in the late 1970s and early 1980s;

2. To develop indicators of drug misuse, such as, treatment demand, police arrests and drug deaths;

3. To assess the validity and reliability of using specified indicators to measure accurately the extent and changing patterns of drug misuse in the cities studied.

Eight indicators were examined and tested by the epidemiology group namely, first treatment demand; hospital admissions; viral hepatitis; drug related deaths; police arrests; imprisonment; seizure of illicit drugs and price/purity of illicit drugs.

The selection of the above indicators was hypothesis-based which in turn often reflected earlier work and/or experience in different cities of the association between drug misuse and the particular indicator.

Throughout the study definitions used by each participating country were made explicit thus permitting a more accurate interpretation of rated findings from the project.

One of the principal findings of this "Multi-city Study of Drug Misuse" was that despite problems of definition and in some cases availability of data two indicators proved to be of particular value in most cities

– first treatment demand from medical and social facilities and

– police arrests for offences involving illegal drugs.[5]

The necessity, however, to supplement statistical data deriving from indicators with information on the context in

which they were collected e.g., cultural attitudes, legislation and available services, and also of the process by which the statistics were generated was noted. The lack of a structure in most cities for collecting and integrating data from very different sources in a consistent and coherent fashion was also referred to.

In the climate of growing awareness of the need for greater liaison between international bodies involved in drug misuse research and policy formation closer links were created between the Pompidou Group and the European Commission (EC). One of the outcomes of this enhanced communication was the EC funding of this current project submitted by two epidemiological experts from the Pompidou Group.

The funding for this project comes primarily from the European Commission, with contributions from the Pompidou Group, Council of Europe and also from the British Department of Health and Social Security and from the Irish Department of Health.

## 4. OBJECTIVES

The twin objectives of the project to develop a first treatment demand indicator and establish a reporting system of information on the socio-economic characteristics of drug misusers will now be discussed.

a) Development of a First Treatment Demand Indicator.

Definition

'First treatment demand' refers to clients who are contacting drug treatment centres and requesting treatment for their drug misuse for the first time ever. It should be noted that it does not mean first contact with a particular centre, but first contact with any treatment centre.

The precise meanings of ‘drug treatment centre’ and ‘drug treatment’ vary between cities and countries, depending on local or national cultures and their traditions in providing treatment. In this report, ‘drug treatment’ is ‘ defined broadly to include treatment provided in either medical or nonmedical settings, and covers detoxification, methadone programmes, psychotherapy, individual, group or family counselling, and special skills or training programmes for drug misusers. Drug treatment may be provided in hospitals, outpatient clinics, drug-free residential or nonresidential programmes, therapeutic communities, prison programmes, street agencies or at the level of primary care. Although treatment is often given by professionally qualified workers, in this context it also includes staff such as ex-addicts who are deemed to possess appropriate therapeutic skills but who lack formal qualifications. ‘Treatment’ does not include information or advice given over the telephone or via intermediaries such as parents or teachers, nor does it refer to services provided solely relating to social assistance or insurance entitlements.

It is important to note that there are differences between cities, and in some cases between treatment centres, regarding the meaning of ‘first treatment demand’. In Dublin, the term refers to first treatment received - that is to say, only clients who enter treatment for the first time ever are recorded. In some London centres, the term has a wider meaning and refers to clients requesting treatment for the first time ever, regardless of whether or not they are taken on for treatment. The Dublin data are thus a measure of treated incidence. London data are a measure of the incidence of first treatment requests.

Significance as an indicator

First treatment demand serves two functions as an indicator. The first is as a direct indicator of the demand on the services that are covered in the reporting

system. The second function is as an indirect epidemiological indicator of trends in drug misuse in the communities or populations served by those services. Since these two functions serve somewhat different purposes, they are discussed seperately.

**Direct indicator of demand on services**

Data on first treatment demand provides answers to questions such as “Who do drug treatment services attract?” and “What is the socio-demographic profile of drug misusers who utilise services?” This information can be valuable to service planners and treatment providers. Thus it can help them to evaluate whether or not their services are succeeding in reaching their target populations, or to examine how different services attract different sorts of drug misusers. For example, in view of the risks associated with HIV infection and drug injecting, it might be decided that an important goal of drug treatment services was to attract drug misusers into treatment at an earlier point in their drug use. Data on the length of the drug-using histories of new clients contacting services would indicate whether or not this goal was achieved. Similarly, programmes aimed at improving the uptake of services by particular subgroups such as adolescents, women with children or ethnic minorities can be evaluated in terms of changes in the socio-demographic characteristics of the clients whom they attract.

To a certain extent, questions concerning the profile of clients who utilise services do not need to be restricted to first treatment demand only. The characteristics of the total clientele of services provide a more complete picture of the overall demand for treatment. However, the particular contribution of data on first treatment demand is that they focus on issues such as how to reach client groups who do not readily seek treatment. First treatment demand thus provides a more sensitive indicator of service attractiveness.

**Indirect indicator of trends in drug misuse**

The incidence of new clients seen at treatment centres may also be assumed to reflect the incidence of drug misuse in the community. For example, a large rise in the numbers of new heroin addicts seeking treatment in several European cities in the late 1970's and early 1980's was taken as evidence of a significant epidemic of heroin addiction in the cities concerned. Subsequently, a stabilisation or decrease in new cases was interpreted as evidence that the epidemic had 'peaked'.

Whilst the example just given points to the potential epidemiological value of the first treatment demand indicator, it is essential to emphasise that there are important methodological reasons why simplistic interpretations such as this can be seriously misleading. A variety of factors influence the demand for treatment apart from changes in the incidence and prevalence of drug misuse. It cannot be assumed that there is a direct relationship between changes in drug misuse in the community and changes in the demand for treatment. For this reason, first treatment demand must be considered as an indirect indicator of trends in drug misuse.

Other factors that must be considered when interpreting data on first treatment demand include: the time lag between first drug use and first treatment demand; the type and availability of treatment services and the impact of local factors such as drug availability or law enforcement efforts. These are now discussed in turn with reference to illustrative examples from the literature.

<u>Time lag between first drug use and first treatment demand</u>

The first important factor to consider is that first treatment demand is a lagged indicator in terms of reflecting changes in the incidence of drug use or of drug dependence in the community. This is because drug users do not seek treatment immediately upon commencing to use

drugs, nor, necessarily, as soon as they become dependent. Rather, there is usually a time lag of several years between initiation into drug use and the first demand for treatment, for example. Dean et al[6] report in 1987 that 21% of opiate users entering a Dublin treatment centre for the first time had been using opiates, mainly heroin, for seven years or more. Similarly, Daviaud et al[7] found that 68% of the heroin addicts seeking treatment from a London drug dependence unit had been using heroin for four years or more. Thus this indicator does not reflect the current incidence of drug use or drug dependence in the community, but changes that occurred some time earlier. A further implication is that since few people seek treatment in their first year of use, first treatment demand indicators always underestimate recent incidence of drug misuse in the community.

Hunt and Chambers in 1976[8] have suggested that the lag between first drug use and first treatment demand should be understood in terms of two independent components. The first component is the time period (t1) between first drug use and the development of dependence or the emergence of drug-related difficulties. The second component is the time period (t2) between dependence or problems and first demand for treatment. The former period, t1, may vary-considerably between individuals. Thus some users may progress rapidly to a dependent or problematic pattern of drug use, whilst others may take several years to do so, or may never experience dependence or serious problems at all. Indeed, there is strong evidence to suggest that even with so-called ‘addictive’ drugs such as heroin or cocaine, only a minority of people who use them at least once go on to become dependent[9]. Since most people who approach treatment centres do so only after they have become dependent or have encountered serious difficulties, the implication is that first treatment demand indicators do not reflect the wider extent of drug misuse in the community, but only the more serious and problematic patterns of use.

Similarly, the time period t2 between the development of dependence and first treatment demand is not uniform but may vary between individuals. On the basis of empirical data on heroin addicts in the United States/ Hunt and Chambers in 1976[10] have suggested that the mean lag time is relatively constant for heroin addicts. On the basis of this, they have developed a technique that corrects for the time lag in treated incidence curves to give a more accurate estimate of the 'true' incidence of heroin addiction. However it is quite possible that lag time may vary between situations that are very different, as for example, when comparing different countries with different attitudes to drug misuse and different forms of treatment. It is thus important to examine empirically the time lag in a given context.

Other factors affecting first treatment demand

The availability of treatment (both the existence of treatment services and their capacity) and the types of treatment that are provided are important influences on the demand for treatment. Clearly, if treatment services are very limited or inaccessible, then data on treatment demand is unlikely to reflect the extent of drug misuse. The creation of a new service may well produce a sudden upsurge in demand that is as likely to reflect previously unmet need as to reflect a sudden or recent change in incidence.

A clear example of this was the creation of a cocaine hotline in the United States which was rapidly inundated with calls, even though the demand on traditional treatment centres had been relatively low[11]. Similarly, in the UK the opening of low threshold needle exchanges for injecting drug misusers attracted younger injecting drug users who had not previously contacted treatment centres[12]. It is thus essential to interpret data on first treatment demand in terms of the treatment services that are available, the extent to which they are operating at full capacity and especially in terms of any significant changes that may have occurred.

The availability of drugs, their price, and the activities of law enforcement departments may also have an impact on treatment uptake. Thus one recent study of addicts seeking help from London treatment centres found that financial difficulties arising from expenditure on drugs was one of the major factors that stimulated people to seek treatment[13]. Thus it is important to interpret data derived from treatment services with information on the state of the drug market and on the policies and activities of law enforcement agencies. The Report of the Multi-City Study carried out in the Pompidou Group provides a framework for integrating information from a package of indicators and emphasises the dangers of relying solely on any one particular indicator[14].

When attempting to make international comparisons of first treatment demand, it is necessary to take account of differences in culture and in the role that treatment plays in different countries. In the Netherlands, the phiolosophy that underlies much of the treatment system gives high priority to establishing contact with as many misusers as possible and to reducing the harmful individual and social consequences of drug misuse, even if this means that some people continue to misuse drugs. Thus the treatment system includes low threshold methadone programmes and needle exchanges. It is likely that the majority of heroin addicts contact treatment services. By contrast, in Sweden, drug policy is emphatically drug free and the treatment philosophy strongly abstinence-oriented. Known addicts tend to come into contact with treatment via prisons. Young drug misusers attending youth treatment centres are most commonly using cannabis. Any simplistic comparison of data on treatment demand between Sweden and the Netherlands would give little insight into the real similarities and differences between the two countries.

b) Establishment of a Reporting System of Information on the Socio-Economic Characteristics of Drug Misusers

To achieve the second objective of this project it was decided to collect core items of information on the socio-economic characteristics of drug misusers attending specified treatment centres in London and- Dublin. Only by testing the feasibility of such an approach could a blue print be developed which could be recommended for future use among European treatment centres.

Feasibility of collecting core data

Experience gained through participation in the "Multi-city Study of Drug Misuse" had shown that core data were being collected from a variety of sources in all cities. In fact findings from that study indicated[15] that it was possible to make rough comparisons between cities on the profile of drug users, even though a low degree of direct comparability pertained.

This present approach would ensure that core data would be gathered in a standard way, using similar definitions and codes for all items of information relating to treated drug misusers. This method would allow for direct comparison of these collected data in both cities.

Collection of a minimum data set

The collection of a minimum set of data was deemed prudent but this meant reaching agreement on what the most important descriptive items of client information should be.

It was acknowledged that this choice of data would be a difficult one. Even in a research context the varying interests in particular aspects of core data required by participating treatment centres where the information would be coming from (and also returning to) were many. By examining forms used by treatment centres in both cities and through consultation with European colleagues (which will be referred to in the following section of the report) it was possible to identify and select those items of

socio-economic input most commonly employed. This became the first stage in what was to become an evolving process.

Utility of such core data

Availability of standard data on the socio-economic characteristics of treated drug misusers in two European cities would provide at least two useful sets of information relating to:

– the current situation and

– longitudinal trends over time.

**Data relevant to the current situation**

The immediate availability of reliable hard data on treated drug misusers in both cities would allow for informed discussion on possible differences in traits of misusers. Such differences could perhaps be explicable in terms of availability of drugs, differences between price and purity, and legislation governing the control of drugs in the cities and have the effect of providing an insight into some of the complexities of drug misuse.

This comprehensive descriptive information could provide a basis for a programme aimed at reducing demand in targeting a particular age group or misusers from particular areas of the city.

Considerable debate has and is taking place on the best way of tackling the drug problem in various countries. Approaches taken have been broadly grouped under reducing the demand side or supply side or tackling both. Many countries and policy makers have to-date favoured an emphasis on supply reduction (a recent example being President Bush's new anti-drugs plan, September 1989). On the other side informed comment from the University of Michigan[16] on results of the 1988 National High School Survey stated that the decline in student use of illicit

drugs, particularly cocaine and crack - in spite of a continuing increase in availability - had been achieved

> "not through supply reduction: they are due almost entirely to the reduction in demand".

The common sense gains resulting from addressing the demand reduction side has been steadily gaining support in recent times[17]

Availability of reliable statistics on the socio-economic characteristics of treated drug misusers would provide base line data from which other studies could be based, e.g., relating to the untreated population in defined areas, i.e., in cities or sections of them. These data could represent a starting point for more thorough epidemiological evaluation, using mathematical models, of questions, such as, the long term consequences of drug misuse.

Finally, useful information would be forthcoming on the socio-economic characteristics of clients using the different treatment centres in the system, their similarities or, if different, reasons as to why this is so.

**Availability of longitudinal information**

Longitudinal data would capture changes, where they occurred, in the profile of the treated population and changes by that population in the use of primary drug(s).

An overview of these two basic trends over time would enable policy makers to understand changes in the size, characteristics and nature of the treated drug problems, identify sections of the population at risk, plan intervention measures and evaluate the effect of these efforts. An advantage of such measures at national level is obvious and would be considerably more enhanced at European level.

Examples of other more specific questions that could be addressed, again both at individual country or within a European framework are:

- the acquisition of more exact information on the 'maturing out' concept. This phenomenon was postulated as the explanation in Hamburg for the lack of increase in the opiate addict population by the 1980s and for the ageing of that particular age cohort first identified in the first half of the 1970s.[18] This 'maturing out of addiction' concept has been the subject of much discussion in the United States by e.g. Robins (1979)[19];
- the specific issue of treated drug users' practices of injecting and sharing equipment could be addressed over time. These are crucial data in the context of AIDS/HIV spread. Whereas current information suggests a decline in the expected increase in AIDS/HIV cases in the UK[20] as a consequence of homosexual/bisexual adoption of safer sexual practices, information of this kind relating to drug users is not systematically available.

The objectives of this project, namely the development of a first treatment demand indicator and the establishment of a reporting system of information on the socio-economic characteristics of drug misuers were achieved through the collection of specified information from drug treatment centres in Dublin and London using a reporting system approach.

## 5. METHODOLOGY

In reaching the stated objectives of the project, the following broad methods were adopted:

- the selection of core items to be collected in the two cities;
- the design of a form to collect agreed data;

- definitions of key concepts and instructions re completion of form;
- the identification and brief description of the participating treatment centres;
- choice of reporting system and procedure adopted;
- data processing system, coding guide and computer arrangements.

Selection and development of core items

As earlier mentioned initial contact concerning the selection of core items was made with those centres in Dublin and London that provided treatment to drug misusers in the defined catchment areas. Forms used by such centres to gather routine data on clients contacting them were obtained. In addition, colleagues from the epidemiology and school survey sections of the Pompidou Group in Amsterdam, Athens, Hamburg, Lisbon, Madrid, Paris, Rome and Stockholm were requested to forward forms commonly used in their cities for the collection of basic client data. All responded, supplying translations of the text on forms where necessary. The American CODAP form, formerly used to monitor admission and discharge of persons to drug treatment centres and what was popularly known as the 'Mariani' form developed by an earlier EC group were also scrutinised.

On examination of the items contained in this representative selection of forms many common elements emerged. In fact all cities collected core information on the socio-economic characteristics of drug misusers e.g., the age, sex, living status and drug(s) of misuse. What differed generally were the codes used, the emphasis given to what information would be gathered on drug misuse and for how many drugs. Definitions were not always made explicit e.g., on 'principal' drug of misuse and due to its recent emergence many centres were not incorporating a history of injecting in their reporting systems of drugs. Not all systems permitted differentiation between those

making a first treatment demand from those making subsequent ones. Some systems were treatment based others were administrative systems developed by the police, or social security departments.

After considerable discussion between the authors of this report to ensure that adequate data would be collected to meet the study objectives an initial selection of core items was made.

The form used to collect data in Dublin and London

It was considered desirable to arrange for the collection of data on a single A4 size form. There were recognisable advantages in requesting treatment centres to return a minimum set of data, and these data were envisaged for a reporting system and not for a survey. All centres it was felt would, in addition, be collecting or would wish to collect further information relevant to their own needs. The first draft of this form containing agreed data was sent to colleagues in the eight European cities earlier referred to, prior to the Pompidou Group meeting in Strasbourg, April 1989. Discussion of this form was an agenda point of this meeting and so provided ample opportunity for discussion, which also included comments from American colleagues from the National Institute of Drug Abuse (NIDA) who regularly attend such meetings. Consequent on informed criticism changes were made to the draft. The form currently in use in London and Dublin treatment centres comprising 19 items of information to meet the study objectives is shown in Appendix B1.

Definitions of key concepts and instructions re completion of the form

Four concepts namely drug treatment; drug treatment centre; drug treatment clients and first treatment demand were considered central to the study and were defined to ensure unambiguous communication between centres in the two cities and also within centres. As information for the project

was coming from centres who provided treatment either exclusively to drug misusers or as a part of their delivery of care this was a core concept on which the subsequent definition of drug treatment centre and drug treatment clients was dependent. Each centre in the study received a copy of this set of definitions - see Appendix B2.

Instructions for the completion of each of the 19 items of information on the form were also issued to each participating centre - see Appendix B3. Care was taken to ensure that codes used for those items e.g., relating to education and residence variables were similar to those used by each country's census thus permitting the rating of output data - an important epidemiological consideration.

Brief description of participating centres

**Dublin Centres**

As no formal drug reporting system existed in Dublin for which the project data could be obtained it was first necessary to identify and obtain the co-operation of those who met with the study criteria. Seventeen such centres were identified, contacted and asked for their co-operation. The objectives were clearly stated and also the advantages accruing to the individual centres by way of analysis of their individual information. All willingly agreed to participate in the scheme. See Appendix B4 for a brief description of those centres. Unfortunately the prison system of Mountjoy, St. Patrick's Institution and Arbour Hill had a delayed start due to certain changes that the Department of Justice felt were necessary to make in their arrangement with the Data Protection Commission as to who could have access to their information. Latterly, two additional treatment centres have been identifed and have expressed a willingness to participate in the system. This level of co-operation represents almost 100% coverage of those centres who provide treatment to drug misusers in the Dublin catchment area. Excluded is a possible handful of general practitioners who treat a small number of addicts.

The Dublin catchment area comprises the Greater Dublin area of Dublin County Borough, Dun Laoghaire Borough and their suburbs with a total population in 1986 of 920,956.

**London Centres**

The situation in London was different. There already existed a national system under which doctors were required to notify narcotic addicts to the Chief Medical Officer at the Home Office. Thus medically based treatment centres, hospitals and general practitioners are supposed to complete a standard notification form on opiate and cocaine addicts. Several of the nonmedical agencies also had already established their own data recording sytems. This situation was complicated by the fact that there are now no Londonwide political or administrative structures apart from the Metropolitan Police. Responsibility for health matters lies with four separate Regional Health Authorities, each of which devolve most operational responsibilities to 12-16 Health Districts. Within some of these Regions, and in some Districts within those Regions, local reporting systems of varying complexity are found. The lack of administrative cohesion, plus the sheer size of London and the number of local treatment services (probably in the order of 100 or so) meant that it was not possible to aim for anything approaching full coverage of treatment centres. The objective in London was therefore to select a sample of centres who were willing to participate in this pilot. The centres covered reflect the major forms of treatment centre found in London - drug dependency units attached to hospitals, general practitioners and non-medical community-based counselling services.

The centres were contacted and asked if they would cooperate. The purposes of the study were explained and the core data items described, together with their definitions. The procedure for collecting the core data varied between centres. Those that already had an established protocol for recording data on clients

demanding treatment were asked to modify their existing forms for the purposes of the pilot. Services that did not have an established protocol were willing to use the form used in the pilot. The centres contacted are listed in Appendix B5. Subsequently, there was an unexpected problem at one of the treatment centres (St. Mary's) which led to a delay in collecting data. This arose from administrative reorganisation in the Health District. Data collection has started, but too late for inclusion in this report.

The catchment areas for the treatment centres include the London boroughs of Camden, Islington, Brent, part of Westminister, part of Kensington and Chelsea, and Enfieid. The total population in this area was about 800,000. Not all of the services that cover this population were included in the pilot.

Choice of reporting system and procedure adopted

As already mentioned it was decided that the focus of this reporting system was on treatment centre usage. The limitations of this approach are that it does not include contact with all law enforcement agencies (only prisons in the case of Dublin) nor does it monitor drug deaths or cases of viral hepatitis. The advantages of this approach are that it permits the attainment of the study objectives. At a broader level it also facilitates the inclusion of information on heavier drug misusers, a group often missed by surveys. This is an important group since it comprises the casualties of drug misuse and a group which consumes most of the treatment and research resources. Another advantage in reporting systems that are treatment centre-based is that they can be built on existing record systems, as was the case in London, and so use data which, with certain adjustment, are already being collected by treatment agencies.[21]

The primary characteristics of a reporting system which are employed by this project are: that reports, in our case

forms, or computer tape, are sent to a central body for collation, analysis and presentation. Another distinguishing feature is that systematic reporting procedures are made explicit, e.g., how the data are to be collected, from whom, over what period of time, as well as the establishment of clear instructions re return of data.

Three types of reporting systems were examined - see WHO description of such systems [22], namely:

- an event-reporting system which reports only events and not necessarily total number of clients involved;
- a case-reporting system which enables the multiple events for the same client to be collated in the same centre and identified as a single case;
- a case register approach which permits the linking of contacts made by clients from a variety of centres. In particular, procedures employed by Irish psychiatric case registers[23] were considered.

What was finally agreed to was a simplified approach that incorporated some but not ail of the case register features. The reporting system would be client-based, with ‘information collected once for the time period under review, irrespective of the number of contacts made by the client.

Data processing system

Each participating centre was fully informed re the study objectives and the process to be followed in meeting these goals. An outline of the project together with a memo which provided guidelines on avoiding the completion of duplicate client information for the period under review were issued to each centre (Appendix B6). A person in each centre was identified as having responsibility for the collection and return of data in the London and Dublin centres. These persons were fully trained in the correct recording of data. In Dublin where, unlike London, a drug reporting system was being set up for the first time,

special plastic bags with seals were issued for the return of completed data to the Health Research Board.

The time period covered by data used in this report is the month of August 1989, although it should be noted that one of the London centres returned a small number of cases in July.

The coding guide adopted in both cities can be seen in Appendix B7.

Computer arrangements in each city were as follows:

In Dublin an IBM PC/2 model 30 286 was used and data analysis was carried out through SPSS PC+. Ms. Mary O' Brien, research assistant, was the person responsible in the Health Research Board for liaising with the centres in the reporting system and for the computer processing.

In London, the data were analysed on an IBM PC/2 using SPSS PC+. Mr. Janaka Perera, research assistant at Birkbeck College, was responsible for collecting data from the centres, and for entering and processing them on the computer.

## 6. STUDY FINDINGS

Descriptive Statistics

### a) City Responses

In Dublin 501 cases were returned to the project for clients who received treatment for their drug misuse in the specified centres during the month of August 1989. Seventeen centres are participating in the project and an additional two have expressed a willingness to join the system.

The treatment centres in the Dublin prisons of Mount joy. Arbour Hill and St. Patrick's Institution were delayed in their commencement of recording data

for the project due to certain legal procedures that the Department of Justice wished to implement and, as a consequence, their data are not included in this report.

Some of the other participating centres, i.e., the consultants in the private psychiatric hospitals of St. Patrick's and St. John of God; the Rutland Centre; the Mater Hospital Child Guidance Clinic and Usher's Island Clinic and Day Centre reported that they had no clients during August that met with the Study criteria.

August was not the most suitable month to launch a research project as many of the treatment centre staff were on annual leave. There were also the anticipated initial problems of communication and comprehension inherent in the establishment of a reporting system. As a consequence the 501 clients included in the project are an underestimation of the numbers that will be involved when the reporting system is fully operational. However, the envisaged participation of 19 centres in Dublin providing treatment to drug misusers represents almost complete coverage of treatment modalities in the city. Only a few individuals, like the occasional general practitioner, would remain outside the reporting system. It is hoped that the Irish Department of Health will fund the continuation of the system.

While, as already noted, the 501 clients, who were recorded once for contact(s) made with the specified treatment centres in August 1989 represent a possible shortfall of all expected clients, this number includes an element of double count with some clients attending more than one centre at the same time. This important point will be elaborated on later in this section.

As a general observation, without exception all centres willingly agreed to participate in the study and expressed a high degree of interest in its objectives and in the overall benefits they saw as accruing to policy makers, researchers and to their own centre in the availability of regular output from the project.

In London, 204 cases were returned for clients who sought treatment from the specified centres during August, 1989 (together with a small number of cases seen in Brent in July). Clients who were in treatment during those months but who had entered treatment prior to the study period were not included.

This was slightly different from the Dublin procedure, which covered all clients seen by the centres, including all those who were already in treatment. The main effect of this was that the total number of cases reported was lower than would have been the case had people who were already in treatment been included. A further effect was that since the data were collected at the first interview with clients who were requesting treatment, there were occasions when the staff of the agencies concerned felt unwilling to ask all of the questions on the sheet if they thought it would interfere with the process of establishing rapport with the client. This partly accounts for the higher level of 'not known' responses in the London data. Specific comments are included in the text when it is felt that these differences affect the interpretation of the data. 'Age left school' had a particularly high non-response rate for reasons that are not yet clear.

A further difference in detail with the Dublin study was that at the Drug Dependence Unit at University College Hospital, the data were collected through modifying their existing contact sheet. This too had the effect of increasing the missing data in some

cases, since staff were not accustomed to including the new items and sometimes used an old version of the contact sheet instead.

There are no cases included in the London data from St. Mary's Drug Dependence Clinic due to an unforeseen delay in access to the data. This arose following administrative reorganisation at the hospital. As in Dublin, August was not a good month for the survey. In particular, Enfield Community Drug Team saw few clients. Thus the data reported below are an underestimate of the demand on the services described in Appendix B5.

It is possible that there was a small degree of duplication in terms of the same cases being reported by more than one centre, though the London investigators feel this is unlikely, since cases were included only at the point at which they were seeking treatment and it was unlikely that many clients requested treatment from more than one centre in the short time period concerned. Referral between the centres in this pilot was rare, since they largely covered different catchment areas.

**b) Overview of Population**

What follows is an overview of the findings in Dublin and London under the broad headings of

- socio-demographic profile
- treatment centre contact
- drug misuse
- injecting/sharing.

Information pertaining to all variables shown on the form (see Appendix B1) was input into the computer. All data were subsequently analysed with the exception of those relating to items 1 (city), 2 (treatment centre), 3 (client number), 4 (date), 7b (currently in

contact with other centres: if yes, specify), 11 (area of residence), 14b (education, highest level obtained).

For most of the above variables an analysis was not considered necessary and for the last two 11, and 14b, information was not directly comparable between the two cities.

Throughout this section on study findings and in the following one which discusses these findings, information from both cities is presented and often compared. It is, however important to keep in mind that these data refer to a pilot study, are not necessarily complete for the catchment areas they represent and certainly in the case of London not reflective of all treated drug misusers in that city.

Because of the differences in the 'not known' categories in London and Dublin it was considered more valid to base percentages shown in the following four tables on the known number of cases and not on the total number for the variables concerned.

**Socio-demographic Characteristics**

The information presented in Table 1, overleaf, comes from the frequency Tables A4 - A9 inclusive in Appendix A. What is shown in the table is the response to the modal category for each variable in each city.

Using the selected socio-demographic variables outlined below, the Dublin data show that the majority of attenders at treatment centres were white Irish unemployed males aged 25 years or over, and living with their family of origin (41%). Almost half had left school before the official school leaving age of 15 years.

**Table 1: Treated Drug Misusers in Dublin & London.**
**Socio-Demographic Characteristics.**
**Percentages.**

| | DUBLIN | | | LONDON | |
|---|---|---|---|---|---|
| Modal | % | Kn* | Modal | % | Kn* |
| male sex | 67 | 501 | male sex | 65 | 203 |
| 25 + years | 60 | 494 | 25 + years | 70 | 187 |
| living with family of origin | 41 | 486 | living with family of origin | 27 | 187 |
| white national | 98 | 496 | white national | 76 | 191 |
| unemployed | 80 | 492 | unemployed | 59 | 178 |
| left school aged <15 years | 53 | 455 | - | - | - |

*kn = known number of cases

Only one third of cases were female and one fifth employed prior to their attendance for treatment.

In London, most people requesting treatment were white British unemployed males aged 25 years or over. In terms of living status, about one quarter respectively were living with family of origin, the remainder were living with partners, with friends or in other, usually temporary circumstances.

However, it should be noted that over one third were female, one quarter were not white British nationals, and about one third were in regular employment.

**Treatment Centre Contact**

Table 2 provides a overview of client contact with the treatment centres in both cities, based on information from Tables Al, A2 and A3 in Appendix A.

**Table 2: Treated Drug Misusers in Dublin & London.**
**Treatment Centre Contact.**
**Percentages.**

| | DUBLIN | | | LONDON | |
|---|---|---|---|---|---|
| Modal | % | Kn* | Modal | % | Kn* |
| old client contact | 81 | 499 | new client contact | 63 | 197 |
| previously treated | 85 | 496 | previously treated | 67 | 177 |
| not in contact with other services | 68 | 495 | not in contact with other services | 69 | 173 |

*kn = known number of cases

In Dublin the majority of contacts were 'old client' contacts in that they had already attended the centre as distinct from those clients attending for the first time. Most had been previously treated for their drug misuse which meant that only 15% were making their first ever contact or demand for treatment. While two-thirds of the treated drug misusers were not in contact with other services when the form was completed/ about one third were double counted, that is receiving treatment from more than one centre in the system. This occurred because it was possible to include most centres in this reporting system who treat drug users, and to provide treatment on demand, unlike London where a high proportion of clients go on a waiting list. In addition, it is commonplace in cities, including London, for clients to be in more than one form of treatment at the same time, e.g., a probation officer may continue to counsel a client who is being de-toxified or on a methadone programme. As a consequence, although 501 clients contacted the treatment centres, when the element of centre contact duplication is taken into account the total number of clients in the system was 336.

In London most of the clients were new to the treatment centre they contacted, though over one third had attended that particular centre before. However, of those clients

whose treatment history was known, only one third had never received treatment before (i.e. were demanding treatment for the first time ever). About one third were also in contact with other services, usually probation, social services, hospitals, voluntary agencies or needle exchanges but these services were not included in the present London Reporting System. As noted earlier, there was little, if any, duplication of cases.

**Drug Misuse**

Some detail of drug misuse is provided in the table overleaf, based on information from Tables A10 - A18 inclusive in Appendix A.

In Dublin for those clients whose primary drug of misuse was known, a very high percentage, 87, misused opiates or opioids, predominantly heroin. A small minority of opiate misusers reported morphine (morphine sulphate tablets), followed by dihydrocodeine and cannabis as their principal drug. The non-opiate/opioid group reported their primary drug of misuse to be, in descending order of frequency, cannabis, hypnotics/sedatives, stimulants and volatile inhalents. Cocaine was recorded in 10 cases. Most drug misusers were less than 25 years old when they first started to misuse.

Information on frequency of drug misuse was confined to the month prior to interview. Therefore, any clients on a methadone treatment programme for a month or more were recorded as ‘drug-free’ during that time. The responses for this variable have been treated as invalid and excluded from the present report. A change will be made in future data collection, and answers on frequency of drug misuse will be related to the period prior to the treatment contact. The other questions relating to drug misuse reported here were not confined to the past month.

**Table 3: Treated Drug Misusers in Dublin & London.**
**Drug Misuse.**
**Percentages.**

| | DUBLIN | | | LONDON | |
|---|---|---|---|---|---|
| Modal | % | kn* | Modal | % | kn* |
| **Primary Drug** | | | **Primary Drug** | | |
| opiates/opioids misuse | 87 | 493 | opiates/opioids misuse | 79 | 198 |
| < 25 years old when first misused drugs | 88 | 474 | < 25 years old when first misused drugs | 72 | 137 |
| frequency of misuse | invalid response | | misused daily | 95 | 187 |
| injected | 75 | 493 | injected | 51 | 190 |
| 5 - < 10 years misusing | 38 | 471 | 5 - < 10 years misusing | 40 | 143 |
| **Secondary Drug** | % | tn** | **Secondary Drug** | % | tn** |
| didn't misuse | 12 | 501 | no record of misuse | 28 | 204 |
| <u>For those who mis</u>used | % | kn* | | % | kn* |
| opiates/opioids misuse | 68 | 439 | opiates/opioids misuse | 41 | 92 |
| < 25 years old when first misused drugs | 87 | 417 | < 25 years old when first misused drugs | 83 | 24 |
| frequency of misuse | invalid response | | daily misuse | 76 | 82 |
| injected | 79 | 299 | eat/drink | 57 | 83 |

* kn = known number of cases

** tn = total number of cases

Three quarters of misusers injected their primary drug, and over a third had been misusing for between five and ten years.

For 59 persons a secondary drug of misuse was not recorded. Because the form (as distinct from information abstracted from existing records) was used to collect information and in almost all cases the data were obtained through an interview with the client, this was taken to mean that these 59 clients had not misused a secondary drug. For those who misused a secondary drug, again opiates/opioids were the preferred drugs. The most popular drug was heroin. The most frequently mentioned non-heroin drugs being morphine (morphine sulphate tablets) followed by dihydrocodeine and methadone. The current availability of morphine sulphate tablets in Dublin, which are crushed with a Stanley blade for IV use, has been commented on by treatment centre personnel. It has been suggested that these tablets are often substituted for heroin, because they are cheaper and more available. It is interesting to note that cocaine was recorded in approximately 15 cases - a higher number than for primary drug misuse.

Over three quarters of persons misusing secondary drugs had been less than 25 years when they first commenced misusing.

The same difficulty encountered with frequency of drug misuse for the primary drug also occurred for the secondary one.

Injection was the most common route of administration for almost half the misusers. The highest proportion of misusers (a third) stated that they had been misusing their secondary drug for less than five years - a much shorter duration than that returned for primary drugs.

In London eight out of ten clients who were seeking treatment reported that their primary drug of misuse was an opiate or opioid. This was usually heroin, though a small number reported methadone, dihydrocodeine or codeine as their main drug. The remaining clients reported their primary drug of misuse to be, in descending order of frequency, hypnotics or sedatives (mainly benzodiazepines), volatile inhalents, central nervous system stimulants, cannabis and hallucinogens. Since the data were collected at the point at which drug misusers were requesting treatment, only one person was drug free.

Almost all clients used their primary drug on a daily basis. About one half injected it (all of them opiate users). The others mostly either smoked it (mainly heroin, plus a few smoking cannabis or cocaine) or took it by mouth (methadone, codeine or tranquillisers), whilst a few sniffed it. Only five clients reported cocaine as their primary drug, of whom three were smoking it. Almost three quarters had started to use their primary drug before the age of 25 years and had by now been using it for some years. Thus 40% had been using their primary drug for between five and ten years.

Secondary drug misuse was not well recorded. This was because at first contact with the client, the treatment centres tended to concentrate on the drug that the client presented as the main problem and only recorded secondary drug use if that also seemed relevant to the case. Thus the secondary drug of misuse was unknown in over one quarter of cases, and information on age first used and duration was missing in over half of the cases. Furthermore, in more than a quarter of cases, the answer given to the question about secondary drug of misuse was “none”. It is not possible on the basis of the data to know whether this meant that clients are not using any other drugs, or whether they did not report any other

drug use to the treatment centre, or whether the treatment centre only recorded a secondary drug in cases where they thought that its use presented some sort of problem.

On the basis of cases where data on secondary drug of misuse were available, the most common secondary drug was an opiate or opioid, followed by hypnotic/sedatives, stimulants, cannabis and alcohol. Most used the secondary drug on a daily basis, but only a minority injected it. The most common route was oral. One interpretation is that the recorded secondary drug was often used as a substitute when the primary drug was not available. This is supported by the observation that heroin was never recorded as a secondary drug. Conversely the opioids that were recorded (methadone, dihydrocodeine, buprenorphine and codeine) were relatively uncommon as primary drugs but were all used by opiate addicts as alternatives to heroin. Similarly, temazepam was never mentioned as a primary drug, but accounted for most of the mentions of hypnotics/sedatives as a secondary drug.

Cocaine, which was reported as a primary drug in only five cases was mentioned as a secondary drug in 15, despite the large number of cases where data on secondary drug were missing. It is very likely that this represents the secondary use of cocaine by drug misusers who present to treatment services as primarily opiate misuers.

A concluding comment on this section is that, on the basis of the London experience, difficulty was not experienced with regard to the frequency of use of the primary drug, since the information was recorded at the point at which drug misusers were requesting treatment. Problems were encountered reporting data on secondary drug misuse, especially age of first use and duration of

use. It did, however, appear valuable to record which secondary drugs were used (or at least those that were presented as problematic in some way) and the route of their administration, since this information well may point to important current patterns of drug misuse that would be missed if primary drugs only were recorded. The examples of buprenorphine, temazepam and cocaine given above illustrate this.

**Injecting/Sharing**

Data for Table 4 comes from Table A20 - A24 inclusive/ Appendix A.

**Table 4: Treated Drug Misusers in Dublin & London.**
**Injecting/Sharing.**
**Percentages.**

| | DUBLIN | | | LONDON | |
|---|---|---|---|---|---|
| Modal | % | kn* | Modal | % | kn* |
| ever injected | 87 | 497 | ever injected | 80 | 174 |
| not currently injecting | 60 | 491 | not currently injecting | 58 | 169 |
| Of those who had ever injected | | | | | |
| < 25 years when first injected | 89 | 390 | < 25 years when first injected | 77 | 121 |
| ever shared | 96 | 433 | ever shared | 67 | 133 |
| not currently sharing | 90 | 426 | not currently sharing | 84 | 129 |

* kn = known number of cases

Nine out of ten of all study cases in Dublin had injected drugs at some stage, but when this study was carried out this proportion had fallen to four in ten. Most were aged under 25 years and whereas almost all of them then shared needles and syringes, only a small proportion (1 in 10) alleged that they were so doing at time of treatment contact.

In London about three quarters were under the age of 25 years when they first injected. Fifty eight per cent of the whole sample were currently injecting when they requested treatment. Whilst two-thirds of those who had ever injected had shared injecting equipment in the past only one in six was recorded as currently sharing.

The rest of the study data are now presented as cross tabulations for

- first treatment demand
- socio-economic characteristics
- other relevant findings

First Treatment Demand

From Table 2 it can be seen that in Dublin 15% of clients were making a first treatment demand; the proportion in London was 33%. The definition of first treatment demand, as noted earlier in this report, differs in each city. In London it represents clients making a first ever contact with a treatment agency who may either be treated or given an appointment to return later for treatment.- In Dublin it constitutes a first ever contact and also signals the commencement of treatment, as to-date services are able to cope with these demands.

Table 5 shown on the following page looks at differences in sex, age, primary drug of misuse and duration of misuse in years for:

- clients making their first treatment demand (who have never been treated for their drug problem) and
- clients who have previously received treatment.

**Table 5: Treated Drug Misusers in Dublin & London.
Sex, Age, Primary Drug of Misuse & Duration,
by Never & Previously Treated,
Percentages & Numbers.**

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | Never Treated | Prev. Treated | Never Treated | Prev. Treated |
| **SEX** | | | | | |
| Male | % | 17 | 83 | 30 | 70 |
| | N | 57 | 273 | 35 | 80 |
| Female | % | 11 | 89 | 39 | 61 |
| | N | 18 | 148 | 24 | 38 |
| **AGE** | | | | | |
| < 25 years | % | 21 | 79 | 50 | 50 |
| | N | 41 | 153 | 24 | 24 |
| 25 + years | % | 12 | 88 | 24 | 76 |
| | N | 34 | 262 | 29 | 92 |
| **PRIMARY DRUG OF MISUSE** | | | | | |
| opiates/ | % | 13 | 87 | 26 | 74 |
| opioids | N | 55 | 370 | 38 | 109 |
| stimulants | % | 36 | 64 | 50 | 50 |
| | N | 4 | 7 | 2 | 2 |
| hypnotics/ | % | 14 | 86 | 25 | 75 |
| sedatives | N | 3 | 18 | 2 | 6 |
| hallucinogens | % | - | 100 | 100 | - |
| | N | - | 1 | 2 | - |
| volatile | % | 29 | 71 | 100 | - |
| inhalents | N | 2 | 5 | 6 | - |
| cannabis | % | 46 | 54 | 100 | - |
| | N | 11 | 13 | 4 | - |
| **DURATION** | | | | | |
| < 5 years | % | 25 | 75 | 44 | 56 |
| | N | 41 | 125 | 20 | 25 |
| 5 - < 10 years | % | 7 | 93 | 24 | 76 |
| | N | 13 | 163 | 12 | 37 |
| 10 + years | % | 14 | 86 | 26 | 74 |
| | N | 17 | 109 | 9 | 25 |

In Dublin 75 misusers or 15% of the known population were making their first treatment demand; the remaining 85% had previously been treated. When the two groups of never treated and previously treated are compared differences emerged. The never treated or those making their first treatment demand had the highest proportion of males, persons in the younger age group of under 25 years, and of those misusing non opiate/opioids. The first treatment demand group also had the highest proportion of clients in the shortest duration category indicating that they were less time on the primary drug before coming for treatment, than the previously treated group.

In the London sample, 59 clients were demanding treatment for the first time ever. This represented one third of the total sample for whom information on previous treatment history was known. In Table 5, it can be seen that if these 59 clients are compared to drug misusers who had previously been treated, then there were differences between the two subgroups on all four variables.

Thus the subgroup who were demanding treatment for the first time ever contained higher proportions of women, of drug misusers who were younger (under 25), of people whose primary drug was a nonopiate such as a stimulant, hallucinogen, volatile inhalant or cannabis. Only for hypnotics/sedatives were new-to-treatment misusers older than their opiate-using counterparts. People who were seeking treatment for the first time were also more likely to report a shorter duration of use of the primary drug.

**Table 6: Treated Drug Misusers in Dublin. Never Previously Treated.
Sex, Age & Primary Drug by
Duration in Years for Primary Drug.
Percentages & Numbers**

| | | DUBLIN | | |
|---|---|---|---|---|
| | | **< 5 years** | **5 - <10 years** | **10 + years** |
| **SEX** | | | | |
| male | % | 59 | 13 | 28 |
| | N | 31 | 7 | 15 |
| female | % | 56 | 33 | 11 |
| | N | 10 | 6 | 2 |
| **AGE** | | | | |
| < 25 years | % | 87 | 10 | 3 |
| | N | 33 | 4 | 1 |
| 25 + years | % | 24 | 27 | 49 |
| | N | 8 | 9 | 16 |
| **PRIMARY DRUG OF MISUSE** | | | | |
| opiates/ opioids | % | 57 | 20 | 23 |
| | N | 29 | 10 | 12 |
| other drugs | % | 60 | 15 | 25 |
| | N | 12 | 3 | 5 |

In Dublin approximately the same proportion of males and females (59% and 56%) were misusing their stated primary drug for less than five years prior to making their first treatment demand. A much higher percentage of those who sought treatment in the less than five year duration period was under age 25, than 25 years or over. Where primary drug of misuse is concerned a slightly higher percentage of persons misusing drugs, other than opiates/opioids, had sought treatment in the less than five year period.

**Table 7:Treated Drug Misusers in London. Never Previously Treated.**
**Sex, Age & Primary Drug by**
**Duration in Years for Primary Drug**
**Percentages & Numbers**

| | | LONDON | | |
|---|---|---|---|---|
| | | **< 5 years** | **5 - <10 years** | **10 + years** |
| **SEX** | | | | |
| male | % | 55 | 26 | 18 |
| | N | 15 | 7 | 5 |
| female | % | 36 | 36 | 28 |
| | N | 5 | 5 | 4 |
| **AGE** | | | | |
| < 25 years | % | 75 | 25 | - |
| | N | 12 | 4 | - |
| 25 + years | % | 32 | 32 | 36 |
| | N | 8 | 8 | 9 |
| **PRIMARY DRUG OF MISUSE** | | | | |
| opiates/ opioids | % | 46 | 28 | 25 |
| | N | 15 | 9 | 8 |
| other drugs | % | 55 | 33 | 11 |
| | N | 5 | 3 | 1 |

Table 7 presents the London data that was given for Dublin in Table 6. It can be seen that males were more likely than females to demand treatment within five years of use of their primary drug. Thus over half of males had been using for less than five years, compared to about one third of females. There was also a marked difference in terms of age. Drug misusers aged under 25 were much more likely to seek treatment sooner than those aged 25 and over. Thus about three quarters of clients aged under 25 had been using their primary drug for less than five years, compared to one third of those aged 25 and over. It can also be seen that users of drugs other than opiates were somewhat more likely to seek treatment for the first time within five years of use than were opiate users.

Socio-Economic Characteristics

**Table 8: Treated Drug Misusers in Dublin & London.**
**Specified Socio-Economic Characteristics**
**by Sex.**
**Percentages & Numbers.**

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| **AGE** | | **Male** | **Female** | **Male** | **Female** |
| < 25 years | % | 67 | 33 | 61 | 39 |
| | N | 131 | 65 | 34 | 22 |
| 25 + years | % | 66 | 34 | 69 | 31 |
| | N | 198 | 100 | 90 | 41 |
| **LIVING STATUS** | | | | | |
| alone/with family | % | 68 | 32 | 66 | 34 |
| with friends/other | N | 231 | 109 | 96 | 49 |
| with partner - drug | % | 41 | 59 | 52 | 48 |
| misuser | N | 25 | 36 | 13 | 12 |
| with partner - not | % | 79 | 21 | 63 | 37 |
| drug misuser | N | 67 | 18 | 10 | 6 |
| **ETHNICITY** | | | | | |
| white national | % | 67 | 33 | 63 | 37 |
| | N | 327 | 160 | 91 | 53 |
| Other | % | 44 | 56 | 67 | 33 |
| | N | 4 | 5 | 31 | 15 |
| **EMPLOYMENT** | | | | | |
| regular work | % | 89 | 11 | 63 | 37 |
| | N | 59 | 7 | 37 | 22 |
| unemployed/student | % | 63 | 37 | 66 | 34 |
| housewife/other | N | 268 | 136 | 79 | 0 |
| **AGE LEFT SCHOOL** | | | | | |
| < 15 years | % | 63 | 37 | 67 | 33 |
| | N | 152 | 88 | 6 | 3 |
| 15 + years | % | 68 | 32 | 67 | 33 |
| | N | 145 | 67 | 6 | 3 |

In Dublin, 67% of cases were male and 33% female (Table 1). From the above table it can be seen that in both the younger and older age categories one third were female. A higher proportion of women than men lived with a partner who was also misusing drugs. For those in

regular employment a much higher percent than would be expected from the sample size were male compared to female. There was little difference between the sexes regarding age left school.

In London, 65 % were male and 35 % female (Table 1). As can be seen in Table 8, a slightly higher proportion of people aged less than 25 were women compared to those aged 25 years and over (i.e. women tended to be younger). Women were also proportionately more represented amongst clients who were living with a partner who was also a drug misuser. There were few differences in the male-female ratio in terms of ethnicity or employment status.

In Dublin 60% were aged 25 years or over and 40% aged under 25 years (Table 1). As can be observed from Table 9 the higher proportion of males was in the 25 and over age category and likewise for the females. The proportion of persons living with a partner was higher in the older age group, likewise for those in regular work.

Thirty per cent of cases in London were under 25 years and 70% were 25 and over (Table 1). As noted overleaf, Table 9 also indicates that the younger age group contained a higher proportion of women than the older age group. The table also suggests, not surprisingly, that people aged 25 and over were more likely to be living with a partner than younger people. In terms of ethnicity, people who were not white British nationals were older than white nationals. Drug misusers in the older age group were slightly more likely to be in regular employment than those under the age of 25.

**Table 9: Treated Drug Misusers in Dublin and London.
Specified Socio-Economic Characteristics
by Age.
Percentages & Numbers.**

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| **SEX** | | **< 25 years** | **25 + years** | **< 25 years** | **25 + years** |
| Male | % | 40 | 60 | 27 | 73 |
| | N | 131 | 198 | 34 | 90 |
| Female | % | 39 | 61 | 35 | 65 |
| | N | 65 | 100 | 22 | 41 |
| **LIVING STATUS** | | | | | |
| alone/with family | % | 48 | 52 | 35 | 65 |
| with friends/other | N | 160 | 175 | 48 | 90 |
| with partner - drug | % | 20 | 80 | 16 | 84 |
| misuser | N | 12 | 48 | 4 | 21 |
| with partner - not | % | 25 | 75 | 15 | 85 |
| drug misuser | N | 21 | 63 | 2 | 11 |
| **ETHNICITY** | | | | | |
| white national | % | 40 | 60 | 33 | 67 |
| other | % | 50 | 50 | 19 | 81 |
| **EMPLOYMENT** | | | | | |
| regular work | % | 41 | 59 | 25 | 75 |
| | N | 27 | 39 | 13 | 40 |
| unemployed/student | % | 40 | 60 | 34 | 66 |
| housewife/other | N | 166 | 253 | 41 | 78 |
| **AGE LEFT SCHOOL** | | | | | |
| < 15 years | % | 39 | 61 | 44 | 55 |
| | N | 92 | 147 | 4 | 5 |
| 15 + years | % | 43 | 57 | 33 | 67 |
| | N | 89 | 120 | 3 | 6 |

**Table 10: Treated Drug Misusers in Dublin & London.**
**Specified Socio-Economic Characteristics**
**by Primary Drug.**
**Percentages and Numbers**

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | Opiates/ opioids | Other Drugs | Opiates/ opioids | Other Drugs |
| **SEX** | | | | | |
| Male | % | 85 | 15 | 81 | 19 |
| | N | 281 | 48 | 105 | 25 |
| Female | % | 90 | 10 | 76 | 24 |
| | N | 147 | 17 | 51 | 16 |
| **AGE** | | | | | |
| < 25 years | % | 83 | 17 | 72 | 28 |
| | N | 163 | 33 | 38 | 15 |
| 25 + years | % | 89 | 11 | 86 | 16 |
| | N | 259 | 32 | 112 | 18 |
| **LIVING STATUS** | | | | | |
| alone/with family | % | 86 | 14 | 79 | 22 |
| with friends/other | N | 288 | 48 | 108 | 31 |
| with partner - drug | % | 95 | 5 | 100 | - |
| misuser | N | 57 | 3 | 25 | - |
| with partner - not | % | 85 | 15 | 94 | 6 |
| drug misuser | N | 70 | 12 | 16 | 1 |
| **ETHNICITY** | | | | | |
| white national | % | 87 | 13 | 88 | 12 |
| | N | 418 | 61 | 126 | 17 |
| other | % | 67 | 33 | 62 | 38 |
| | N | 6 | 3 | 26 | 16 |
| **EMPLOYMENT** | | | | | |
| regular work | % | 78 | 22 | 84 | 16 |
| | N | 51 | 14 | 49 | 9 |
| unemployed/student | % | 89 | 11 | 82 | 18 |
| housewife/other | N | 371 | 48 | 95 | 21 |
| **AGE LEFT SCHOOL** | | | | | |
| < 15 years | % | 92 | 8 | 100 | - |
| | N | 219 | 18 | 9 | - |
| 15 + years | % | 84 | 16 | 89 | 11 |
| | N | 175 | 33 | 8 | 1 |

In Table 10 the primary drug of misuse categories, except for opiates/opioids, have been combined under ‘other drugs’ because the numbers involved are small. Notwithstanding the opiate/opioid group predominates and as a consequence any analysis of the ‘other drugs’ category must be regarded with caution because of the small numbers and the heterogeneity of the ‘other’ categories.

In Dublin 87% stated that opiates/opioids were their primary drugs of misuse (Table 3).’ The above table shows that females were more likely than males to be opiate misusers and likewise persons aged over than under 25 years. In each of the living status categories opiates/opioids predominate, but the highest proportion is in the ‘living with partner - drug misuser’. Clients who were unemployed/student/housewife/other, had a higher proportion misusing opiates than those in regular work. There was no marked difference in opiate misuse for school leaving age.

Seventy nine per cent of the London sample (Table 3) reported an opiate or opioid as their primary drug of misuse. Table 10 indicates that males were slightly more likely to be opiate misusers than females, and that people aged under 25 were less likely to report opiates as their primary drug. Almost all of those living with a partner were opiate users, regardless of whether or not the partner was also a drug misuser. White nationals were more likely to be opiate users than non white nationals. Conversely, a higher proportion of people who were not white nationals reported drugs other than opiates as their primary drug (38% compared to 12% of white nationals). There were no differences between the employed and others in terms of their primary drug of use.

Other Relevant Findings

The two remaining areas of drug misuse covered in this section relate to

– currently injecting

– currently sharing

**Currently Injecting**

**Table 11: Treated Drug Misusers in Dublin & London. Specified Characteristics of those who had Ever Injected by Currently Injecting. Percentages & Numbers.**

| | | DUBLIN Currently Injecting | | LONDON Currently Injecting | |
|---|---|---|---|---|---|
| **SEX** | | **Yes** | **No** | **Yes** | **No** |
| Male | % | 34 | 66 | 65 | 35 |
| | N | 95 | 185 | 61 | 33 |
| Female | % | 26 | 74 | 84 | 16 |
| | N | 39 | 109 | 38 | 7 |
| **AGE** | | | | | |
| < 25 years | % | 32 | 68 | 75 | 25 |
| | N | 52 | 111 | 24 | 8 |
| 25 + years | % | 32 | 68 | 73 | 27 |
| | N | 82 | 178 | 71 | 26 |
| **PRIMARY DRUG OF MISUSE** | | | | | |
| opiates/ | % | 33 | 67 | 73 | 27 |
| opioids | N | 132 | 269 | 99 | 36 |
| other drugs | % | 9 | 91 | - | 100 |
| | N | 2 | 20 | - | 1 |
| **ETHNICITY** | | | | | |
| white national | % | 31 | 69 | 74 | 26 |
| | N | 131 | 286 | 78 | 27 |
| other | % | 17 | 83 | 75 | 25 |
| | N | 1 | 5 | 18 | 26 |
| **EVER INJECTED** | | | | | |
| yes | % | 31 | 69 | 73 | 27 |
| | N | 134 | 293 | 99 | 36 |
| no | % | - | - | - | - |
| | N | - | - | - | - |

From Table 4 it can be seen that 87% of all study cases in Dublin had ever injected. The corresponding figure for London was 80%. In Dublin the above table shows that only 31% of those who had ever injected were currently so doing. This is probably an underestimation of the actual number when one remembers that almost half the entire sample was recorded as 'drug-free'. This was accounted for by the fact that information in all cases did not correspond to the point of entry to treatment, but to the time the study was conducted. The question in 'the problem drug use' section of the form referred to frequency of misuse in the past month, consequently those persons who were on a methadone maintenance programme for a month or more prior to the study were recorded as 'drug-free'. It follows that that particular group would not have been 'curently injecting'. This situation casts doubt on the validity of differences in variables like sex, age and primary drug of misuse on currently injecting shown in the table.

From the London data in Table 11 it can be seen that 73% of those who had ever injected were still currently injecting. A higher proportion of females than males were still currently injecting, but there were no differences in terms of age or ethnicity in the proportions who were still injecting. Only opiate/opioid users were recorded as currently injecting.

**Currently Sharing**

An earlier table (4), provided the information that in Dublin 96% or 433 persons who had ever injected had also shared needles/syringes at some time or other. At the time the project information was gathered current sharing was recorded for only 10% or 44 persons. In London of those who had ever injected 67% had also shared at some earlier time; the current percentage was 16.

**Table 12: Treated Drug Misusers in Dublin and London.
Specified Characteristics of those who had Ever Injected
by Currently Sharing.
Percentages & Numbers.**

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | Currently Sharing | | Currently Sharing | |
| **SEX** | | **Yes** | **No** | **Yes** | **No** |
| Male | % | 11 | 89 | 11 | 89 |
| | N | 30 | 251 | 9 | 73 |
| Female | % | 10 | 90 | 26 | 74 |
| | N | 14 | 131 | 12 | 35 |
| **AGE** | | | | | |
| < 25 years | % | 9 | 91 | 18 | 82 |
| | N | 15 | 146 | 7 | 31 |
| 25 + years | % | 11 | 89 | 15 | 84 |
| | N | 29 | 231 | 14 | 76 |
| **PRIMARY DRUG OF MISUSE** | | | | | |
| opiates/ | % | 11 | 89 | 16 | 84 |
| opioids | N | 44 | 354 | 21 | 107 |
| other drugs | % | - | 100 | - | 100 |
| | N | - | 23 | - | 1 |
| **ETHNICITY** | | | | | |
| white national | % | 10 | 90 | 17 | 83 |
| | N | 43 | 372 | 16 | 80 |
| other | % | - | 100 | 17 | 83 |
| | N | - | 6 | 5 | 20 |
| **CURRENTLY INJECTING** | | | | | |
| yes | % | 95 | 5 | 25 | 76 |
| | N | 41 | 2 | 21 | 64 |
| no | % | 23 | 77 | | 100 |
| | N | 89 | 292 | - | 44 |

Regarding the Dublin data in Table 12, the likely existence of the ‘drug-free’ group in the categories of ‘not currently sharing’ and ‘not currently injecting’ poses problems of validity.

Table 12 shows that in London of those who were currently injecting, one quarter were also currently sharing. This can be compared with data for Table 4 which indicated that of those who had ever injected two thirds had at some stage likewise shared equipment.

As with injecting, a higher proportion of women than men were currently sharing. There were no differences in terms of ethnicity or age.

## 7. DISCUSSION

It bears repeating here that this project is a pilot one which aims at testing the feasibility of establishing a drug reporting system in London and Dublin to collect similar core data on treated drug misusers. These data in turn will provide information on first treatment demand and on the socio-economic characteristics of drug clients attending specified treatment centres. But due to limitations inherent in the data from both cities -e.g., they do not represent complete coverage in either catchment area, the form has revealed some anomalies which need amending and certain differences in coding have been identified - they cannot therefore be regarded as providing comparable statistics of treated clients in the two cities. For these reasons it was decided not to compare results from this project with relevant findings in the literature.

By abstracting relevant information from all tabular sources the main findings will be presented for the following areas,

- profile of the study population
- first treatment demand
- socio-economic characteristics of clients
- other relevant findings.

Main Findings

**Profile of the study population**

Before going on to present the principal findings under the stated headings a general statement can be made regarding the two drug misusing populations in London and Dublin. The sex ratio was similar in both cities, but in London the drug misusers were slightly older than in Dublin.

Almost one quarter of the London population comprised non white nationals whereas the proportion in Dublin was negligible.

Eight in ten of the Dublin client group were unemployed compared to six in ten in London. Fewer drug misusers in Dublin than in London were making their first treatment demand.

In both cities most clients who were seeking treatment reported that their primary drug of misuse was an opiate or opioid, predominantly heroin. Dublin drug users were more likely to have ever injected their drugs and ever shared injecting equipment than their London counterparts.

**First treatment demand**

Fewer drug misusers in Dublin were making their first treatment demand on services than in London/ 15% compared to 33%.

When this ‘first treatment demand’ group was compared to the group who had previously received treatment an interesting and quite similar pattern emerged in both cities. Those on their first treatment demand tended to be younger (aged under 25 years), misusing a drug which was not an opiate/opioid and had been doing so for a shorter period of time. The only difference between the

cities was that in London a higher proportion of first treatment demand cases was female, the reverse was true in Dublin.

In Dublin females were more likely to seek treatment within five years of misusing their primary drug than males; in London the opposite situation pertained. In both cities, almost a third of the older age group of 25 years and over had been misusing their primary drug for five to less than ten years before seeking treatment for the first time.

A significant minority of clients in both cities had been ten or more years on a primary drug before making a first contact with a treatment centre.

**Socio-economic characteristics of clients**

The treated populations in the two cities were alike in terms of the sex ratio, with about 2 males to every female.

However the age structure of the populations differed somewhat with the London clients being slightly older. There were some differences between the sexes also where in London women were younger than men, but not so in Dublin where the proportions were alike.

In both London and Dublin more people were living with their parental families than in other living arrangements, with a higher proportion so doing in Dublin. In London, clients were twice as likely to be living on their own than in Dublin.

In both cities those living with partners, irrespective of whether the partner was a drug user or not, tended to be older than those who had not such living arrangements. A higher proportion of women than men in both cities lived with a partner who was also a drug misuser. In

Dublin this may be due to poverty where fewer women than men have an income of their own. This is also reflected in this study where for those in regular employment a much higher percent, than would be expected from the sample size, were male than female. The reasons why more women than men are living with a drug misusing partner in London are unclear.

More London clients were described as being other than white nationals. This is not unexpected in that the population of London is more heterogeneous than Dublin. Detailed data on the ethnic distribution of the areas of London covered by this pilot were not readily available, but it is likely that the proportion of people in the London treated population who were not white nationals is lower than in the general population.

Not suprisingly, perhaps, a higher proportion of London clients were in regular work than was found in Dublin and this proportion tended to be older than the corresponding proportion employed in Dublin.

The main difference noted for drug misuse in the treated populations of the two cities was in the route of administration. Clients in London were less likely to inject their drug than in Dublin.

There were no striking differences in inter-city comparisons of the socio-economic characteristics of those misusing either opiates/opioids or other drugs. In Dublin, more females than males were misusing opiates/opioids, while the reverse was true in London. For the other variables of age, living status, ethnicity and employment there were some but no marked differences.

**Other relevant findings**

The only valid inter-city comparisons regarding the injecting/sharing practices of clients that can be made

are for those who ever injected or ever shared. In Dublin the proportion for both practices was higher than for London. However, the existence of a high proportion of 'drug free clients' earlier discussed in section 6 of the report made comparisons between what pertained in a 'current situation' impossible.

Methodological Considerations

**Reliability**

The reliability of the data (do they record accurately what they are supposed to record?) is an important issue in any study. The data for this study were collected by the staff of the treatment centres concerned. In all cases the data were obtained in face-to-face clinical settings.

A full evaluation of the reliability (accuracy) of the data would have involved checking those data against other sources that were independent of the clinical interviews, (for example through separate research interviews, urine tests, enquiries of employers, checks with records of the same individuals at other treatment centres they had attended, and so on). These checks were not feasible in this study. Resources did not allow for independent, research-based interviews with clients concerned, nor, for reasons of maintaining confidentiality, was it possible to cross-check the data with other sources of information. Factors likely to affect reliability were (a) whether the client perceived or assumed some advantage in giving incorrect information, (b) errors of memory, and (c) errors in recording the data for the staff.

Assessment of the reliability of the data varies according to the type of data concerned. In terms of the socio-demographic variables, it is very likely that sex, age and ethnicity were correctly recorded since the staff

member could directly observe if they were likely to be correct, and drug misusers had little reason to give misleading answers. In terms of living status, there was again little reason to mislead, except, perhaps, regarding whether or not a partner was a drug misuser. In neither city was employment status a factor that influenced treatment responses, though it is possible that a few clients who were particularly wary of treatment centres might have concealed their employment for fear of their employers finding out about their drug misuse. Age left school was probably recorded accurately.

In terms of drug misuse, it is more difficult to be certain of the reliability of the data. For example, if certain treatment centres are known primarily to treat opiate users (e.g., methadone programmes), then clients may emphasise their opiate use and omit reference to other drugs. Likewise, if clients are in treatment, they may conceal non-sanctioned drug use. In most centres in the two cities, assessment of clients include urinanalysis, so there were some checks on the drug use reported by clients. Similarly, data on route of administration (or at least injection) could be checked through clinical examination. The reliability of data on frequency, age of first use, and duration of use could not be cross-checked. We must therefore caution against complete acceptance of the reliability of these data.

Data on the sharing of injecting equipment should be viewed with particular caution. Given the increasing disapproval that is associated with sharing, there are strong psychological reasons to suppose that clients may have under-reported the extent to which they shared. Even if they were willing to admit they had shared in the past, some may well have denied that they continued to do so.

Data on treatment centre contact were very probably reliable in terms of whether clients were new or not to particular centres. There was more room for error regarding whether they had ever been treated before, since it is not known how clients understood the term 'previously treated'. However, in an earlier (unpublished) study by the London investigator/ the reliability of this item was found to be high.

In conclusion, we feel that it is reasonable to assume that most of the data are sufficiently reliable to warrant analysis, although there remains the need for future studies to address questions of reliability of data on drug use history, frequency of use, secondary drug use and the sharing of injecting equipment.

**Representativeness**

Since this was primarily a pilot of a procedure and not a substantive research study, the issue of representativeness was not central. However, if this procedure is to be applied in future comparisons of treatment demand between cities or countries, it becomes of the utmost importance.

In Dublin, the pilot involved almost all treatment centres and was thus representative. The exceptions included some G.P.s. In London, most of the major type of treatment centres (in terms of numbers of clients seen) were included. However there were some important exceptions. These included residential therapeutic communities or longer term hostels. The sample of centres also under-represented the extent of involvement of G.P.s in the treatment of drug misuse. Previous experience in the U.K. has demonstrated the serious difficulty that is encountered in persuading G.P.s to participate in a reporting system such as that described in this report. It is the London investigator's belief that low compliance rates for G.P.s constitute a major

problem in any routine reporting system in the U.K. It should be noted that in this project data were not collected from accident and emergency departments, nor from psychiatric hospitals, except in the case of Dublin, where consultants in two private psychiatric hospitals have agreed to participate in the project. The reason for this decision was that admissions to hospitals and to Emergency Departments were seen as separate indicators of misuse. Earlier evidence has shown that only a small percentage of drug users are in hospital care,

**Comparability**

'Comparability' should be understood to include two aspects. The first is methodological, in terms of the comparability of procedures, definitions, variables and data categories. The second is substantive in terms of the interpretation of the similarities and differences between the situations in the two cities.

In methodological terms, the data themselves are almost all directly comparable. The same items were collected in both cities using proceedures that were as similar as the different circumstances permitted. The definitions employed were identical, with two exceptions which are discussed below. Identical analyses were carried out. Thus the investigators are confident that this pilot has demonstrated the feasibility of collecting comparable data on the first treatment demand indicator and on the socio-demographic characteristics of treated drug misusers. However there are certain areas where lessons may be learnt that will be of value in any future work.

One area where differences between the two cities led to problems in comparing the data was the time period for the variables concerning frequency of drug misuse and current injecting and sharing practices. In London, since the data were all collected at the first stage of entering treatment (i.e. when clients were requesting

treatment) these items referred to the month prior to treatment contact. In Dublin, since data for almost half the clients were gathered when they were already in treatment (and in some cases more than one month after entering treatment) then they were recorded as 'drug free' and 'not injecting' etc. For strict comparability, these items should have referred to the month prior to entering treatment.

The other area of difference concerned first treatment request (London) as opposed to first treatment received (Dublin). The main effect of this was that the London data included some cases who did not subsequently enter treatment. In terms of this study, this probably made little difference to the outcome of the pilot. However, it should be noted that if in the future, first treatment demand is used as an indicator, then there are circumstances where this might make a difference. These are where treatment services are operating at full capacity. First treatment received would then reflect the availability of treatment "slots", and first treatment requested would be a better indicator, though if drug misusers were aware that treatment centres were full, then this indicator too might become insensitive to changes in drug misuse. The main point here is to emphasize the importance of interpreting the data in terms of the treatment situation in the city concerned.

Evaluation of the core data

In consultation with National and European colleagues a set of core project data was agreed as shown on the form, Appendix B1. Information for 19 items was collected in both London and Dublin. Analyses in this report excluded the folowing items, 1, 2, 3, 4, 7b, 11 and 14b for reasons already given, therefore the evaluation of core data is restricted to the remaining variables. No problems were encountered either with the treatment centres' recording of information or with the coding for

items 5, 6, 7a, 8, 9, 13, 14a, 16, 17, 18 and 19. Various problems were associated with the remaining items.

Commencing with item 10, the principal difficulties were associated with code 2 - 'with family', which limited the concept of family in the instructions (Appendix B3), to parental family or family of origin. Provision needs to be made to include a code for marital family. The code for 'institution' also was ill-defined, in that therapeutic communities in Dublin with residential accommodation had to use this code; it was also used by other treatment centres for clients who resided in an institutional-type hostel.

Whereas the variable 'ethnicity' was of considerable utility in London where general agreement exists on the appropriateness of its collection, some European colleagues and personnel in Dublin treatment centres had reservations about the advantage of this detail of information fearing that output arising from it might be used to stigmatise minority groups.

Instructions regarding 'problem drug use' posed problems in Dublin, regarding the definition of problem drug use as "the drug for which client alleges at the time of contact is causing most problems and for which treatment is sought". Several centres mentioned that by using this definition important information could be missed. They gave the example of clients using opioids, like morphine sulphate tablets for brief periods due to the non-availability or high price of their long misused and preferred drug, heroin, having their primary drug of misuse incorrectly recorded.

A more fundamental problem concerning the restriction of frequency of drug use to the 'past month' occurred in Dublin, which has been commented on in the previous

section. When the form is revised the instructions used should relate to frequency in the month prior to the treatment contact. Because of the slightly different procedure used in London centres this problem did not arise there.

A simple analysis of the percentage of 'not known' cases (see frequency tables Appendix A) provides some insight into difficulties encountered in the collection of certain core items. This showed that in both London and Dublin apart from client age the 'not known' responses were associated with the recall of time in years for, age left school; age of first misuse of drugs, frequency of misuse, and duration in years for both primary and secondary drug misuse. The London investigator has earlier commented in the study findings section of the report on possible reasons for the higher level of 'not known' responses there, especially for secondary drug misuse, than in Dublin.

## 8. CONCLUSION

In this final section a brief comment will assess the results of the study objectives and give some examples of questions raised by the findings. The concluding section will address 'European collaboration in the collection of core data items?'

Brief comment on objectives

The investigators feel that the twin objectives of this study have been achieved. This pilot project demonstrated:

(a) That it is possible and useful to collect data on first treatment demand. The dangers of making simple inferences from the data are discussed. When other factors that can distort the data are taken into account, then the data can provide a direct indicator of the

attractiveness of services, and an indirect indicator of trends in drug misuse.

(b) It is also possible and useful to establish a reporting system on the socio-economic characteristics of treated drug misusers. Some of the problems of collecting these data are described, and some of the issues regarding comparability are examined.

The information collected can illuminate questions such as "Whom do treatment centres attract?" "Which subgroups are more reluctant to use services?" "What drugs have people demanding treatment been using?" "What are the differences in the profiles of drug misusers who contact different treatment centres?" "Do younger users seek treatment more rapidly than older users?" "What are the trends in terms of injecting drugs?" All of these questions and others that have been described above are of value to both service providers and to policy makers. The possibility of drawing international comparisons adds a further important dimension.

<u>European collaboration in the collection of core data items?</u>

The interest and involvement of European colleagues in the adoption of the core set of treatment items developed in the course of this project has already been mentioned (see sub section 'selection and development of core items' in the Discussion section). Earlier this year a small questionnaire was sent to colleagues in the eight cities of Amsterdam, Athens, Hamburg, Lisbon, Madrid, Paris, Rome and Stockholm requesting information on the intake form(s) most commonly used for the collection of treatment data in their cities. Their reponses showed that in Madrid a standard form is used - recently developed for national use. In Athens an adaptation of the 'Mariani' form is used in the two treatment centres

there. In Lisbon the two main treatment systems each have their own form, but differences between them are small. The other cities who responded stressed the lack of uniformity or standardisation in the collection of treatment data, e.g., at least five different forms are used in Amsterdam, and three in Hamburg. This is an understandable situation given the size and complexity of the many existing provisions in these cities involving a range of services, such as, detoxification clinics, pension assurance schemes and social assistance schemes. It should also be noted that the range of drugs covered by these various systems also varied.

While many European colleagues believed it might be possible to incorporate the set of core treatment items developed by this project into some of their existing systems, Lisbon and Madrid asserted that it would be feasible. An epidemiologist in Antwerp has likewise expressed a positive interest in using the finalised form and a Paris colleague thinks it should be possible to pilot the form in at least one treatment centre there. Lisbon piloted an earlier version of the form and treatment agency personnel there have all expressed a willingness to integrate the core variables either totally or in part to their system, when the form becomes available.

At a workshop earlier this year on “European Standards for Drug Abuse Services”, a proposal for a Concerted Action within the Medical and Health Research Program 4 of the European Communities, agreed that if the project was successful, client data required by them would be similar to items developed by this project.

While future collaboration among other cities is desirable to provide additional ongoing comparable data on first treatment demand and on the socio-economic characteristics of drug misusers at city level (and

perhaps to extend this process to include national coverage), two important considerations should be referred to.

Firstly, the need to integrate these data, at some future date, with output derived from other indicators of drug misuse such as, police arrests, seizures, price and purity of drugs. One of the findings from the Multi-city study already mentioned here stressed the importance of integrating information from a package of indicators and drew attention to the limitation, even the danger of relying solely on one indicator as a measurement of drug activity. Indicator data should also be complemented by information from other sources like ethnographic studies.

Finally it is appropriate to conclude by re-iterating another crucial multi-city study recommendation[24] that a specific European framework be created for receiving, synthesising and interpreting agreed drug information. This we believe should be viewed as an imminent research priority. Two suggested approaches have been put forward:

- that the Pompidou Group with its tradition of regular meetings with epidemiologists could provide such a forum.
- alternatively, that a European epidemiology centre be set up liaising with national centres. Such a model could be developed under the auspices of the Pompidou Group or it could be based elsewhere. Either prospect would of course involve full consultation with other European bodies, such as the European Commission and the European regional office of the World Health Organisation.

To ensure progress and in the case of this project the further development of core data and the accompanying necessary context to further understanding of drug misuse and its problems, a political commitment is necessary.

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**APPENDIX A.**

## FREQUENCY TABLES

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | % | N | % | N |
| Table A1 | **Type of Contact** | | | | |
| | new client | 19 | 96 | 61 | 124 |
| | old client | 80 | 403 | 36 | 73 |
| | n/k | 0.4 | 2 | 3 | 7 |
| Table A2 | **Ever Previously Treated** | | | | |
| | never | 15 | 75 | 29 | 59 |
| | previously treated | 84 | 421 | 58 | 118 |
| | n/k | 1 | 5 | 13 | 27 |
| Table A3 | **In Contact with Other Centres** | | | | |
| | no | 67 | 336 | 59 | 120 |
| | yes | 32 | 159 | 26 | 53 |
| | n/k | 1 | 6 | 15 | 31 |
| Table A4 | **Sex** | | | | |
| | male | 67 | 334 | 65 | 132 |
| | female | 33 | 167 | 35 | 71 |
| | n/k | - | - | 0.5 | 1 |
| Table A5 | **Age** | | | | |
| | < 25 years | 39 | 196 | 28 | 56 |
| | 25 + years | 60 | 298 | 64 | 131 |
| | n/k | 1 | 7 | 8 | 17 |
| Table A6 | **Living Status** | | | | |
| | alone | 10 | 48 | 23 | 46 |
| | with family | 39 | 198 | 25 | 51 |
| | with friends | 3 | 16 | 12 | 24 |
| | partner-drug misuser | 12 | 61 | 13 | 26 |
| | partner-not drug misuser | 17 | 85 | 9 | 19 |
| | institution | 13 | 64 | 1 | 2 |
| | homeless/transient | 0.2 | 1 | 3 | 6 |
| | other | 3 | 13 | 6 | 13 |
| | n/k | 3 | 15 | 8 | 17 |
| Table A7 | **Ethnicity** | | | | |
| | white national | 97 | 487 | 71 | 145 |
| | other | 2 | 9 | 23 | 46 |
| | n/k | 1 | 5 | 6 | 13 |

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | % | N | % | N |
| Table A8 | **Employment Status** | | | | |
| | regular work | 13 | 66 | 29 | 59 |
| | unemployed | 79 | 395 | 52 | 106 |
| | student | 1 | 4 | 4 | 9 |
| | housewife | 4 | 22 | 2 | 4 |
| | other | 1 | 5 | - | - |
| | n/k | 2 | 9 | 13 | 26 |
| Table A9 | **Age Left School** | | | | |
| | <15 years | 48 | 240 | 4 | 9 |
| | 15+ years | 42 | 212 | 4 | 9 |
| | still at school | 1 | 3 | - | - |
| | n/k | 9 | 46 | 91 | 186 |
| Table A10 | **Primary Drug of Misuse** | | | | |
| | opiates/opioids | 85 | 428 | 77 | 157 |
| | stimulants | 2 | 11 | 3 | 7 |
| | hypnotics/sedatives | 4 | 21 | 7 | 15 |
| | hallucinogens | 0.2 | 1 | 2 | 4 |
| | volatile inhalents | 1 | 7 | 4 | 9 |
| | cannabis | 5 | 25 | 3 | 6 |
| | other | - | - | - | - |
| | n/k | 2 | 8 | 3 | 6 |
| Table A11 | **Age First Used** | | | | |
| | < 25 years | 83 | 416 | 48 | 99 |
| | 25 + years | 12 | 58 | 19 | 38 |
| | n/k | 5 | 27 | 33 | 67 |
| Table A12 | **Frequency Past Month** | | | | |
| | drug free | 47 | 237 | 0.5 | 1 |
| | < once weekly | 6 | 29 | 2 | 3 |
| | once weekly | 2 | 8 | - | - |
| | twice + weekly | 5 | 25 | 3 | 5 |
| | daily | 12 | 62 | 87 | 177 |
| | twice + daily | 26 | 128 | 0.5 | 1 |
| | n/k | 2 | 12 | 8 | 17 |
| Table A13 | **Route** | | | | |
| | inject | 74 | 368 | 48 | 97 |
| | smoke | 8 | 41 | 20 | 41 |
| | eat/drink | 13 | 67 | 21 | 42 |
| | sniff | 3 | 17 | 5 | 10 |
| | n/k | 2 | 8 | 7 | 14 |
| Table A14 | **Duration in Years** | | | | |
| | < 5 years | 33 | 166 | 26 | 52 |
| | 5 - < 10 years | 36 | 178 | 28 | 57 |
| | 10 + years | 25 | 127 | 17 | 34 |
| | n/k | 6 | 30 | 30 | 61 |

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | % | N | % | N |
| Table A15 | **Secondary Drug of Misuse** | | | | |
| | opiates/opioids | 59 | 297 | 19 | 38 |
| | stimulants | 2 | 13 | 7 | 15 |
| | hypnotics/sedatives | 3 | 16 | 11 | 22 |
| | hallucinogens | 1 | 3 | 0.5 | 1 |
| | volatile inhalents | 0.4 | 2 | - | - |
| | cannabis | 9 | 43 | 5 | 11 |
| | alcohol | 13 | 63 | 3 | 5 |
| | other | 0.4 | 2 | - | - |
| | didn't misuse | 12 | 59 | 28 | 57 |
| | n/k | 1 | 3 | 27 | 55 |
| Table A16 | **Age First Used** | | | | |
| | < 25 years | 73 | 365 | 10 | 20 |
| | 25 + years | 10 | 52 | 2 | 4 |
| | didn't misuse | 12 | 59 | 28 | 57 |
| | n/k | 5 | 25 | 60 | 123 |
| Table A17 | **Frequency Past Month** | | | | |
| | drug free | 43 | 214 | - | - |
| | < once weekly | 7 | 34 | 4 | 8 |
| | once weekly | 5 | 28 | 1 | 2 |
| | twice + weekly | 8 | 42 | 5 | 10 |
| | daily | 6 | 29 | 30 | 62 |
| | twice + daily | 15 | 77 | - | - |
| | didn't misuse | 12 | '59 | 28 | 57 |
| | n/k | 4 | 18 | 32 | 65 |
| Table A18 | **Route** | | | | |
| | inject | 47 | 236 | 8 | 17 |
| | smoke | 8 | 39 | 9 | 18 |
| | eat/drink | 29 | 145 | 23 | 47 |
| | sniff | 2 | 10 | 0.5 | 1 |
| | didn't misuse | 12 | 59 | 28 | 57 |
| | n/k | 2 | 12 | 32 | 64 |
| Table A19 | **Duration in Years** | | | | |
| | < 5 years | 31 | 154 | 3 | 7 |
| | 5 - < 10 years | 29 | 145 | 5 | 10 |
| | 10 + years | 23 | 116 | 2 | 4 |
| | didn't misuse | 12 | 59 | 28 | 57 |
| | n/k | 5 | 27 | 62 | 126 |
| Table A20 | **Ever Injected** | | | | |
| | yes | 86 | 433 | 69 | 140 |
| | no | 13 | 64 | 17 | 34 |
| | n/k | 1 | 4 | 15 | 30 |

| | | DUBLIN | | LONDON | |
|---|---|---|---|---|---|
| | | % | N | % | N |
| Table A21 | **Age First Injected** | | | | |
| | < 25 years | 70 | 349 | 45 | 93 |
| | 25 + years | 8 | 41 | 14 | 28 |
| | n/a | 12 | 63 | 17 | 34 |
| | n/k | 10 | 48 | 24 | 49 |
| Table A22 | **Currently Injecting** | | | | |
| | yes | 27 | 134 | 48 | 99 |
| | no | 59 | 294 | 18 | 36 |
| | n/a | 12 | 63 | 17 | 34 |
| | n/k | 2 | 10 | 17 | 35 |
| Table A23 | **Ever Shared** | | | | |
| | yes | 83 | 414 | 44 | 89 |
| | no | 4 | 19 | 21 | 44 |
| | n/a | 12 | 63 | 17 | 34 |
| | n/k | 1 | 5 | 18 | 37 |
| Table A24 | **Currently Sharing** | | | | |
| | yes | 9 | 44 | 10 | 21 |
| | no | 76 | 382 | 53 | 108 |
| | n/a | 12 | 63 | 17 | 34 |
| | n/k | 2 | 12 | 20 | 41 |

APPENDIX B1

# Draft Core Data For Drug Treatment Reporting System

## POMPIDOU-EC PROJECT

(Complete Boxes, write information and circle codes as appropriate)

1. City ☐

2. Treatment Centre ☐☐

3. Client No. ☐☐☐☐☐☐☐☐

4. Date DAY ☐☐ MTH. ☐☐ YEAR ☐☐

5. Type of Contact with This Centre
   1. new client
   2. old client
   9. n/k

6. Ever Previously Treated
   1. never
   2. prev. treated
   9. n/k

7. Currently in Contact with Other Centres
   (a) 1. no
   2. yes
   9. n/k
   (b) if yes, specify .....

8. Sex
   1. male
   2. female

9. Age in Years (99 n/k) ☐☐

10. Living Status
    1. alone
    2. with family
    3. with friends
    4. with partner – drug misuser
    5. with partner – not drug misuser
    6. institution
    7. homeless/transient
    8. other .....
    9. n/k

11. Area of Residence
    .....

12. Ethnicity
    1. white national
    2. black – afro-caribbean
    3. black – asian
    4. other ethnic minority
    specify .....
    5. other white (non-national)
    specify .....
    9. n/k

13. Employment Status
    1. full-time
    2. part-time/regular
    3. unemployed
    4. full-time student
    5. full-time housewife
    6. other .....
    9. n/k

14. Education (a) Age left school (99 n/k) ☐☐
    (b) Highest level reached
    .....

15. Problem Drug Use

| | Drug Name | Age First Used | Frequency Past Month (see code) | Route (see code) | Duration in years |
|---|---|---|---|---|---|
| Primary | | | | | |
| Secondary | | | | | |

(Alcohol may only be recorded as a secondary drug of misuse)

**Frequency Past Month**
1. drug free
2. less than once weekly
3. once weekly
4. twice or more weekly
5. daily
6. twice or more daily
9. n/k

**Route**
1. inject
2. smoke
3. eat/drink
4. sniff
9. n/k

16. Ever injected
    (a) 1. yes
    2. no
    9. n/k
    (b) Age first injected ☐☐

17. Currently Injecting
    1. yes
    2. no
    9. n/k

18. Ever Shared
    1. yes
    2. no
    9. n/k

19. Currently Sharing
    1. yes
    2. no
    9. n/k

## APPENDIX B2

## DEFINITIONS OF KEY CONCEPTS

### Drug Treatment

Drug treatment is therapy given to clients in various specified centres. It may include medical treatment such as, de-toxification, methadone programmes and psycho-therapy, or non-medical modalities like counselling, individual or group therapy. Whereas therapy is commonly given by workers with professional qualifications, in this context it also includes workers employed by centres who are deemed by them to have the necessary therapeutic skills, but lack formal qualifications.

Drug treatment may be provided in prisons, therapeutic communities, residential centres, out-patient dines or street agencies. Treatment can also include drug-free programmes operated, for instance, in rehabilitation centres. Treatment does not include, however, information given over the telephone, or information solely related to social assistance or insurance entitlements.

### Drug Treatment Centre

A drug treatment centre for the purpose of this study is a centre, agency or individual where drug treatment, as already defined, is given.

### Drug Treatment Clients

Clients are persons who contact the specified drug treatment centres in the system and who currently reside in the study catchment area. This may include non-nationals, or in the case of residential centres, or prisons, persons resident there irrespective of their permanent area of residence.

Persons who contact the centres for treatment for a primary alcohol related problem or for gambling or .tobacco misuse are to be excluded from the system.

### First Treatment Demand

Persons requesting treatment, as defined above, for the first ever time. It is important to note that in some centres first treatment demand in fact relates to first treatment received and that this distinction will be made at the analysis stage.

**APPENDIX B3**

**INSTRUCTIONS FOR COMPLETION OF FORM**

1. **City**

   Enter city code which will be provided.

2. **Treatment Centre**

   Enter treatment centre code which will be provided.

3. **Client Number**

   This should be a number which uniquely identifies the client. In the Dublin centre the first two digits will be the treatment centre code, the third digit the specialist code, where one exists within the centre, otherwise a zero will be used. The remaining five digits relate directly to the client and will be computer generated or supplied by the centre.

4. **Date**

   This refers to the date on which the client makes contact with the centre. The first two digits refer to the day, the second two to the month and the last two to the year. Where day or month is represented by one digit, this digit should be entered in the second box of day or month, and a zero entered in the preceding box of day or month.

5. **Type of Contact with This Centre**

   Circle the relevant code. New client is a client making a first contact with the treatment centre, old client is a client making a second or subsequent contact. It should be possible in all cases to distinguish between new and old clients and code accordingly, however code 9 is provided when this information is not known.

6. **Ever Previously Treated**

   Circle the relevant code. Never, refers to a client who has never had a treatment contact anywhere for drug misuse and is therefore making a first ever treatment contact

with the centre. Previously treated, refers to a client who has already made contact either with the centre for which information is being completed or who has had any other drug treatment contact anywhere. This is a crucial question and it is essential that accurate information be obtained.

7. **Currently in Contact with Other Centres**

a) Circle the relevant code. No, refers to a client who has not been in contact with another drug treatment centre(s) in the 30 days prior to the current contact. Yes, relates to a client who is or has been in contact with another centre(s) in the 30 days prior to this contact. It should be possible in all cases to establish whether a client is currently in contact with other centre(s) or not; however, code 9 is provided when this information is not known.

b) Where a current contact with other centre(s) has been ascertained and code 2 in the a) part of the question is circled then the name(s) of the other centre(s) should be recorded.

8. **Sex**

Circle the appropriate code.

9. **Age**

Record the client's age in years at time of contact with the centre in the boxes provided.

10. **Living Status**

Circle the relevant code, and specify where necessary. Living status refers to current living status." Code 2, with family, refers to living with parent(s). Codes 4 and 5 relating to partner - drug misuser/not drug misuser, may refer to a spouse or to a male/female partner lived with.

11. **Area of Residence**

Record the current area of residence by writing the street or road name and the postal code, where one exists.

12. **Ethnicity**

Circle relevant code and specify where necessary.

13. **Employment Status**

Record current employment status by circling the relevant code and specifying where necessary.

14. **Education**

a) Record age in years when left school in boxes provided.

b) Record the highest educational level reached. Government sponsored work schemes are not regarded as educational schemes and therefore should not be recorded here.

15. **Problem Drug Use**

Primary

Record the drug name which the client alleges at the time of contact is causing most problems and for which treatment is sought.

Alcohol may not be recorded as a primary drug of misuse and clients whose primary drug of misuse is alcohol should be excluded from the system.

Secondary

Where client is misusing a second drug in addition to the primary one specified record the name.

Alcohol may be recorded as a secondary drug of misuse.

Age First Used

Record age in years for the drug recorded

Frequency Past Month

Record the relevant code for the drug recorded in the space provided from the list supplied.

Route

Record the relevant code for the drug recorded in the space provided from the list supplied.

Duration in Years

Record the number of years for which the drug recorded has been actively misused. Six months to less than 12 months misuse should be recorded as one year. Less than six months misuse should be recorded as 0.

16. **Ever Injected**

a) Circle the relevant code.

Injection refers to inserting a needle into a vein, muscle tissue, or under the skin.

b) Record age in years when first injected.

17. **Currently Injecting**

Circle the relevant code.

Injection refers to inserting a needle into a vein, muscle tissue, or under the skin.

18. **Ever Shared**

Circle the relevant code.

19 **Currently Sharing**

Circle the relevant code.

**APPENDIX B4**

**Dublin Centres**

**The Drug Treatment Centre Board**
(formerly the National Drug Advisory and Treatment Centre).

– A statutory outpatient counselling, prescribing (methadone)and detoxification service, with 10 beds in Beaumount Hospital.

**Coolemine Therapeutic Community**

– A voluntary non-prescribing agency providing counselling and support at induction, day programme, residential and after care level.

**The Rutland Centre**

– A voluntary non-prescribing agency providing counselling and therapy at residential and day care level,

**The Ana Liffey Project**

– A voluntary non-prescribing street agency offering counselling and support at day care level.

**The Addiction Counsellors**

– A statutory non-prescribing service operated in the Dublin Community Care areas by eight professional workers from various health centres offering counselling and support at day care level.

**Ballymun Youth Action Project**

– A voluntary non-prescribing community based agency offering individual counselling, group work, family counselling and a range of social activities.

**General Practitioner**

– A non-prescribing, counselling and support service offered by a general practitioner. Benzodiazepines have occasionally been used to detoxify patients.

**Consultant Psychiatrists, St, Patrick's Hospital**

– A service offered by a group of psychiatrists from a private psychiatric hospital at in or out-patient level.

**Consultant Psychiatrists, St. John of God Hospital**

– A service offered by a group of psychiatrists from a private psychiatric hospital at in or out-patient level.

**Mount joy Prison**

– A detoxification, counselling and support service.

**St. Patrick's Institution**

– A detoxification, counselling and support service.

**Arbour Hill**

– A detoxification, counselling and support service.

**Probation Service, Smithfield**

– A statutory counselling and support service for clients on probation.

**Talbot Day Centre**

– A statutory community-based programme for drug free youth providing remedial education, individual and group counselling. Group therapy is also available for family members.

**Mater Dei Counselling Centre**

– A voluntary specialised counselling unit for adolescents, providing out patient services, such as, individual counselling, family therapy and drama group.

**Mater Hospital Child Guidance Clinic**

– A statutory agency providing out-patient services, for example, counselling and therapy.

**Ushers Island Clinic and Day Centre**

– A statutory agency providing assessment and treatment for disturbed adolescents on an out-patient basis.

**APPENDIX B5**

**LONDON CENTRES**

**Brent Community Drug Service (BCDS)**

– an NHS-based non-prescribing and counselling service at the Central Middlesex Hospital.

**Four satellite clinics of BCDS based in Health Centres around Brent**

– Kilburn
– Craven Park
– Neasden
– Chalkhill

**St. Mary's Drug Dependence Unit**

– an outpatient counselling, prescribing (methadone) and detoxification service.

**Two general practices in Brent**

– both provide treatment at primary care level to addicts.

**University College Hospital (UCH) Drug Dependence Unit**

– similar to St. Mary's.

**Rathbone Place**

– satellite of UCH Drug Dependence Unit providing easy access low threshold advice and prescribing service in West End.

**Enfield Community Drug Team**

– non-prescribing counselling and advice service.

**City Roads Crisis Intervention Centre**

– short term residential (3 weeks) crisis centre for drug misusers.

**Hungerford Project (possible)**

– non-statutory street agency offering advice, counselling and referral. Decision pending - may or may not be in time for pilot.

**APPENDIX B6**

**OUTLINE OF PROJECT**

The principal objectives of the Pompidou-EC project are:

– to develop a first treatment demand indicator (seen as one of the best indicators of drug misuse in a given area) and

– to test the feasibility of establishing a reporting system of information on the socio-economic characteristics of drug misusers. Both these objectives, in addition to the accumulation of other relevant information, can be achieved from a drug treatment reporting system.

This system will collect a set of basic client information from a number of specified drug treatment centres in London and Dublin. In Dublin this will be achieved largely through the co-operation of the treatment centres in completing a form that sets out the basic information to be gathered and the range of codes employed. In London this form will be used to collect data from some treatment centres. However, for those centres with developed reporting systems the required information will be abstracted from existing data sets making what changes are necessary at the input stage to ensure comparability of output.

The reporting system will be person, rather than event based, with information collected once for the period under review irrespective of the number of contacts the client may have had with a centre. The system will be a confidential one, with clients identified through the use of a unique number.

A pilot study which will operate for approximately three months in both cities will test the feasibility of achieving the project objectives through the use of selected variables and codes. Following a review of the pilot data and feed back from the participating centres the form will then be finalised.

**Memo to Drug Treatment Centres**

**Re Pilot Phase of the Pompidou-EC Drug Project**
**from the Health Research Board**

---

The pilot phase of the study commences on August 1st 1989 and will be on-going for three months. Please complete a form once, starting on August 1st, for each client who receives treatment from your centre during the pilot phase.

Please return completed forms to the Health Research Board, in the special bag provided, at the end of each month with an accompaning note stating the number of forms being returned and the month to which they refer.

To avoid duplication of records we suggest you maintain a list of client numbers, names and addresses for which you have returned data to us. This checking procedure could be further enhanced by also maintaining the data on a card file system with names in alphabetic order.

The first three codes on the form are as follows:

1. The City code for Dublin is 1.
2. Your Treatment Centre code is
3. The Client no. is for the first two digits, the third digit is the specialist code; where none exists a zero is recorded. The remaining five digits relate directly to the client. Where this number is less than five digits zeros should preceed the number.

**APPENDIX B7**

## CODING GUIDE

**CITY:**

1 Dublin
2 London

**TREATMENT CENTRE:**

Each treatment centre was allocated a two digit code. In Dublin the codes were 01 through 17 for each of the 17 centres in the study. In London the codes were 01 to 13 inclusive.

**CLIENT NO:**

This is a five digit number which uniquely identifies a client, It was either computer generated as in Dublin for some of the centres, or was the number used by the treatment centres to identify their clients. In London each client was allocated a sequential number which was retained by the centres in their case files.

**DATE:**

Two digits are recorded for day, two for month and two for the last two numbers of the year.

**TYPE OF CONTACT:**

1 new client
2 old client
9 not known (n/k)

**EVER PREVIOUSLY TREATED:**

1 never
2 previously treated
9 n/k

**CURRENTLY IN CONTACT WITH OTHER CENTRES:**

(a) 1 no
2 yes
9 n/k

(b) if yes, specify by name
if no, 88 not applicable (n/a)

**SEX:**

1 male
2 female

**AGE IN YEARS:**

Two digits are receded for client's age
99 n/k.

**LIVING STATUS:**

1 alone
2 with family
3 with friends
4 with partner-drug misuser
5 with partner-not drug misuser
6 institution
7 homeless/transient
8 other
9 n/k

**AREA OF RESIDENCE:**

This variable is coded differently in London and Dublin to accord with census areas.

**ETHNICITY:**

| | | | |
|---|---|---|---|
| 1 | white national | 4 | other ethnic minority |
| 2 | black - afro-carribean | | specify _____ |
| 3 | black – asian | 5 | other white (non-national) |
| | | | specify _____ |
| | | 9 | n/k |

**EMPLOYMENT STATUS:**

| | | | |
|---|---|---|---|
| 1 | full time | 5 | full-time housewife |
| 2 | part-time/regular | 6 | other |
| 3 | unemployed | 9 | n/k |
| 4 | full-time student | | |

**EDUCATION:**

(a) Two digits are recorded for age in years left school
88 for persons still at school
99 n/k

(b) This variable is coded differently in Dublin and London because of the different educational systems
888 for persons still at school
999 n/k

**PROBLEM DRUG USE:**

**PRIMARY DRUG** of misuse, as defined in instructions - see Appendix B3 - is returned by the centres and coded according to the following broad groups

| | | | |
|---|---|---|---|
| 1 | opiates/opioids | 5 | volatile inhalants |
| 2. | stimulants | 6 | cannabis |
| 3 | hypnotics/sedatives | 8 | other |
| 4 | hallucinogens | 9 | n/k |

and also according to the individual drug name.

See Appendix B8 for detailed codes

**AGE FIRST USED:**

Two digits are recorded for age first used.
99 n/k

**FREQUENCY PAST MONTH:**

| | | | |
|---|---|---|---|
| 1 | drug free | 5 | daily |
| 2 | less than once weekly | 6 | twice or more daily |
| 3 | once weekly | 9 | n/k |
| 4 | twice or more weekly | | |

**ROUTE:**

| | | | |
|---|---|---|---|
| 1 | inject | 3 | eat/drink |
| 2 | smoke | 4 | sniff |
| | | 9 | n/k |

**DURATION IN YEARS:**

A one or two digit code is recorded for number of years drug is actively misused. Six months to less than 12 months is recorded as 1. Less than six months is recorded as 0.

**SECONDARY DRUG** of misuse, as defined in instructions - see Appendix B3 - is returned by the centres and coded according to the following groups:

| | | | |
|---|---|---|---|
| 1 | opiates/opioids | 6 | cannabis |
| 2 | stimulants | 7 | alcohol |
| 3 | hypnotics/sedatives | 8 | other |
| 4 | hallucinogens | 888 | not misused |
| 5 | volatile inhalants | 999 | n/k |

and also according to the individual drug name.

See Appendix B8 for detailed codes

**AGE FIRST USED:**

Two digits are recorded for age first used
88 not misused
99 n/k

**FREQUENCY PAST MONTH**

| | | | |
|---|---|---|---|
| 1 | drug free | 5 | daily |
| 2 | less than once weekly | 6 | twice or more daily |
| 3 | once weekly | 8 | not misused |
| 4 | twice or more weekly | 9 | n/k |

**ROUTE:**

| | | | |
|---|---|---|---|
| 1 | inject | 4 | sniff |
| 2 | smoke | 8 | not misused |
| 3 | eat/drink | 9 | n/k |

**DURATION IN YEARS:**

A one or two digit code is recorded for number of years drug actively misused. Six months to less than 12 months is recorded as 1. Less than 6 months is recorded as 0.
88 not misused
99 n/k

**EVER INJECTED:**

(a) 1 yes
2 no
9 n/k

**AGE FIRST INJECTED:**

(b) two digits are recorded for age 88
n/a where no is recorded for ‘ever injected’
99 n/k

**CURRENTLY INJECTING:**

1 yes
2 no
8 n/a where no is recorded for ‘ever injected’
9 n/k

**EVER SHARED:**

1 yes
2 no
8 n/a where no is recorded for ‘ever injected’
9 n/k

**CURRENTLY SHARING:**

1 yes
2 no
8 n/a where no is recorded for ‘ever shared’
9 n/k

**APPENDIX B8**

# D R U G  C L A S S I F I C A T I O N

## 1. OPIATES AND OPIOIDS

| | |
|---|---|
| Buprenorphine | 01 |
| Codeine (linctus) | 02 |
| Dextromoramide | 03 |
| Dextropropoxyphene | 04 |
| Dihydrocodeine | 05 |
| Dipipanone | 06 |
| Heroin | 07 |
| Methadone | 08 |
| Morphine (including Morphine Sulphate MST) | 09 |
| Opium | 10 |
| Pentazocine | 11 |
| Pethidine | 12 |
| Other opiates/opioids | 88 |

## 2. STIMULANTS

| | |
|---|---|
| Amphetamine | 01 |
| Dexamphetamine | 02 |
| Methylamphetamine | 03 |
| Methyphenidate | 04 |
| Other amphetatamine like drugs | 05 |
| Cocaine | 06 |
| Crack | 07 |
| Other cocaine forms | 08 |

**3. HYPNOTICS AND SEDATITIVES**

| | |
|---|---|
| Barbiturates | 01 |
| Chlordiazepoxide | 02 |
| Diazepam | 03 |
| Flurazepam | 04 |
| Lorazepam | 05 |
| Oxazepam | 06 |
| Nitrozepam | 07 |
| Temazepam | 08 |
| Triazolam | 09 |
| Other minor tranquillizers | 10 |
| Major tranquillizers | 11 |
| Other hypnotics and sedatives | 88 |

**4. HALLUCINOGENS**

| | |
|---|---|
| Lysergic Acid | 01 |
| Amanita Muscaria | 02 |
| Psilocybin | 03 |
| Phencyclideine | 04 |
| Phenylethylamine (MDA or MDMA) | 05 |
| Other hallucinogens | 88 |

**5. VOLATILE INHALENTS**

| | |
|---|---|
| Glue | 01 |
| Butane | 02 |
| Other solvents | 03 |
| Petrol | 04 |
| Nitrites | 05 |
| Other volatile inhalants | 88 |

**6. CANNABIS**

| | |
|---|---|
| Herbal | 01 |
| Resin | 02 |
| Oil | 03 |
| Other cannabis forms | 88 |

**7. ALCOHOL**

**8. OTHER DRUGS**