TREATED DRUG MISUSE IN THE GREATER DUBLIN AREA 1990

by
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and
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THE HEALTH RESEARCH BOARD

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ISBN 0 9517193 3 5

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Acknowledgements

We wish to acknowledge our indebtedness to the participating centres in the Dublin Drug Treatment Reporting System who provided us with anonymous information on clients treated by them for drug misuse, thereby making this study possible. Their co-operation is truly appreciated.

Valuable comments are also gratefully acknowledged on earlier drafts of this report from Dr. T. O'Dwyer and Mr. T. O'Mahony, Department of Health, Professor C. Kelleher, University College, Galway, and Mr. R. Hartnoll, Epidemiology Group, Council of Europe Pompidou Group.

We thank Dr. V. O'Gorman and Mr. J. O'Gorman, Health Research Board, for their support and advice.

We are indebted to the Department of Health who support the work we undertake and who arranged funding for this project through the National Lottery.

A warm word of thanks to Ms. E. Mulleady for her patient and competent word processing through the various draft stages of this report.

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Summary of Main Findings

The findings from this study refer to treated drug misuse and are based on information from a reporting system on clients who received treatment for their problem drug taking in 1990, and who resided in the greater Dublin area. Treatment was provided by a range of statutory and voluntary treatment centres considered representative of drug treatment availability in the catchment area.

The main findings were:

- An estimate of 1752 persons received treatment for drug misuse in 1990;
- The estimated number who entered treatment for the first time ever was 574;
- Seventy four percent of clients were male;
- Most clients, 95%, were between 15 and 39 years old;
- Half lived with their family of origin;
- One third resided in the inner city area;
- Forty four percent had left school before the official school leaving age of 15, women proportionally more so than men;
- Eight out of ten clients were unemployed;
- In 80% of cases an opiate was the primary drug of misuse, chiefly heroin;
- The majority, 68%, had injected their primary drug;
- Slightly more than half the study population had been misusing their primary drug for five or more years;
- Of those who had ever injected their drugs 65% were currently injecting, but only 17% were currently sharing, and
- Proportionally more women than men were living with a drug misusing partner, and also more women than expected were sharing injecting equipment.

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CHAPTER 1

Introduction and Background

1.1 Introduction

In September 1968 the Irish Press published a series of articles on drug abuse in Ireland. It was the first time the media had focused on the problem or that anyone had even suggested there was one (Flynn and Yeates, 1985:5).

Now more than two decades later drugs and their misuse have become a major concern for the Government, who recently produced a "Strategy to Prevent Drug Misuse" and for parents, schools, service providers and above all for problem drug users, many of whom also have to deal with the spectre of HIV or AIDS.

The purpose of this report is to document the extent of treated drug misuse among residents in the greater Dublin area in 1990, and to provide basic information on the socio-demographic profile of drug misusers, and on their injecting and sharing practices. A reporting system is the method used to collect the data.

For years now wide ranging estimates have been made of the number of drug users in Dublin usually without any defining statement of whether they refer to 'treated drug users', 'all drug users', those 'in contact with treatment services during a given year' or 'at a given point in time'. This paper provides a first attempt at identifying cases of treated drug misuse and the number of persons involved as a person may be attending more than one treatment centre thus introducing an element of double count. There are some gaps in the information presented mainly relating to general practitioners, but coverage on the whole is good and very representative of the range of treatment services, statutory, voluntary, medical and non-medical in the catchment area.

Ongoing information from this reporting system will facilitate an understanding of the epidemiology of treated drug misuse, and provide useful data to policy makers on its social and health care implications. Access to the database will be available to bona fide researchers. It will also be a data source for the participating centres in providing access to their own data on an annual basis and to reasonable requests for other data.

1.2 History of Drug Misuse in Dublin

As noted in the Introduction the alleged first media reference to problem drug use in Dublin was made in 1968. In December of that year the then Minister of Health set up a Working Party to establish the extent of drug misuse in the country. This was largely prompted by public disquiet at the increasing evidence of drug misuse in their capital city. The Working Party's interim report of November 1969 documented a significant drug problem in Dublin with 350 regular users known to the Gardai. The drugs involved were predominantly amphetamines, barbiturates and tranquillisers, usually obtained by larceny, in addition to LSD and cannabis smuggled into the country.

The recommendations of this interim report (a summary of which is contained in the final report) urged that action should be taken forthwith to update legislation; to improve security in pharmacies and manufacturing wholesalers to minimise theft; to strengthen the Garda Drug Squad; to prevent doctors from overprescribing addictive drugs; to develop an out-patient facility for drug users in Jervis Street Hospital and to disseminate informed, as distinct from sensational, information on drug abuse.

The final report of this Working Party recorded an increase in the number of known drug users to 940 from 350 in 1969, (Report of the Working Party on Drug Abuse, 1971). Its recommendations covered statutory controls and other preventive measures, including one concerning the availability of hypodermic syringes, which stated ironically (p. 23) in the light of subsequent events

> *we are fortunate in this country that heroin and other drugs normally administered intravenously are not abused to any significant extent.*

Action on the overprescribing of drugs and on the registration of persons dependent on drugs was proposed, in addition to recommendations on education, treatment and rehabilitation.

The reports of the Working Party established a benchmark of the first wave of drug misuse in Dublin – elsewhere in the country it was not seen as presenting a significant problem. The ensuing recommendations which were adopted created structures for prevention and treatment, for example: the strengthening of the Garda Drug Squad; The Medical Preparations (Control of Amphetamines) Regulations, 1969, which imposed rigid controls over the manufacture, importation and sale of amphetamines; the establishment of

a statutory outpatient treatment facility, the National Drug Advisory and Treatment Centre, and the introduction of rehabilitation services by Coolemine, a voluntary organisation.

However, the Misuse of Drugs Bill presented to the Dail in 1973 and introduced in 1977, was not in force until 1979 by which time the problem had taken root. This new Act marked a watershed in drugs legislation by recognising the criminal dimension of drug-related crime and it was subsequently used to try some of Ireland's well known drug dealers. Likewise there was a considerable delay in the implementation of drug education programmes. The proposed registration of addicts, as carried out by the British Home Office, was never introduced here and the problem of medical overprescribing is still with us.

Heroin hit Dublin's north inner city area in 1981 well over a year after it had gripped the southside communities, and in a matter of a few weeks it had devastated the area (Flynn and Yeates, 1985 : 155). Reports of heroin misuse by youngsters, some still in primary school, were viewed with scepticism. In general there was considerable resistance to accepting how rampant the drug problem had become in the inner city area and how widespread was the fear of pushers in the community.

The report of the Eastern Health Board Task Force (1982) included evidence from sources, such as the National Drug Advisory and Treatment Centre, Coolemine Therapeutic Community, the Garda Drug Squad, general practitioners, and accident and emergency hospital departments which confirmed a sudden and dramatic rise in the number of young people misusing drugs, predominantly opiates. In response to this evidence the government established an Inter-ministerial Task Force (1983) to examine the question of drug misuse with special reference to the inner city area.

Directly arising out of their recommendations, made later in the same year, the following measures were introduced:

- the Misuse of Drugs Act 1984 (which extended and amended the 'Principal Act' of 1977) came into operation;
- the Criminal Justice Bill 1983 was drawn up;
- 'life skills' programmes were introduced in a number of schools;
- a Diploma course in Addiction Studies in Trinity College, Dublin, was established;

- funding was provided to the Medico-Social Research Board to carry out drug research and
- a National Co-ordinating Committee on Drug Abuse was set up to advise the Government on an ongoing basis on general issues regarding prevention and treatment of drug misuse.

This sudden increase in the misuse of opiates by a young population in Dublin in the early 1980s was mirrored in most other European countries, the exception being that the onset was later in Dublin. Again, in common with these cities, the extent of serious drug use stabilised at a lower level until 1990 when indications of certain changes emerged.

There is increasing concern in Europe with the rapid change in patterns of drug use. The consequent need for effective action by each member state, supported by joint action by the twelve, has been voiced by the EC. The idea of setting up a European Drugs Monitoring Centre dates from 1989 and a European Committee to Combat Drugs (CELAD) composed of representatives of the twelve member states and the Commission was set up later in the same year to undertake the work, which is still ongoing.

As part of its role in developing an appropriate drug demand reduction programme the Irish Government re-constituted and strengthened the National Co-ordinating Committee on Drug Misuse in 1990 which was charged with the reponsibility of developing a policy to prevent drug misuse. Its report was adopted to become the Government Strategy to Prevent Drug Misuse (1991).

1.3 Role of the Pompidou Group in Collaborative Drug Research

The background to the collection of treatment data described in this report is grounded in the epidemiology work of the Pompidou Group, Council of Europe. This group was formed in 1971 following a proposal by Georges Pompidou, the then President of the French Republic, to his colleagues in the European Community and to the head of state of the United Kingdom. The aim of the group was defined as an examination, from a multi-disciplinary point of view of the problems of drug abuse and illicit trafficking. Since 1980 it has continued its activities within the framework of the Council of Europe, while remaining open for countries who are not members of the Council. An epidemiological sub-group was set up by the 6th Ministerial Conference in November 1981. The current work within this section is embodied in the decision made at that conference for

the development of administrative monitoring systems for the assessment of public health and social problems related to drug abuse.

Administrative monitoring systems are now in place in 13 European cities including Dublin. These systems are based on information from a range of indicators of drug activity such as, first treatment demand; hospital admissions; viral hepatitis; drug-related deaths; persons charged for drug offences; imprisonment; seizures of illicit drugs; price/purity of illicit drugs; survey data and drug-related AIDS cases. Data derived from these indicators are put in the context of each country's differing cultural, legal and health care provisions for drug misusers. These systems provide interpretations of drug misuse in the various participating cities and offer informed insight into similarities and differences between them. Analysis of information from the first multi-city study comprising Amsterdam, Dublin, Hamburg, London, Paris, Rome and Stockholm was published by the Council of Europe (1987). The co-ordination of data from the expanded multi- city study covering the period 1980-1991 inclusive, is currently taking place and publication, again by the Council of Europe, is expected shortly.

The future inclusion of material from Eastern European countries is planned as recently three countries have joined the Pompidou Group.

Some indicators are better developed than others e.g., first treatment demand, which will be referred to later in this chapter, while others such as drug-related deaths have emerged as unreliable both within cities and between cities. Efforts are ongoing to tease out what specific information relating to a particular indicator is available in each city and how these data can be made more comparable. The EC has recently made funding available to the 12 member states to examine the process by which drug-related deaths are ascertained in each country, highlight problem areas and on the basis of this analysis propose ways by which more accurate data can be derived.

New indicators have been proposed for development, such as, non-fatal urgent admissions to hospital for drug misuse and police arrests, and protocols have already been developed for discussion purposes.

It is important to note here that information from one indicator is never sufficient to indicate trends in drug misuse and can in fact be misleading. Analysis of drug misuse must include data from as many indicators as possible and, as earlier mentioned, supplement this source by information on the legal and socio-cultural context of drug taking. Recent proposals have focussed on the importance of getting some measure of the 'hidden' population of drug users not manifest by the indicator approach. Such proposals include

the desirability of carrying out a household survey of the general population, conducting ethnographic studies and improving methods of estimating the total number of drug users.

The work of the Pompidou Group is continually guided by directives from ministerial conferences and monitored by the permanent correspondents, usually senior civil servants, appointed by each of the participating member states to ensure the implementation of the work programme established by the ministers. The Pompidou Group maintains close contacts with other intergovernmental and non-governmental organisations concerned with problem drug use.

1.4 Pilot Drug Treatment Reporting System in Dublin and London

This project was undertaken and part funded as a direct consequence of the European Commission's current policy on the fight against drug misuse. As already noted the increase in recent times in the availability and consumption of drugs in Europe has evoked a response from international bodies like the EC.

The broad objectives of the study were to develop further the first treatment demand indicator – seen as one of the best indications of treated drug misuse – and to explore the feasibility of establishing a reporting system on the socio-demographic characteristics of drug users in defined catchment areas. The seminal work in this field was carried out in the epidemiology section of the Pompidou Group where at the outset differences in the definition of first treatment demand were identified. In Dublin and certain other cities the term refers to first treatment contact, and only those clients who enter treatment for the first time ever are included. In other cities and in some London treatment centres the term has a wider meaning and refers to clients requesting treatment for the first time ever, regardless of whether they are taken on for treatment or not. The Dublin data are a measure of treated incidence, while the London data are a measure of the incidence of first treatment requests.

First treatment demand serves two functions which will be elaborated on later in the methodology section. The first as a direct indicator of the demand on services, the second function as an indirect epidemiological indicator of trends in drug misuse in communities, or populations served by these services.

The collection of standard detail on the socio-demographic characteristics of clients, their past history of problem drug use, their former and present injecting and sharing practices provides information on clients seeking treatment which could be used to monitor change over time, and target specific groups for both treatment and preventive purposes. It would also permit more valid comparisons between clients attending Dublin and London treatment facilities.

A set of basic core data was agreed to between London and Dublin following a careful scrutiny of similar data collected elsewhere in Europe. In Dublin a single one page form was used to collect these data; in some London centres the same form was used, while in others these data were abstracted from centres' existing data set. An accompanying set of instructions re completion of the form, definitions of key concepts, coding guide, drug classification, computer arrangements were all in place before the commencement of the pilot study.

The outcome and report (O'Hare and Hartnoll, 1989) demonstrated the feasibility of undertaking such a comparative study especially in the context of fairly similar legislation and drug policies in both cities. It provided interesting comparisons between clients and their drug practices in the two cities. It was also a most useful learning experience and in the light of one quite basic misunderstanding that arose between the two collaborating researchers, underlined the need for explicit written communication prior to the execution of such comparative studies.

The data set collected in the two cities has been implemented on a pilot basis in 11 European cities, with some minor changes but with a more detailed protocol and set of instructions (Hartnoll, 1991). It is expected that such systems will be ongoing in most of the cities.

1.5 Government Role and Policy on Drug Misuse

The Government plays a crucial role in all areas of problem drug use from supply to demand reduction and increasingly in international co-operation.
Ireland has active links with a wide ranging number of international bodies including the European Community; the United Nations; World Health Organisation; Pompidou Group Council of Europe; CELAD; Ad Hoc Group on Drug Addiction; the TREVI Group on Police Co-operation; the Mutual Assistance Groups on Customs Co-operation, and Interpol.

The most recent statement on drug policy comes from the Government's "Strategy to Prevent Drug Misuse". Areas covered by this report concern an assessment of the drug problem in Ireland, supply reduction, demand reduction, manpower and training development, and international co-operation.

Some of the more interesting policy formulations include recommendations: to establish a national database which would use and integrate indicators developed by the Pompidou Group; to introduce whatever legislative action is necessary to strengthen the powers of the customs authorities to deal with persons importing prohibited drugs concealed in body cavities; to develop 'Community Drug Teams' under the direction of the regional health boards to operate with the involvement of general practitioners and other health professionals in targeted areas; to strengthen both formal and informal drug education programmes, including the related areas of drug misuse and AIDS and to maintain our commitment to European co-operation in the field of drug misuse.

The expansion of the existing database in Dublin to the country as a whole is being implemented on a regional basis, using the Health Boards as the units of administration. Structures are now in place in the Southern Health Board area to collect data on a range of indicators and to ensure accurate interpretation of information emanating from them. These data should enable the monitoring of drug misuse activity, identify trends and as such provide ongoing useful information for the prevention, treatment and rehabilitation of those affected.

CHAPTER 2

Methodology

2.1 Objectives of the Study

The objectives of this study were two-fold

- to implement the first treatment contact indicator
- to establish a reporting system of information on the socio-demographic characteristics of treated drug users.

The first treatment contact indicator was piloted in the Dublin/London project and refers to the first ever entry to treatment by drug users who have never been previously treated for their drug problem. Data from this indicator serve two purposes. The first as an indirect indicator of trends in drug misuse, i.e., treated incidence, which may also reflect 'true' incidence in the catchment population. For example, the rise in the number of opiate users attending for treatment at the National Drug Advisory and Treatment Centre in the late 1970s and early 1980s was taken as evidence of an epidemic of opiate addiction in Dublin. The subsequent stabilisation or decrease of new cases attending the Centre (the largest treatment centre in Dublin) was interpreted as evidence that the epidemic had peaked. While this example shows the potential epidemiological value of the first treatment contact indicator it must be stressed that this is a lagged indicator and that 21% of all opiate attenders at the above centre had, at the peak time of the epidemic, been using drugs for seven or more years prior to their first contact (Dean, O'Hare, O'Connor, et al, 1987). Furthermore other factors must be considered when interpreting data on first treatment contact, such as, the availability and acceptability of treatment services in the catchment area.

The second purpose of first treatment contact is as a direct indicator of the demand on services covered by the reporting system. Such information is of benefit to service providers and planners in enabling them to determine whether or not services are reaching the target populations e.g., women, generally seen as being slow to use such services, perhaps because they do not meet their needs, or methadone maintenance in the case of IV

drug users. The planned introduction of community drug teams will provide important data on the pick-up rate for this new service and by whom.

The establishment of an ongoing reporting system is the vehicle by which core socio-demographic information can be collected on first contacts, re-contacts and all contacts entering treatment in a given year with one or more of the specified centres in the Dublin catchment area.

As reporting systems are being established in other European cities with similar dual objectives and methodology, a future comparison of output will be feasible between cities. Some of the benefits accruing from this type of co-ordinated approach include improved interpretation of data, an early warning of changes in patterns and type of drug misuse, in routes of drug administration, and feedback on successful intervention policies.

In an Irish context these treatment data are the first of their kind to be gathered in a systematic way, and as already mentioned this approach is to be extended to the country as a whole. In addition to the benefits outlined above, findings from this study will suggest new areas of further investigation thereby providing an informed response to the treatment of drug misuse in this country.

2.2 Catchment Area

The study catchment area is that of the greater Dublin area at 504 km2, within Dublin county. According to the 1986 Census of Population the greater Dublin area comprised Dublin County Borough, its north suburbs (Fingal-part) and its south suburbs (Belgard-part) together with Dun Laoghaire County Borough and its suburbs, with a population of 920,956. (See Appendix B for a breakdown by age and sex of this figure).

The population increased by only 6% between 1981 and 1986. The principal difference seen in the age structure of the population between the two censuses was a decrease in the age groups of under 20 years and an increase in all other older age groups.

2.3 Population Surveyed

Persons who received treatment in 1990 from centres in the reporting system in the greater Dublin area and who reside there are the subject of our analysis. Twenty centres participated in the system (see Appendix C for a list of these centres and their service provision). Between them they cover the range of facilities available to drug users in the Dublin area such as, medical treatment including methadone, and non- medical care from

both statutory and voluntary services. As will be seen later in this chapter we believe that the group of drug users analysed is representative of those who seek treatment for their problem. Excluded are persons who receive treatment outside the greater Dublin area for example in the United Kingdom. However the common belief is that the group of people who 'drift' between the two countries probably enter treatment at some stage in Dublin and are included in our statistics. However this possible source of missing information on Dublin drug misusers should be the subject of a special research enquiry.

2.4 Study Definitions

The following are definitions of the principal terms or concepts used in this study.

Drug Misuse

The taking of a legal and/or illegal drug or drugs (excluding alcohol, other than as a secondary drug of misuse, and tobacco) which harm the physical, mental or social well-being of the individual, the group or society.

Drug Treatment

Drug treatment is therapy given to clients in various specified centres. It may include medical treatment such as, de- toxification, methadone or drug-free programmes, and psychotherapy or non-medical modalities like counselling, individual or group therapy. Whereas therapy is generally provided by professional personnel it also includes persons employed by some centres who are deemed by them to have the necessary therapeutic skills, but lack formal qualifications.

Drug treatment may be provided in e.g., hospitals, therapeutic communities, residential centres, out-patient clinics, street agencies and prisons. Treatment does not include, however, information given over the telephone, or information solely related to social assistance or insurance entitlements.

Primary Drug

The primary drug is the drug which the client alleges at the time of the current treatment contact is causing most problems and for which treatment is sought.

Census or Point Treated Prevalence

Census data refer to persons in treatment during a particular day or time period, rather similar to information from a census of the general population. For those in residential care the census day was 31 December 1989. However, for the majority of clients not in residential treatment a census count included clients who were in treatment for their drug problem in the 30 days prior to the census day. The census information comprises a baseline or starting point to which subsequent treatment contacts are added.

One Year Treated Prevalence

These data refer to all persons who received treatment for their drug misuse during the calendar year of 1990, including census data which comprise the beginning of this set of information and without which persons in treatment, as distinct from those coming into treatment, would have been omitted from the 1990 statistics.

First Treatment Contact, or One Year Treated Incidence

This output refers to clients who entered treatment for the first time ever in 1990 and had not previously been treated anywhere for their problem drug use.
Details of the operational aspects of the above three sets of statistics are covered in the following chapter.

2.5 Study Questionnaire

A one page questionnaire or form designed for the EC Dublin/London pilot project was used to collect information from the participating centres in the catchment area of greater Dublin. Prior to the commencement of this study considerable public relations work was undertaken to identify and then ensure participation of centres providing treatment to drug users. The objectives and the benefits of the project were discussed and assurances

regarding the confidentiality of the data given i.e., that information from an individual participating centre would not be divulged without prior consent.

Each participating centre received information on the definitions of key concepts central to the data collection and instructions regarding how the form was to be completed. Particular attention was given to informing the treatment centres that the form was to be completed once during 1990 for each client who received treatment regardless of the number of contacts made by that client. A liaison person in the treatment centres was identified as having responsibility for the return of completed data on a regular basis to the Health Research Board.

Copies of the study form, instructions used to complete the form, and the drug classification are contained in Appendix D.

2.6 Coverage

Each of the twenty centres identified as possible providers of treatment to drug users in the Dublin area was contacted and their participation in this project requested. All agreed to co-operate. A few said that whereas they had in the past provided such treatment they were not currently so doing. No information was received during 1990 for four of these named centres on the list. However provided that the possibility existed of clients presenting for treatment it appeared prudent to retain their agreed participation. Since 1990 some centres who then had no drug clients have since been approached for treatment. There is an understandable variation in the number of clients treated among the 16 centres who provided statistics on treated drug use. From our knowledge of service providers in the catchment area we feel confident that centres co-operating in the scheme represent almost complete coverage of treated drug misuse. The main gaps in our network are those general practitioners who e.g., provide methadone to opiate users; Mountj oy Prison, in particular the Separation Unit, which initially returned data to us but had to discontinue due to pressure of work. Discussions are in progress to include information for drug users who receive treatment while in Mountjoy Prison, thereby providing complete cover of all treated users in Dublin prisons. We are also conscious that middle class users evade the net. This may be due to the fact that their drug use has not reached a problem level, or that they receive treatment from persons or centres not yet participating in our reporting system.

2.7 Data Processing

Completed forms are returned to the Health Research Board in sealed plastic bags for security reasons. Data are initially checked for completeness and accuracy and this process in some instances requires further clarification with the participating treatment centres. Anonymous information is entered on an IBM compatible PC and the software used is the Statistical Package for the Social Sciences (SPSS).

CHAPTER 3

Findings

The findings are presented under the two broad headings of

– One year treated prevalence

– Census and first treatment contact.

In the following sections, numbers refer to cases and not to individuals. While there is no duplication of information within participating centres in the reporting system there is an element of double count between some centres. Examples of this are: where a client is attending one centre and receiving methadone maintenance from another; or where the probation service continues to counsel a client referred to another agency, thereby giving rise to an individual being counted twice or seen as two separate cases.
This situation will be elaborated on in greater detail in the concluding section of this chapter dealing with Estimation of Rates for Treated Drug Misuse.

3.1 One Year Treated Prevalence

The operational definition of prevalence in this section refers to the number of cases in the greater Dublin area who received treatment for their drug misuse during 1990, without any distinction between old and new cases (N=2,037). This number includes clients in treatment who met with the census criteria at the beginning of 1990, together with those clients from each participating centre who entered treatment either as old or new cases during 1990, excluding those who were already in the census count.

These cases will be examined in greater detail under the following headings:

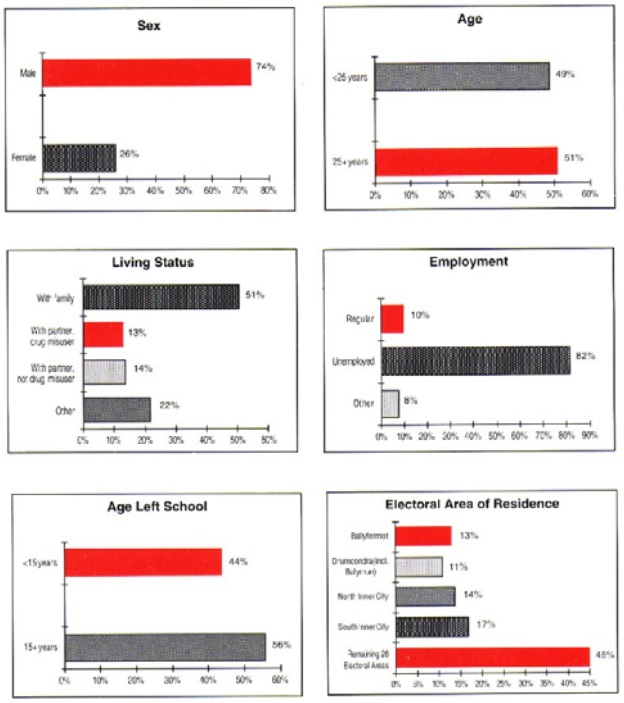
(i) Socio-demographic characteristics;
(ii) History of drug misuse;
(iii) Injecting and sharing practices.

Firstly, basic information for the above three sets of data will be presented as figures giving the percentage value for each variable, e.g., percentage of cases that are: male and female for sex; opiates, cannabis, and ‘other drugs’ for primary drug of misuse. Secondly, cross tabulations follow which provide a more composite picture of drug misusers and their

patterns of use, e.g., does a drug misuser's sex have any bearing on whether or not he/she is living with another drug user? The percentage responses from these cross tabulations are compared with the expected values estimated in the basic analysis (see pp. 18, 24 & 28). Differences which occur are focussed on in the comments following each cross tabulated table.

Socio-demographic Characteristics (valid %)

The characteristics of prevalence cases are presented below in barchart format and refer to the valid percentage thereby excluding not known and not applicable data. Frequency data presented in Appendix A show the number of not known cases is small except for a few variables.



Almost three quarters of the prevalence population were male, compared with a quarter who were female.

There was little difference in the distribution of cases between the two broad groupings of less than 25 years and 25 years and over. The mean age was 25 years.

An analysis of living status showed that a little more than half the population, 51 %, had been living with their family of origin prior to their treatment contact; 27% with a partner, either a spouse or a cohabitee, of whom half or 13% lived with a drug misusing partner. The remaining 22% included those who were living alone, with friends, in an institution, homeless or as lone parents.

The vast majority, 82%, of prevalence cases were unemployed. The mean age left school was 14.7 with 44% having left before the official school leaving age of 15, and 3 8% at age 13 or 14.

For obvious reasons we are opposed to identifying communities within the catchment area associated with problem drug use. However, to ensure that appropriate resources to ameliorate the problem are made available we have cited area of residence information to the wider electoral areas.

Our catchment area covered 30 Census Electoral Areas. We were able to identify 55% of cases resident in four of these areas associated with inner city decay, or elsewhere with pockets of poor quality housing and high levels of unemployment and deprivation.

To provide more detail on the prevalence population the following cross tabulations are presented and commented on.

Table 1: One Year Treated Prevalence, Dublin 1990.
Specified Socio-demographic Characteristics by Sex.

Numbers and Percentages.

Age		**Male**	**Female**
under 25 years	N	731	249
	%	49.8	47.5
25 years & over	N	738	275
	%	50.2	52.5
Living Status			
with family	N	823	183
	%	56.9	35.2
with partner,	N	121	132
drug misuser	%	8.4	25.4
with partner,	N	218	48
not drug misuser	%	15.1	9.2
other		285	157
		19.7	30.2
Employment			
regular work	N	162	37
	%	10.9	7.1
unemployment	N	1256	384
	%	84.8	73.3
other		63	103
		4.3	19.7
Age Left School			
under 15 years	N	471	225
	%	40.1	54.0
15 years & over	N	704	192
	%	59.9	46.0

Table 1 presents information on specified socio-demographic characteristics of treated cases by sex to determine possible differences between the sexes regarding their age, living status, employment and age left school. The comment which follows while relating to the table, also incorporates data shown in bar chart format on p. 18 which provides the expected proportion of all cases for each of the variables analysed.

There was no real difference between the sexes regarding age with males and females distributed more or less as expected between the two broad age groups of under 25 years and 25 years and over.

However, interesting differences emerged for drug misusers' living arrangements prior to contact for treatment. When a comparison was made between men and women living with a drug misuser it can be seen that women (25%) were much more likely to be living with a drug misuser when compared with the expected percentage (13) and men much less so at 8%. The reverse pattern, though not so marked, showed that men were more commonly living with a non drug misuser than women. The higher than anticipated proportion of women returned as 'other' comprised mainly those living alone and lone parents.

Women were less likely to be unemployed than men when compared with the expected figures. It is relevant to note than the 20% of women in the 'other' designation referred principally to housewives.

Proportionally more women and less men than expected left school before the official school leaving age of 15.

Table 2: One Year Treated Prevalence, Dublin 1990.
Specified Socio-demographic Characteristics by Age.

Numbers and Percentages.

Sex		**Under 25 years**	**25 years & over**
Male	N	731	738
	%	74.6	72.9
Female	N	249	275
	%	25.4	27.1
Living Status			
with family	N	619	370
	%	64.5	38.1
with partner,	N	73	171
drug misuser	%	7.6	17.6
with partner,	N	69	195
not drug misuser	%	7.2	20.1
other	N	198	234
	%	20.6	24.1
Employment			
regular work	N	83	111
	%	8.6	11.1
unemployment	N	786	824
	%	81.1	82.7
other	N	100	61
	%	10.3	6.1
Age Left School			
under 15 years	N	330	360
	%	41.5	45.9
15 years & over	N	466	424
	%	58.5	54.1

Table 2 examines the same socio-demographic characteristics as the previous table by age group, and the following comment takes into account the expected values shown on p. 18 for the variables in question. The proportions of males to females were as expected in both the under 25 and 25 years and over age groups in a ratio of 3 : 1.

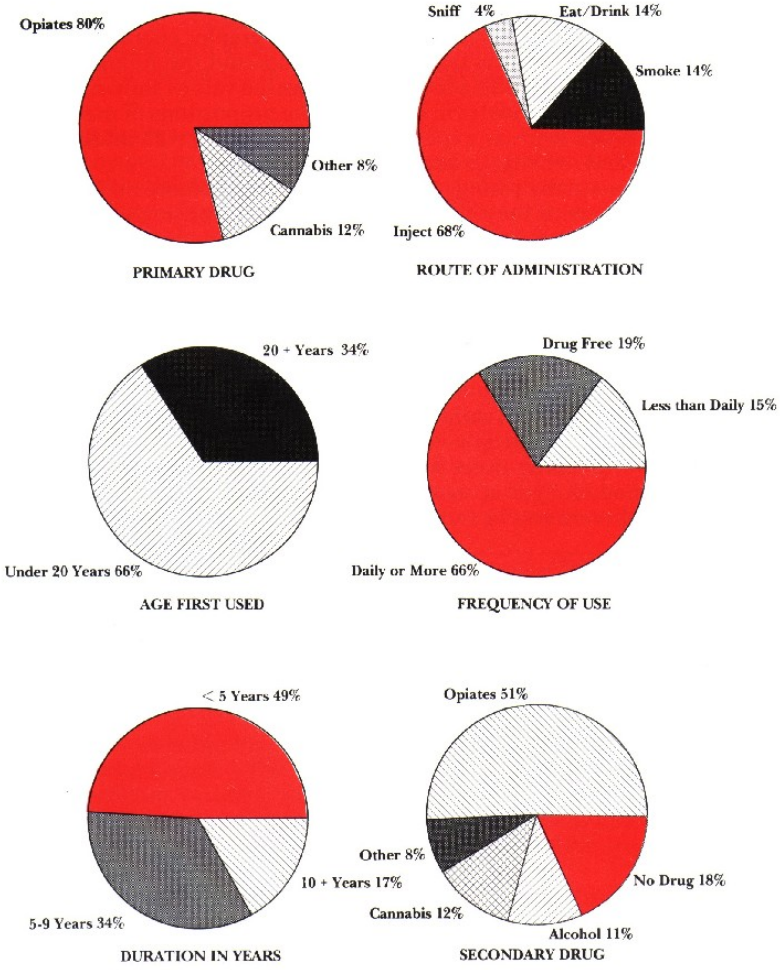
Clients in the younger age group were much more likely to be living with their family of origin, not surprisingly, than those in the older age category. Younger drug users were much less likely to be living with a partner whether a drug misuser or not, while the older users were more commonly living with a partner, particularly non drug misusers. The 'other' category is comprised of those living alone, with friends, as lone parents, homeless or in an institution.

Little difference emerged between the age groups unemployed with similar high proportions, of over 80%, in both age categories.

Younger drug users were somewhat more likely to have remained longer at school whereas those in the older age groups were less likely to have done so.

History of Drug Misuse (valid %)

The history of drug misuse for the one year prevalence cases, using piecharts is shown below.



The profile of drug misusers, using valid percentage data, shows that 80% reported that their primary drug of misuse, that is, the one which at the time of treatment contact was causing most problems and for which treatment was sought, was an opiate or opioid, chiefly heroin. An opiate is a natural derivative of the opium poppy, such as, heroin, morphine or codeine. An opioid is a synthetic drug, for example, methadone, pethidine or buprenorphine, with effects similar to that of an opiate. Sometimes the term 'opiate(s)' is used in this paper to include opioids. Twelve per cent had come for treatment for cannabis-related problems, and less than one per cent for cocaine misuse. Sixty eight per cent had injected their primary drug, by inserting a needle into a vein, muscle tissue or under the skin. This method is generally associated with opiate misuse. A similar proportion, 14%, either smoked or ate/drank their preferred drug. In this study both herbal and resin cannabis have been smoked, also heroin. Drugs mentioned as being eaten or drunk include morphine sulphate tablets (MST), dihydrocodeine (DHC), and minor tranquillisers. A small proportion sniffed their drugs such as solvents, glue, butane and also heroin.

When asked the age at which they had first used their named primary drug 66% admitted to having done so before the age of 20 the mean age being 19 years. Information relating to frequency of drug use in the month prior to treatment contact showed that during that time 66% used drugs on a daily or more frequent basis – over 90% of whom were opiate users – 15% less than daily and 19% were drug free.

The drug free category referred mainly to clients who:

– had been recorded as drug free although on a methadone maintenance programme in the month previous;
– were referred directly from prison where they had been drug free, or by a probation officer and who had stopped drug use during the remand period, or by Narcotics Anonymous;
– sought counselling for their drug problem, as many only seek counselling and support when they are drug free in an attempt to "look behind the drugs and get grounded", thereby gaining an understanding of their problem and avoiding a future relapse.

Almost half the population, 49%, had been actively misusing their preferred drug for less than 5 years, 34% from between 5-9 years with 17% having done so for 10 or more years.

When queried about misuse of a secondary drug the majority, 51 % of drug misusers again stated an opiate. Because 80% had also reported an opiate as their primary drug of misuse there was an overlap between those for whom such a drug was both their primary and secondary choice. Examples of this are heroin in combination with MST, DHC, methadone or palfium. To some extent drug choice is dependent on availability. Cannabis was the next preferred drug. Whereas the definition of drug misuse precluded alcohol as a stated drug of primary misuse it could be recorded as a secondary one. Eleven per cent admitted to its use in combination with a primary drug. For 18% of users no secondary drug was recorded.

Table 3: One Year Treated Prevalence, Dublin 1990. Specified Characteristics by Primary Drug. Sex

Numbers and Percentages

Sex		**Opiates**	**Other Drugs**
Male	N	1191	298
	%	73.8	73.4
Female	N	422	108
	%	26.2	26.6
Age			
under 25 years	N	713	263
	%	45.0	65.6
25 years & over	N	870	138
	%	55.0	34.4
Age First Used Drugs			
under 20 years	N	943	319
	%	62.2	83.5
20 years & over	N	574	63
	%	37.8	16.5
Duration of Drug Use			
under 5 years	N	679	207
	%	47.2	55.6
5-9 years	N	509	101
	%	35.3	27.2
10 years & over	N	252	64
	%	17.5	17.2

Table 3 elaborates on selected characteristics of clients who cited an opiate (including an opioid) as their primary drug of misuse compared with those whose primary drug was other than an opiate. It should be recalled that in 8 out of 10 cases in this study an opiate was named as the primary drug on treatment contact and as a consequence the numbers involved in the 'other drugs' category are small. Differences which emerge between these two broad drug groups must therefore be regarded cautiously.

From the table we see that the breakdown between the sexes within the opiate and 'other drugs' categories was similar to the profiles (pp. 18 & 24).

Age had an effect on the choice of drug users' primary drug as proportionally more cases in the 'other drugs' group were aged under 25, while conversely higher percentages of opiate cases were in the older age category.

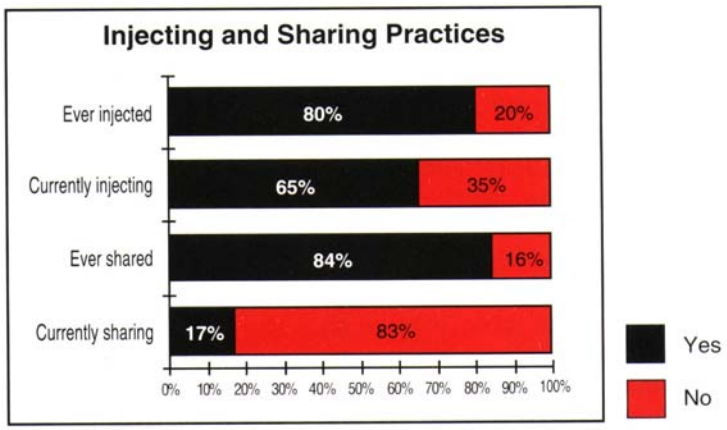
Clients who first used drugs from the younger age group were more likely to have used a drug other than an opiate.

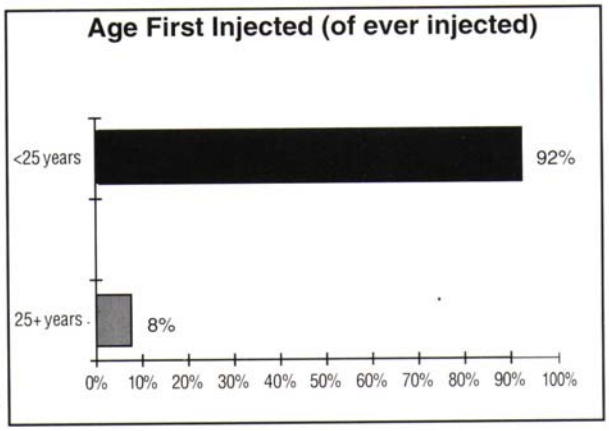
The 'other drugs' category contained a higher proportion of cases in the under 5 years duration of drug use period than the opiates one.

Interestingly there was no difference between the two drug using groups and the expected figure for the duration period of 10 years or over at 17%.

Injecting and Sharing Practices (valid %)

The salient features to emerge for treated cases who injected or shared their drugs during 1990 are shown below.





The majority, or 80%, acknowledged having at some time injected their drugs.

On treatment contact 65% of those who had ever injected stated that they were currently injecting.

More than eight in ten of those who ever injected drugs had at some time in the past shared their injecting equipment, the proportion who were currently sharing dropped to 17% (245) when questioned on treatment contact.

Most of these (92%) were aged under 25 when they first started the practice of drug injecting; the mean age for first injecting was 19 years.

The following Tables 4 and 5 provide further information on specified characteristics of those who had ever injected with those currently injecting and currently sharing.

Table 4: One Year Treated Prevalence, Dublin 1990. Specified Characteristics of these who had Ever Injected by Currently Injecting.

Numbers and Percentages.

		Currently Injecting	
Sex		**Yes**	**No**
male	N	752	384
	%	75.9	72.2
female	N	239	148
	%	24.1	27.8
Age			
under 25 years	N	448	229
	%	46.1	43.7
25 years & over	N	523	295
	%	53.9	56.3
Primary Drug of Misuse			
opiates	N	973	480
	%	98.4	90.7
other drugs	N	16	49
	%	1.6	9.3
Ever Injected			
yes	N	991	532
	%	100.0	100.0
no	N	-	-
	%	-	-

As can be seen from Table 4 of those who had ever injected 991 cases, or 65% (as shown in the figure relating to injecting and sharing practices p. 28) were currently injecting their drugs. Slightly higher proportions of men and lower of women than expected were currently injecting their drugs. Somewhat lower percentages of the younger age group were currently injecting and higher percentages among the older clients. Drugs used by those who had ever injected were predominantly opiates, with less than 2% injecting other drugs, such as minor tranquillisers and cocaine.

Table 5: One Year Treated prevalence, Dublin 1990. Specified Characteristics of those who had Ever Injected by Currently Sharing.

Numbers and Percentages.

		Currently Sharing	
Sex		**Yes**	**No**
male	N	156	912
	%	63.7	74.7
female	N	89	267
	%	36.3	22.6
Age			
under 25 years	N	101	537
	%	42.6	46.1
25 years & over	N	136	629
	%	57.4	53.9
Primary Drug of Misuse			
opiates	N	245	1114
	%	100.0	94.6
other drugs	N	-	63
	%	-	5.4
Currently Injecting			
yes	N	245	653
	%	100.0	56.0
no	N	-	514
	%	-	44.0

Table 5 presents information for those who had ever injected and were currently sharing their injecting equipment. Of those who had ever injected 245 or 17% (see p. 28) were currently sharing their drugs. However here we see that women were proportionally more likely than expected to be sharing their injecting equipment. A higher than anticipated percentage of drug users in the older age group were currently sharing compared with those in the younger age category. Opiates were the only drugs involved in the sharing practice.

3.2 Census and First Treatment Contact

Census cases are those, already defined in greater detail, who were in treatment on January 1 1990, N cases = 462. Such cases would include a mix of those with both short and long term lengths of stay in treatment. The majority, we believe, refer to the somewhat older methadone maintenance cases from the large Drug Treatment Centre Board.

First Treatment Contact is the current estimate of treated incidence relating to those clients who received treatment for the first-ever time during 1990, N cases = 624.

A comparison of these two distinct treatment classes was considered to be a useful exercise. It provides a way of documenting possible differences between the two client groups regarding, for example, age, primary drug of misuse, and current injecting practices. Such findings are of value in themselves but in addition afford insights for treatment and policy approaches.

The comparative analysis of Census and First Treatment Contact data which follows takes the approach used for the prevalence data (see p. 17). This consists of providing basic information, followed by cross tabulations. Where proportional differences between the variables analysed in these tables occur, they are compared with the expected values established initially and commented on.

A higher proportion of males, 75%, were in the first contact group than the census one at 66%. Conversely there was almost 10% more females in the census group than the first contact one.

As is in order more young people, 69%, were making their first contact with a treatment centre than those who were in treatment, 43%. Following on from the fact that the first treatment group was the younger of the two, more in that group, 61%, were living with their family of origin than in the census category of 40%.

Drug users from the older census cases were more likely to be living with a drug misusing partner, in fact were twice as probable to be living with a partner than the first contact group.

Differences between the two groups were not as marked for employment, with the first contact category containing a slightly higher proportion in regular employment, and more unemployed in the census category.

More first contact drug misusers had remained on at school after the school leaving age of 15 than census cases.

Socio-demographic Characteristics (valid %)

A profile of the socio-demographic characteristics of census and first treatment contact case is presented here.

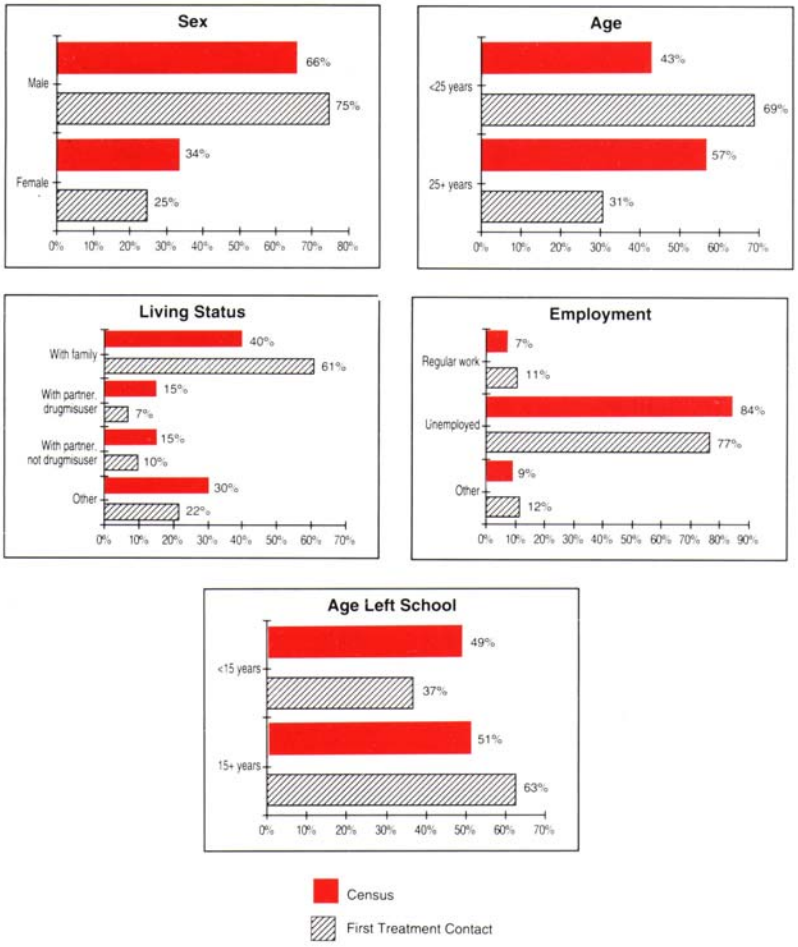


Table 6: Census and First Treatment Contact, Dublin 1990. Specified Socio-demographic Characteristics by Sex.

Numbers and Percentages.

		CENSUS		FIRST CONTACT	
		Male	**Female**	**Male**	**Female**
Age					
Under 25 years	N	130	67	3.22	103
	%	43.2	43.8	70.0	66.0
25 years & over	N	171	86	178	53
	%	56.8	56.2	30.0	34.0
Living Status					
with family	N	133	48	307	68
	%	44.6	30.8	67.2	43.6
with partner, drug misuser	N	28	38	20	26
	%	9.4	24.4	4.4	16.7
with partner not drug misuser	N	53	17	48	12
	%	17.8	10.9	10.5	7.7
other	N	84	53	82	50
	%	28.2	34.0	17.9	32.1
Employment					
regular work	N	30	3	49	19
	%	10.0	1.9	10.6	12.2
unemployed	N	257	124	370	104
	%	86.0	80.5	80.3	66.7
other	N	12	27	42	33
	%	4.0	17.5	9.1	21.2
Age Left School					
under 15 years	N	119	78	120	47
	%	44.6	58.6	35.3	42.7
15 years & over	N	148	55	220	63
	%	55.4	41.4	64.7	57.3

Table 6 provides additional detail for specified socio-demographic characteristics by sex for census and first treatment contacts, see also data presented on p. 35. There were few differences in the male female groups in terms of age for either the census or first contact cases, except for a small shortfall for younger first contact females.

Higher proportions of men and less women than expected from both treatment modalities were living with their family of origin, markedly so for the first contact clients. Conversely percentages of women living with a drug misusing partner were higher than anticipated. Almost a quarter of census women were in such a relationship compared to 17% of first contacts. Census and first contact male drug users were somewhat more likely than their female counterparts to be living with a non drug user.

The proportions of unemployed men were somewhat higher than those for women.

Proportionally more women and less men than expected, for both census and first treatment clients, left school aged under 15 years.

Table 7: Census and First Treatment Contact, Dublin 1990. Specified Socio-demographic Characteristics by Age.

Numbers and Percentages.

		CENSUS		FIRST CONTACT	
		Under 25 years	**25 years & over**	**Under 25 years**	**25 years & over**
Sex					
male	N	130	171	322	138
	%	66.0	66.5	75.8	72.3
female	N	67	86	103	53
	%	34.0	33.5	24.2	27.7
Living Status					
with family	N	97	82	310	60
	%	49.5	32.8	73.6	32.3
with partner, drug misuser	N	18	46	22	24
	%	9.2	18.4	5.2	12.9
with partner not drug misuser	N	20	50	16	44
	%	10.2	20.0	3.8	23.7
other	N	61	72	73	58
	%	31.1	28.8	17.3	31.2
Employment					
regular work	N	14	19	37	30
	%	7.2	7.6	8.8	16.0
unemployed	N	162	214	320	147
	%	83.5	85.3	75.8	78.6
other	N	18	18	65	10
	%	9.3	7.2	15.4	5.3
Age Left School					
under 15 years	N	80	115	115	50
	%	46.8	51.6	37.0	36.5
15 years & over	N	91	108	196	87
	%	53.2	84.4	63.0	63.5

Table 7 looks at the possible relationship between age and a range of selected socio-demographic characteristics for the treatment contacts, see also data presented on p. 35. The proportions were as expected in the analysis of age group by sex for census cases. Where first treatment contact is concerned women from the older age category were more likely to present later for treatment than men.

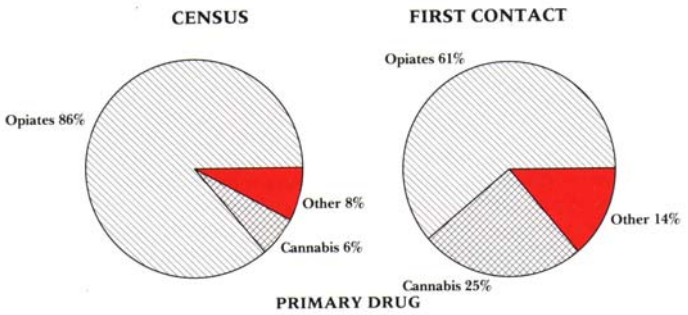
The younger age groups for both census and first treatment contact were more commonly living with their families; the difference was more marked than might be anticipated for the first contact cases. Proportions were higher in the older age group of 25 years and over for those living with a drug misuser in both treatment modalities, but surprisingly higher than expected in the first treatment one. A similar trend existed for drug users living with a non using partner.

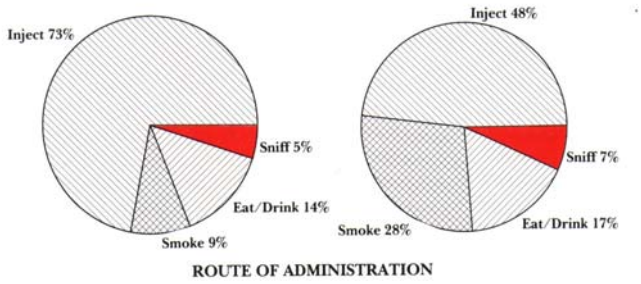
The age distribution of census and first contact cases regarding their unemployment status was similar. However a higher than anticipated percentage of the 25 years and over first contact cases were in regular work.

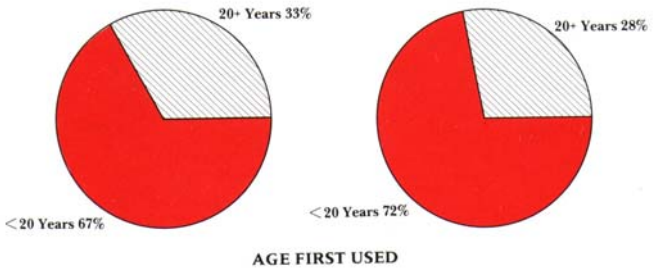
As earlier remarked first contact clients remained on longer at school than census ones. This table shows no difference between the younger and older first contacts for that finding.

History of Drug Misuse (valid %)

A summary history of drug misuse among census and first Treatment contact cases can be seen below.



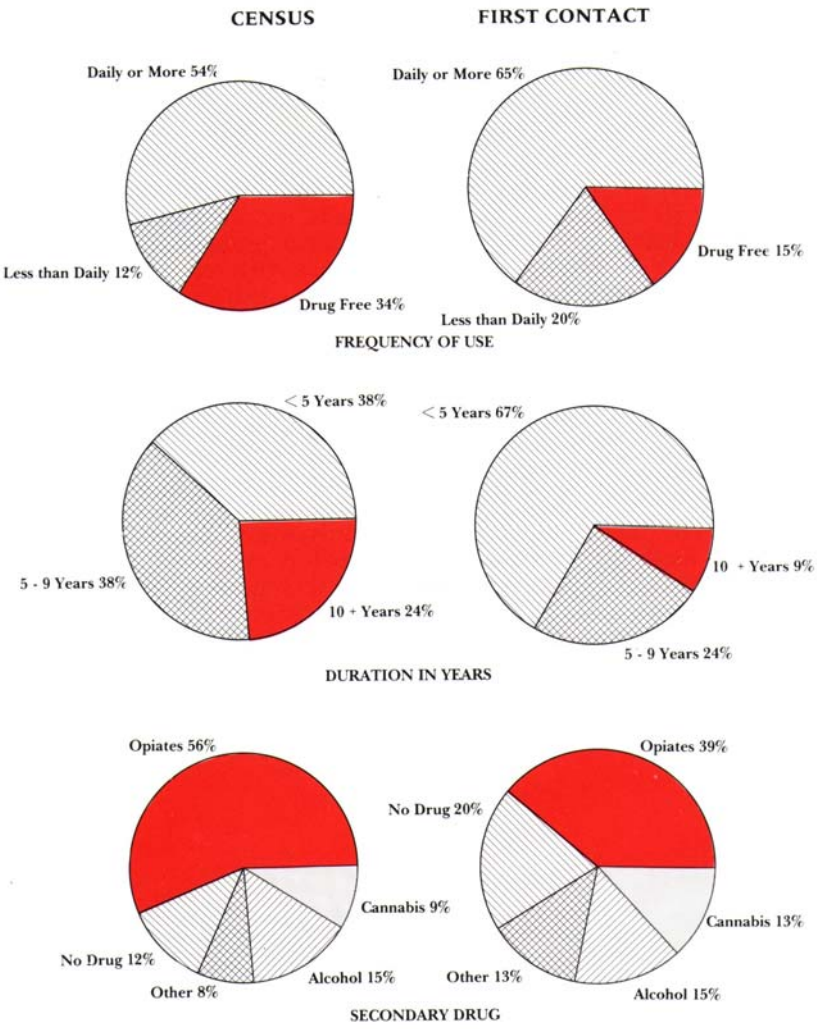




This profile shows that opiates were the preferred primary drug for both census and first contacts. It is not surprising that a higher percentage, 86%, in the census group named an opiate, than the first contact group at 61 %. Of interest is that a quarter of clients on their first treatment contact reported cannabis as their primary drug, in contrast to only 6% in the census category.

Differences between the two treatment groups emerged for route of administration of their primary drug, with the majority of census cases, 73%, injecting compared with less than half, or 48%, in the first contact class. A high proportion of the latter group 28%, smoked their drug. This can be allied to the relatively high number who stated cannabis as their primary drug. Approximately two thirds of census cases had first used their stated primary drug before the age of 20, a slightly higher percentage, 72% of first contacts having so done. More detailed analysis shows that first contact women were more likely than men to have first used their primary drug at an older age.

History of Drug Misuse (contd.)



Daily or more frequent use of drugs was engaged in by more than half the two groups in the month before treatment contact. Reasons from participating centres have already been noted for the recording of drug free clients (see p. 25). However the higher proportion of those in the census group at 34% compared with 15% for first treatment contact must be queried. All centres had been sent a memo reminding them that census data should refer to the time prior to contact with their centre. It was possible to establish that those on a methadone programme in the Drug Treatment Centre Board, the only service in this reporting system then providing such a programme, returned only 2.7% of clients in their annual prevalence count, including census, as drug free. Therefore, the recording of drug free by the treatment centres referred principally to reasons recorded earlier. Notwithstanding, a question referring to "drug frequency in the past month" on a census form is open to misinterpretation and should be reconsidered for future use.

Because of the on average older age of the census category 24% from that group had been actively using drugs for 10 or more years in contrast to 9% of the first treatment clients.

Treatment in Dublin is centred predominantly on problems with opiates as seen from the high proportion who cite such a drug as their primary one. The same pattern emerged for secondary drug with opiates first on the list for census and first contact clients. Alcohol plays a small but significant role in both treatment groups, as in 15% of cases in each group it was used in association with a primary drug.

Table 8: Census and First Treatment Contact, Dublin 1990. Specified Characteristics by Primary Drug.

Numbers and Percentages.

		CENSUS		FIRST CONTACT	
		Opiates	**Other Drugs**	**Opiates**	**Other Drugs**
Sex					
male	N	257	45	284	180
	%	65.1	69.2	75.5	74.1
female	N	138	20	92	63
	%	34.9	30.8	24.5	25.9
Age					
under 25 years	N	150	47	243	179
	%	38.6	73.4	65.1	74.6
25 years & over	N	239	17	130	61
	%	61.4	26.6	34.9	25.4
Age First Used Drugs					
under 20 years	N	241	57	233	190
	%	63.3	90.5	65.3	83.7
20 years & over	N	140	6	124	37
	%	36.7	9.5	34.7	16.3
Duration of Drug Use					
under 5 years	N	133	29	234	151
	%	35.9	47.5	67.4	66.8
5 – 9 years & over	N	145	19	82	55
	%	39.2	31.1	23.6	24.3
10 years & over	N	92	13	31	20
	%	24.9	21.3	8.9	8.8

In Table 8 the primary drug of misuse categories, except for opiates which include opioids, have been combined under ‘other drugs’, because the number involved is small. Information shown on pp. 35, 40 & 42 are used in the following analysis. As the opiate group comprises 80% of all drug cases, the ‘other drugs’ category must be viewed with caution because of the small numbers and the heterogeneity of the ‘other’ categories. As expected the opiates and ‘other drugs’ categories for both census and first treatment contact contained higher male than female proportions.

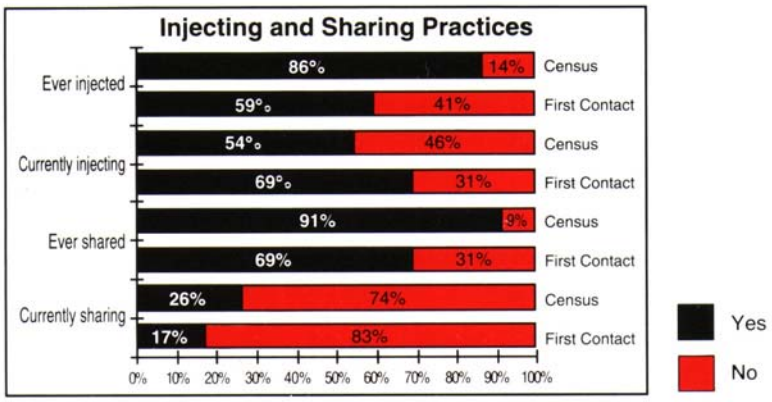
There was little difference in percentages between opiates and ‘other drugs’ by age except for the younger age group of census misusers of ‘other drugs’. There the proportion was much higher than expected.

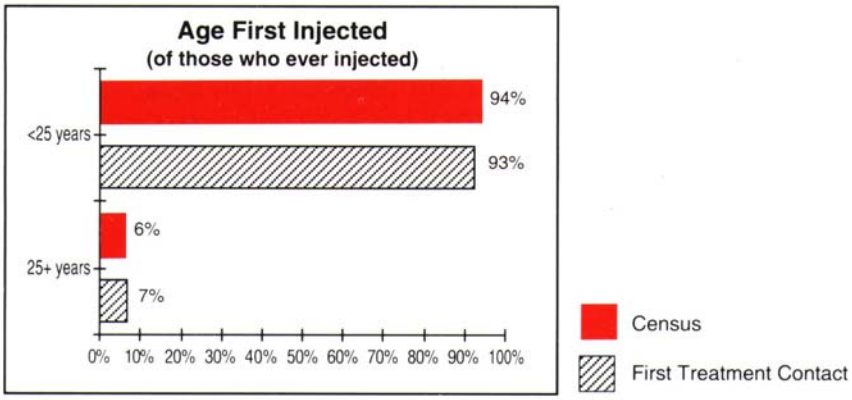
Proportionally higher numbers in the census and first contact groups had commenced using drugs, other than opiates, before the age of 20.

Between the opiates and ‘other drugs’ by duration of use differences from expected levels did not emerge except for census clients where almost half had been on drugs other than opiates, for less than 5 years compared to 36% of opiate users.

Injecting and Sharing Practices (valid %)

The figures which follow highlight the main features of injecting And sharing practices among the census and first treatment contact cases.





A much higher percentage of census cases at 86, had ever injected their drugs than those in the first contact category at 59. Subsequent information refers to that group of ever
injected.

A higher proportion, 69%, of first contact clients were currently injecting compared to 54% of the census group. Conversely, a lower percentage of first contacts, 69, had ever shared their equipment, while the percentage for census cases was 22 points higher at 91. Similarly a lower proportion of first contact clients were currently sharing, 17, versus 26 for the census group.

We see that almost all those, 94% who injected their drugs had done so before the age of 25 years in the census group, the proportion was almost identical for the first contact group at 93%.

A relevant point to be elaborated on is the higher proportion of census drug takers than first treatment contacts who were drug free referred to on p.43. This means that about one third fewer census clients who had ever injected were currently using drugs or injecting and sharing, and has an effect on the comparative statistics between the two groups. This drop in drug taking by census clients may or may not reflect a firm decision by an older age group of users.

Table 9: Census and First Treatment Contact, Dublin 1990. Specified Characteristics of those who had Ever Injected by Currently Injecting.

Numbers and Percentages.

		CENSUS		FIRST CONTACT	
		Currently Injecting		Currently Injecting	
		Yes	No	Yes	No
Sex					
male	N	124	124	180	76
	%	60.2	70.5	80.7	75.2
female	N	82	52	43	25
	%	39.8	29.5	19.3	24.8
Age					
under 25 years	N	76	75	157	58
	%	37.1	43.4	71.4	57.4
25 years & over	N	129	98	63	43
	%	62.9	56.6	28.6	42.6
Primary Drug of Misuse					
opiates	N	205	163	220	82
	%	99.5	92.6	98.7	81.2
other	N	1	13	3	19
	%	0.5	7.4	1.3	18.8
Ever Injected					
yes	N	206	176	223	101
	%	100.0	100.0	100.0	100.0
no	N	–	–	–	–
	%	–	–	–	–

Table 9 provides additional information for census and first contact clients to that presented in the figure relating to injecting and sharing practices (p. 46). There it was observed that 86% of census cases and 59% of first contacts had ever injected their drugs in the past. This table shows that 206 or 54% of census cases who had ever injected were currently injecting; the figure for first contact cases was 223 or 69%.

A higher proportion of women than expected were currently injecting in the census group and a lower percentage in the first treatment one. Clients who were currently injecting were more likely to come from the 2 5 and over census age group. The drugs that clients injected in both treatment groups were primarily opiates.

Table 10: Census and First Treatment Contact, Dublin 1990. Specified Characteristics of those who had Ever Injected by Currently Sharing.

Numbers and Percentages.

		CENSUS		FIRST CONTACT	
		Currently Sharing		Currently Sharing	
		Yes	No	Yes	No
Sex					
male	N	48	187	34	208
	%	51.6	69.3	65.4	82.5
female	N	45	83	18	44
	%	48.4	30.7	34.6	17.5
Age					
under 25 years	N	31	112	35	168
	%	33.7	41.9	67.3	66.9
25 years & over	N	61	155	17	83
	%	66.3	58.1	32.7	33.1
Primary Drug of Misuse					
opiates	N	93	256	52	231
	%	100.0	94.8	100.0	91.7
other drugs	N	–	14	–	21
	%	–	5.2	–	8.3
Currently Injected					
yes	N	93	100	52	153
	%	100.0	37.0	100.0	61.7
no	N	–	170	–	95
	%	–	63.0	–	38.3

Table 10 is concerned with the current sharing of drugs by clients who entered treatment either as census or first treatment cases. From information on an earlier figure (p. 46) we see that 26% of census cases who had ever injected were currently sharing compared with 17% of first contact clients.

Census and first contact women were much more likely than expected to be sharing their injecting equipment in both of these treatment categories. Drug users in the older age group of 25 years and over who were sharing were proportionally over represented in the census group, while the difference was less marked for first contact cases. Opiates were the only drugs implicated in current drug sharing among both treatment categories.

33 Estimation of Rates for Treated Drug Misuse

Definitions of the three basic concepts

one year treated prevalence,
census, or point treated prevalence, and
first contact, or one year treated incidence

have been noted earlier. What follows here is an explanation of how rates of treated drug misuse for these three periods have been estimated. Rates are compiled for a 15-39 age group as 95% of drug users in this study were in that age range.

In the Dublin Drug Treatment Reporting System all participating centres are provided with written instructions regarding definitions of key concepts, such as, drug treatment and first treatment contact. In addition, designated persons in each centre have been trained in how these instructions are to be followed when completing the data collection form. Information reported on here refers to the first year of operation of the system during which some teething problems occurred. Some were due to our lack of anticipation of problems that arose, and others to pressure of work within treatment centres or their lack of familiarity with the requirements of the reporting system.

The determination of rates for each of our three measures of treated drug misuse involves (i) the definition of cases, (ii) the population from which they are drawn, and (iii) the time period involved. Leaving the first requirement aside for the moment, the population from which drug cases come is that of the greater Dublin area. As a consequence only those resident in that area were eligible for inclusion in the system and information returned to us regarding clients from outside this catchment area were excluded from the study (see Appendix B for details of the population of the greater Dublin area).

The time period involved differs for each of the measures. The term one year treated prevalence is used to stress that figures derived from treatment centres reflect contacts with specified, usually specialist services, and not the true frequency of drug misuse in the Dublin area. However, any research strategy must begin with the known and work toward the unknown.

There are two main components in a one year treated prevalence rate. The first is the number of clients on census day together with those non-residential clients who received treatment for their drug problem in the 30 days prior to that date, giving a point treated

prevalence or census count. The second component is the number of clients who received treatment with the specified services during the year following the census day and who are not included in the census figure. This second component includes those clients who enter treatment for the first ever time and comprise a one year treated incidence figure.

Returning now to the importance of case definition. If rates are to be computed for the three time periods cases must relate to persons. It can confidently be said that there was little or no duplication of individuals reported to the Health Research Board from the treatment centres, as all forms are manually checked prior to entry to the computer and again in the computer at the end of the year to detect duplicate client numbering within centres. There was, however, an element of double count between centres. Our way of dealing with this problem was the inclusion of a question on the intake form relating to "currently in contact with other centres"? and "if yes, specify". In this context 'currently' referred to within the past 30 days. When the form is revised we plan to relate the question to received or receiving treatment since January 1st last at any other Dublin treatment centre. This altered approach, together with the use of clients' date of birth, would further reduce the duplication of cases within the system. However, given the anonymous nature of this procedure we may always have to accept some degree of double count, confirmed by evidence from other European cities where, in addition, initials of forename and surname are collected.

Other reasons for excluding data on the grounds of case definition included information for clients not resident in the catchment area and for those whose primary drug of misuse was alcohol.

In our instruction re completion of the form and in our discussions with treatment centre personnel it is always stressed that forms should not be completed unless an entry to treatment, as defined, has been made. Initial assessments where clients do not return to commence treatment are excluded.

What follows is a critical look at our data with the objective of differentiating between cases and persons thereby reaching an estimate of persons in receipt of treatment for each of the time periods involved.

One Year Treated Prevalence

The recorded figure refers to 2037 cases of which

1400	were not in contact with another centre or		1400 persons
504	were in contact estimated at half or		252 persons
133	were unspecified re centre contact of which		
67	were presumed not in current contact or		67 persons
66	were presumed in contact, estimated at half or		33 persons
		Total	17 52 persons

Census or Point Treated Prevalence

The recorded figure refers to 462 cases of which

327	were not in contact with another centre or		327 persons
118	were in contact estimated at half or		59 persons
17	were unspecified re centre contact of which		
9	were presumed not in current contact or		9 persons
8	were presumed in contact, estimated at half or		4 persons
		Total	399 persons

First Contact or One Year Treated Incidence

The recorded figure refers to 624 cases of which

507	were not in contact with another centre or		507 persons
84	were in contact, estimated at half or		42 persons
33	were unspecified re centre contact of which		
17	were presumed not in contact or		17 persons
16	were presumed in contact, estimated at half or		8 persons
		Total	574 persons

An anomaly can be seen in the First Contact or One Year Treated Incidence data where 84 cases were recorded as in current contact with another centre. According to instructions clients who are making their first ever contact for treatment cannot be currently in contact with another centre (because of the temporal sequence where one contact must preceed the other). We believe this error arose largely from incorrect recording of the never previously treated question.

In conclusion our estimates for the number and rate of persons who received treatment for their drug problem from centres in the greater Dublin area in 1990 are

In Treatment (Jan 1 1990)	**Treatment Contact** (during year 1990)	**Census*** (Dec 1989)
399	1353 of whom 574 were never previously treated	X

One year treated prevalence	N	399 + 1353= 1752
	Rate	4.5 per 1000 of the pop. aged 15-39
Census or point treated Prevalence	N	399
	Rate	1.0 per 1000 of the pop. aged 15-39
First contact or one year treated incidence	N	574
	Rate	1.5 per 1000 of the pop. aged 15-39.

* December 1989 census data = In treatment on January 1 1990

We are not happy with the estimate of one year treated incidence given above and believe it to be an overestimation of the actual figure. Similar difficulties in identifying unique individuals in the incidence of problem drug use in the Wirral were noted (Parker, Bakx, and Newcombe, 1986: 120-132). Estimates arrived at by us are somewhat analogous to the approach adopted by them.

CHAPTER 4

Discussion

Age

There is evidence to suggest that the group of treated drug misusers in the greater Dublin area 1990, is older than groups who received treatment in earlier years. As 1990 represents the first year for which information is available from the Drug Treatment Reporting System it is not possible to make comparisons with similar data for former years. However, information is available from the National Drug Advisory and Treatment Centre (Dean, Kelly, O'Hare et al, 1985) now the Drug Treatment Centre Board, which shows that the percentage of treated clients aged 25+ was
37% in 1981
35% in 1982
40% in 1983 and
51% in 1990 (present study).
Despite some differences in coverage and definition both sets of data refer to clients from the same population base. Since 1983 there has been a decline in the proportion of first contacts with a corresponding increase in the number of re-contacts (personal communication. Drug Treatment Centre Board). That may indicate ongoing treatment of former cohorts. Some idea of this ageing process can be gleaned from the fact that first contact clients of this study are considerably younger than those identified during the census period. There was a full 26 percentage points difference between the two groups. Regrettably we have no current information on the length of time in treatment for the census group, but there is a longer duration time on drugs for that group than the first contact one suggesting perhaps a longer time in treatment.

While Home Office Addict Notification Statistics for the United Kingdom need to be interpreted cautiously, due to incomplete coverage and reference to opiate and cocaine addicts only, they are still a useful indicator of underlying drug misuse trends. As in Dublin, notifications of all treated drug addicts between 1987 and 1990 inclusive refer to an ageing group, 67% aged 25 or more in 1990 compared to 60% in 1987 (United Kingdom Home Office, 1991:6b), in fact much older than their Dublin counterparts. A London study (Hartnoll, Power, Daviaud et al,

1989) of regular drug users attending six local treatment services showed the same high percentage of 69% aged 25 years or more.

A recent national survey in France of 4,846 drug abusers attending a representative sample of treatment centres (Facy, Rosch, Angel et al, 1991) showed a marked increase in age when compared to an earlier study. In 1986,.44% of attenders were aged 25 or more.

Preliminary information from the Pompidou Group study on the Development of Treatment Reporting Systems in Europe (Hartnoll, 1991) shows Dublin with the lowest mean age for census clients (December 1990) at 25.7 years, with 43% aged under 25. Of the other cities in the study the mean age for clients was almost six years older in Copenhagen and eight in Amsterdam. While census data are not in all cases representative for cities they do indicate a trend of older long term users in those cities like Amsterdam, Copenhagen and Stockholm with a longer history of problem drug use.

Available data for all treated drug users (as distinct from census clients only) show current Dublin users to be younger than most of their European counterparts, with the exception of Lisbon and Scotland. Recently released figures from the new Scottish drug misuse database (Scottish Health Services, 1992) showed a surprising 56% of clients were aged under 25. This compares with 49% of Dublin clients for approximately the same time period.

Sex

In common with change over time in the age structure of the treated drug population in the Dublin area, the male/female ratio likewise seems to have altered. Using the same data source as for age shows a decline in the male proportion over time, with a corresponding increase in the female one, as follows the male/female ratio was

3.9:1 in 1981
3.6:1 in 1982
3.1:1 in 1983 and
2.8:1 in 1990 (present study).

The male/female ratio for all drug addicts reported to the Home Office (United Kingdom Home Office, 1991:6a) was approximately 2.6:1 for the four year period 1987 to 1990, very similar to the current Dublin one. The male/female ratio for the London study, mentioned above, was less than two males to every female. In the French national survey the male/female ratio was 3:1 in 1986. A study of 1214 Italian heterosexual drug users during the period 1985-1987 showed a similar male female ratio (Sasse, Salmaso, Conti et al, 1991). Data from the Dublin Ana Liffey

Drug Project show the same trend (Annual Report, 1991). Information from these combined sources suggests that more women are coming forward for treatment but at what stage in their drug careers?

An important point to emerge in this study was differences in the male/female ratio between the census and first contact groups. The ratio for the census group was 1.9:1 while the first contact male/female ratio at 3.0:1 showed a marked male predominance and female shortfall. This gender difference will be commented on later.

Living Status

Fifty one percent of treated drug misusers in Dublin in 1990 were living with their family of origin. As expected a higher proportion of the younger first treatment group, 61%, were so doing and correspondingly a lower proportion (40%) of the census group. These proportions are high, when compared with 27% of all clients in a similar situation in London at the time of a joint pilot study with Dublin (O'Hare and Hartnoll, 1989), and with the French study findings of 45% – further outcome from the Development of Treatment Reporting Systems in Europe is pending.

The explanation must lie in how the family functions in Ireland, as distinct from most European cultures. In 1986, the most recent census year for which such data are available, children aged under 15 years made up 29% of the Irish population. Compared to other European countries this proportion is very high. In fact among OECD countries only Turkey has a higher proportion of children (Nolan and Farrell, 1990: 7-8).

Whereas recent changes in the patterns ofnuptiality and fertility, the main demographic variables which define the family, have brought us closer to the European norm (Clancy, 1991) the traditional nuclear family still predominates. Furthermore a high proportion of unmarried children continues to live with their family of origin. According to the 1986 Census of Population, 44% of households (97% of the Irish population) contained 60% of persons, consisting of one or more unmarried children of any age (Nolan and Farrell, 1990: 11-12).

In addition to structural features of the Irish nuclear family economic necessity and high levels of unemployment deter young people from leaving home, particularly if emigration outlets are blocked.

The present study findings showed that a higher than expected percentage of females than males were living with a drug misusing partner, which could be either a husband or cohabitee. Confirmation of this gender preference of a partner comes from a recent Italian study which showed that females were more likely to have drug-using partners, while males were more likely

to have non drug-using partners. (Sasse, Salmaso, Conti et al, 1991). In the Dublin context this was particularly true of the first contact group.

Gender

Important gender differences emerged from this study showing that women were more likely than men to have first used their primary drug at an older age, and were older when they presented for treatment for the first time. These findings go some way towards explaining differences in the male female ratio, noted earlier, of almost 2:1 for census cases and 3:1 for first contact clients. They further substantiate the belief of many drug workers that women tend to present later for treatment, if at all (Woods, 1992 : 11).

Additional differences between the sexes which should be highlighted relate to higher proportions of women than men living with a drug misusing partner and currently sharing injecting equipment. These are areas which warrant further study.

While there is general recognition of the legitimacy of research and treatment of women as a 'special population' within the substance abuse field, there is little evidence that such work has been carried out. A special issue on women and drug abuse entitled Women 2000 (United Nations, 1987) suggests that this in part stems from the fact that more male than female subjects have been used for research. However, they note that epidemiological studies have shown consistent differences in drug use by men and women including higher levels of personal distress such as, depression and anxiety and lower levels of self-esteem experienced by women. Recent studies from the UK (Report of a Workshop, London, 1989; Waterson and Ettorre, 1989) have identified problems, such as, fear associated with help seeking, of embarrassment, shame, and most important of all fear of losing their children. Under New York state law, for example, a child who tests positive for drugs at birth is presumptive evidence of neglect or abuse by the mother. The outcome of this punitive legislation is that about 50% of such cases end up in foster care – more than 90% of them African-American or Hispanic (Drucker, 1990).

Such indifferent treatment of women indicates their powerlessness, (a possible explanation for the higher than expected percentage of women living with a drug using partner) in particular those from certain minority groups and those disadvantaged by adverse socio-economic circumstances. A recent Irish discussion paper on Women, Drugs and HIV (Woods, 1992 : 9-15), referred to the sociological concept of labelling common in studies of mental illness. The label referred to here was deviance or how society viewed women's drug use as somehow less acceptable than men's use, though both would be labelled as deviant. The consequent marginalisation of women reinforces their isolation and findings from another study (Hedrich, 1990) suggest that women's cessation of drugs was strongly related to her social relationships and emotional support from other people.

Education

The mean school leaving age for respondents in this study was 14.7 years, which meant that 44% left before the official age of 15 years, women proportionally more so than men. In 1988, 22% of persons ceased full-time education under 15 years in the greater Dublin area; the percentage in this study, as noted was double that. The effect of dropping out of school or early school leaving has well documented adverse consequences on a person's chances of employment, and personal development. A variety of government and non-governmental agencies have developed programmes, including drug prevention ones, in an attempt to diminish or bridge the deficit caused by an inadequate education background. It is appropriate here to outline some of the best known approaches to acknowledge the recognition of this problem, and to stress the importance of monitoring and evaluating the course and outcome of such programmes.

The Youth Affairs section of the Department of Education grant aid three main projects:

- Mainline Youth work, which has an overall objective of providing information, activity, and stimulation to young people. Specified organisations are grant aided, most of which would be aware of the drug problem and provide relevant talks and discussions around the issue of drug misuse.
- Community projects specifically aimed at disadvantaged young people perceived as detached from mainstream living, such as, those involved in crime, alcohol and drug misuse and non-marital pregnancies. Selected agencies carrying out this type of work receive grants.
- Youth Information Centres, which provide appropriate information to meet the needs of young people.

The Youth Affairs staff of the Department of Education is very conscious of the need to evaluate how these various projects are meeting their objectives and have plans as to how this might be carried out.

The Green Paper on Education proposes raising the school leaving age to 16 and includes a special emphasis on disadvantaged youth.

YouthReach, is an initiative of the Department of Labour and Education. This project set up in 1989 focuses on young people who are typically at least six months in the labour market, aged between 15-18 years and who have left school without formal qualifications or training. It provides "two year co-ordinated and integrated training, work experience and temporary employment for the most marginalised and disadvantaged early school leavers" (YouthReach, a summary, 1989).

The Health Promotion Unit, Department of Health, makes available materials on the subject of drugs to educate targeted groups about problems in these areas. It has embarked, with the Department of Education, on a pilot substance abuse preventive programme in selected second level schools. The project is conducted by Mater Dei Counselling Centre, with funding from the EC. It has also initiated a pilot parenting programme in drug prevention strategies in conjunction with the Southern Health Board, and also supports summer schools which provide teachers with in service courses in the drug misuse area.

A variety of non-governmental agencies such as Comhairle Ie Leas Oige and Feroige an Oige organise programmes for the young and disadvantaged. The Catholic Social Services Conference has a Drug Awareness Programme (DAP) which includes a 'Youth to Youth' project. It consists of a trained team of young persons who go to schools, youth clubs etc., using peer group influences to prevent drug taking among Dublin youth. DAP also produced an entertaining video for young people showing how and why to say 'no' to drugs.

Unemployment

While data from this study are not available for clients' longest held employment we know that 82% of treated drug users were unemployed when they last contacted a treatment service in the Dublin reporting system. A more detailed analysis for this unemployed group shows that 77% were male and 23% female. The proportion was almost equally divided between those aged under and over 25, and 98% were between the ages of 15-39. Compared with data from the Live Register, (Labour Force Survey, 1989, personal communication CSO), we find that a much lower percentage, 17%, of the population aged 15-44 were unemployed in the Dublin area.

Data from the European Foundation for the Improvement of Living and Working Conditions (Burton, Forrest and Stewart, 1989) of comparable unemployment rates for under 2 5 year olds as of end 1988 showed Ireland and the UK with higher male than female rates (Luxembourg had marginally higher rates but low overall unemployment figures). This was in the context of a clear excess of female rates for the combined 12 Euro countries. The report acknowledges that young women may be regarded as less well prepared for the labour market than men and more socialised into regarding the family as a legitimate alternative to employment. However the low participation of Irish women, the lowest in Europe at 22.6% (Eurostat, 1989), may have a bearing on this statistic, making it easier for women (as there are fewer of them) than men to get particular types of employment. The UK with one of the highest female participation rates in the labour force has a different explanation of higher young male unemployment rates which may be related to marked ethnic differences in unemployment resulting in young black males experiencing difficulties in finding work.

Recent UK and Irish studies have demonstrated that unemployment is one of the key adverse socio-economic factors associated with drug use. This is further elaborated on in the following section.

Area of Residence

Study clients were allocated to Electoral Areas in the greater Dublin area on the basis of their addresses. This broad classification of residence had to be used because as yet much of the information supplied to us has not sufficient detail to code according to wards or DEDs. Ideally we would like all centres to use the Street Index (Johnson, Johnson and Lambe, 1987) currently used by health personnel in the Eastern Health Board area. Such detail would allow us to rate our information rather than use percentages as we do here. However a crude estimation of rates for the age group 15-39 shows the south inner city with the highest rate, a gradient similar to percentages shown for the other areas (see p. 18) and a much lower overall rate for remaining electoral areas in the catchment area. When, hopefully, more detail regarding area of residence becomes available it would not be for general publication, for reasons already given, but rather for distribution to institutions or persons who could make constructive use of these data.

Our findings show that 31% of the study population reside in either the north or south inner city areas, characterised by high levels of unemployment, poor housing and lack of leadership. There is also a well documented history of drug misuse in these areas (Dean, Bradshaw and Lavelle, 1983; O'Kelly, Bury, Cullen et al, 1988). Other areas with high levels of treated drug

misuse are Ballyfermot and Drumcondra, including Ballymun, representing 13% and 11% of the study population respectively where adverse socio-economic conditions are also known to exist.

Findings from studies in the UK in the mid to late 1980s, such as those in the Wirral and Glasgow area, stopped short of attributing causal effects to such conditions in the case of devastating problem drug use. To illustrate the basis of such conclusions, the investigators of drug misuse in the Wirral devised nine indicators of social deprivation, using census data. They demonstrated consistent, significant, and positive correlations between the rates of known opiate use and six of the socio-economic indicator rates: unemployment, council tenancies, overcrowding, larger numbers of children, unskilled work force, and single parents (Parker, Bakx and Newcombe, 1986: 88-94).

Primary Drug of Misuse

An opiate was the primary drug for the majority of treated cases; 86% in the census category, and 61% of first contacts. This preference for an opiate as a primary drug of misuse is generally in line with that experienced in other European countries. The mean age when misuse of primary drug began for respondents of this study was 19, a similar age for those who first injected their drugs. There is concern in Dublin regarding the increased number of intravenous drug users abusing prescribed opiates, notably morphine sulphate, buprenorphine and methadone (O'Connor, 1992). Comparable data from treatment centres in European cities for variables analysed in this study will be available shortly from the Pompidou Group, thus affording an interesting basis for comparison between the various cities.

Cannabis is probably the most widely misused drug in Ireland, but few users present for treatment. One quarter of Dublin first contacts reported cannabis as their primary drug mainly from centres treating school going clients, compared with 6% of census clients. This raises the question of whether cannabis is a gateway drug for the neophyte, who once initiated into the drug culture goes on to sample the more addictive hard drugs. Alternatively one could speculate that a proportion of cannabis users discontinue the habit and no longer remain in the system to be replaced by a new wave of users in the subsequent year.

Cannabis use in Britain is largely associated with a young age group with evidence to suggest that most of these young adults will have only used cannabis (The ISDD Report on Drug Misuse in Britain, 1991). Here in Dublin, albeit for a school going group (12-18), the reported lifetime prevalence rate was 22% for illicit drugs with marijuana, followed by glue or other

inhalants, as the most popular drugs. While lifetime use of marijuana increased with age, use of solvents decreased among the oldest age group (Grube and Morgan, 1986). The debate on possible adverse effects of cannabis has been ongoing since the Indian Hemp Drugs Commission investigation of 100 years ago. The overwhelming consensus from international official enquiries is that moderate use of cannabis carries little if any health risk (Royal College of Psychiatrists, 1987). While accepting that the dangers of moderate use of cannabis had been exaggerated a dispassionate evaluation of what is known and not known at present about the drug does not recommend its legalisation.

Injecting Practices

Because such a high proportion of study clients misused opiates a correspondingly high percentage acknowledged having ever injected their drugs at 80%. The habit of injecting opiates has been almost indigenous among Dublin users, compared to opiate addicts in the UK where a high proportion have always smoked the drug (Hartnoll, Avico, Ingold et al, 1989).

Eighty six per cent of the census group had ever injected their drugs in contrast to less than 60% of first contacts. All clients reported a decline in current injecting practices.

Currently Sharing Practices

Of those who had ever injected their drugs the majority had also shared. This contrasted markedly with those who stated that they were currently sharing, for instance 26% of census clients and 17% of first contacts.

Data on the sharing of injecting equipment must be viewed with caution. Given the increasing disapproval that is associated with sharing there are strong psychological reasons to suppose that clients may have underreported the extent to which they share. Notwithstanding, a similar decrease has also been observed among attenders of the methadone programme and regular attenders of the needle exchange at the AIDS Resource Centre in Dublin (Pomeroy, O'Connor, and Barry, 1991; Scully, Pomeroy, Johnson et al, 1991). A sharp drop in the prevalence of drug-related Hepatitis B cases in the Dublin area tends to confirm this trend.

This drop in reported needle sharing among intravenous drug users has likewise been noted in the UK (Donoghoe, 1991; Klee, Faugier, Hayes et al, 1991; Martin, Serpelloni, Galvan et al, 1990; Power, Hartnoll and Daviaud, 1988) and France (Ingold, Ingold and Toussiat, 1991). A

study of risk factors for HIV-1 infection in Vienna (Loimer, Werner, and Presslich, 1991) made the same observation.

Despite encouraging observations regarding the decline in current sharing practices among intravenous drug users there is need to monitor the stability of these changes over longer periods of time as well as developing strategies for reaching those injecting drug users (IDU) not in treatment. There is also reason to believe that the present number of IDU who are HIV positive is higher than the official figure (Dean, Lavelle, O'Kelly et a\, 1992). Injecting drug use plays a significant role in the development of AIDS in Ireland. Data from AIDS surveillance in Europe (WHO-EC Collaborating Centre on AIDS, 1992) show that only three European countries, Italy, Spain and Yugoslavia had a higher percentage of drug-related AIDS cases than Ireland out of 31 participating centres, by the end of December 1991. Up to the same date 1,156 persons had tested positive for the HIV antibody in Ireland of whom 54% were IDU. (National AIDS Strategy Committee, 1992).

Chapter 5

Conclusions

The findings from this study confirm much of what is already known about problem drug use in Dublin. Since the late 1970s the use of opiates in preference to other drugs of addiction has been well documented, as has the association of high levels of unemployment with this drug taking group. Misusers tend to be young males who live in those areas of the city linked with poverty in the sense of inadequate financial resources to cope with consumer demands, and also with the poverty of their physical environment. In Dublin these are areas which have been neglected by officialdom in terms of housing and amenities appropriate for community living. Concomitant with this is a high level of vandalism and movement out of such districts resulting in a loss of identification and sense of community among people who continue to live there.

New insights from this study include an estimate of the number and rate for one year treated prevalence of drug misuse in the greater Dublin area and the same for one year treated incidence. The prevalence count gives a measure of the extent of the drug taking phenomenon while the incidence can be seen as a benchmark against which to measure a future increase or decrease.

Study findings indicate the relatively young age of drug users here vis a vis most of their European counterparts, although in 1990 terms Dublin drug users are older than they were 10 years ago. A high percentage live with their family of origin. It must be assumed that many are ill prepared for employment as 44% had left school before the official school leaving age of 15. This figure goes some way in explaining the high percentage of unemployed in the study.

Interesting gender differences emerged from the results which highlight different patterns of treatment use by men and women. Despite an increasing proportion of women now coming for treatment they are older when they present for the first time than men. Women are more likely than men to be living with a drug misusing partner. This appears to be the case in other cultures and linked with women's relative lack of power and economic control in society generally. Another worrying feature is that of those users in Dublin who

were currently injecting their drugs a higher proportion of women than expected were currently sharing.

While there is encouraging news in the current decline of injecting and sharing practices, noted also in other European cities, it must be stressed that drug-related AIDS cases in Ireland are considerably higher than most European countries. This demands ongoing efforts to encourage users to alter their intravenous route of administering opiates to less lethal ways.

Research findings are of no value in a problem context like drug misuse, unless acted upon. Our data show that drug takers presenting for treatment are characterised by disadvantage and youth. We suggest that the situation could be more effectively tackled if viewed primarily as a social problem with an element of psychopathology. Acknowledgement of some of these social deficits have been noted in recent government policy documents. The Government Strategy to Prevent Drug Misuse Report and the more recent one from the National AIDS Strategy Committee (1992) acknowledge the problematic social background of drug users. The AIDS strategy report (p. 12) states that

> *all the indications are that the majority of people affected (by HIV) at present are from the deprived urban areas and many have experienced social and economic disadvantage unrelated to HIV and AIDS.*

One of the key objectives to emerge from the Government Strategy to Prevent Drug Misuse was the establishment of a national drug misuse database, similar to that in operation in the greater Dublin area. This is now being implemented and will provide factual data to inform future action in this problem area. As drug misuse is an acknowledged problem in all European countries, national databases can facilitate an understanding of the epidemiology of drug misuse, its social and health care implications and the effect of prevention and treatment programmes. The standardisation of data collection at European level by the epidemiology group of the Council of Europe, Pompidou Group, greatly enhances the interpretation, monitoring and evaluation of such data.

The Government Strategy Report referred to above emphasises the importance of comprehensive demand reduction policies covering areas of education, treatment and rehabilitation. Education has a crucial role to play in primary prevention and a range of health, education and labour based projects have been outlined earlier. Common sense suggests the importance of evaluating such existing programmes (and indeed such interventions are planned in certain projects) rather than let them operate uncritically

without some check on their use and value. Outcome evaluation of the impact of school-based drug education in Scotland (Coggans, Shewan, Henderson et al, 1991) revealed that the effect of the programme was to make young people more knowledgeable about drugs rather than prevent their misuse of them. It has more recently been suggested that health education works cumulatively by repeated exposure to the same message presented in different ways over a period of years, rather than as once-off campaigns (Sutton, 1992).

The proposed extension of the school leaving age in Ireland to 16 appears irrelevant to Dublin drug users when as seen from this study, a high proportion leave school before the present leaving age of 15. Rather the reference in the Green Paper to make people more employable is the direction appropriate for the disadvantaged.

The Government's approach is clearly one of pragmatism when commenting on the range of existing treatment and rehabilitation services in its strategy report (p. 16) as follows,

> *of its nature, the treatment, care and management of the drug misuser does not lend itself to any 'one solution approach'. The Government accepts that the provision of services aimed at the achievement of a drug-free society only or harm reduction programmes solely are inappropriate.*

In conclusion two recommendations are outlined for consideration; firstly, that some specific approach should be found of using the findings from this study in ameliorating problem drug use in Dublin. Secondly, suggested areas are noted for further data collection and research.

One of the measures proposed by the Government in its strategy on drug misuse (see pp. 18 and 19 of the report) is the development of Community Drug Teams (CDT) under the auspices of the health boards to operate with the involvement of general practitioners and other health professionals in targeted areas. The role of these CDT covers: the identification of the extent of drug misuse through contact with known drug users and persons at risk; on going monitoring of drug misusers following treatment and the establishment of links with appropriate statutory and voluntary treatment services.

The role and structure of CDT provide an ideal context for addressing the findings of this study. Our proposed approach is the appointment of a small team to undertake action research in one of the CDT's areas of operation. The suggested focus of study is

– unemployed drug misusers and
– the special needs of women drug takers.

The CDT would have access to a range of professional expertise from both statutory and voluntary agencies and could tap into additional information on, for example, health promotion and women's studies. Strategies to reduce the drug taking practices of the two targeted groups would be developed, tried, altered as appropriate, and progress reported on. Successful measures from this pilot study could then be implemented in other areas of Dublin.

The focus of this report has been persons in receipt of treatment for their drug misuse. Information from other indicators of problem drug activity, such as, persons charged for drug offences, seizures of illicit drugs, price and purity of drugs, and drug-related Hepatitis B, has already been collated for the Dublin area for the past 10 years and will be available shortly. These data will give a more comprehensive insight into problem drug use. In addition, collaborative work at European level will provide a context for such data as well as access to drug trends in Europe and interpretation of changes that may occur.

Having established the treated number and rate for drug misuse we are now at the stage to progress further. Several approaches are open to gaining information on the 'true' prevalence of drug taking. These include a household survey in association with special surveys of high risk groups not easily accessible such as, the 'travellers', the homeless, early school drop outs and highly mobile sections of the population. Other methods include statistical projections based on death rates of drug users, or the capture/recapture technique using information from independent sources of problem drug use. The snowball approach has been used successfully in many European projects involving a chain referral type of sampling within drug-using networks.

Based on information available to us in Dublin on treated drug use it is now time to undertake qualitative ethnographic research. This approach could provide more sensitive information on e.g., drug users' social networks, their perceptions of different drugs, and unemployment. It would, in addition, be an ideal follow-up to understanding some of the findings from this study, notably why proportionally more women than men live with a drug misusing partner and also currently share their injecting equipment.

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APPENDIX A

Frequency Tables

Frequency Tables

	TREATED PREVALENCE		CENSUS		FIRST CONTACT	
Table A1	N	%	N	%	N	%
Type of Contact						
new client	1022	50.2	98	21.2	589	94.4
old client	1005	49.3	364	78.8	33	5.3
n/k	10	0.5	–	–	2	0.3
Table A2						
Ever Previously Treated						
never	698	34.3	74	16.0	624	100.0
previously treated	1300	63.8	384	83.1	–	–
n/k	39	1.9	4	0.9	–	–
Table A3						
In Contact with Other Centres						
no	1233	60.5	292	63.2	473	75.8
yes	749	36.8	168	36.4	131	21.0
n/k	55	2.7	2	0.4	20	3.2
Table A4						
Sex						
male	1501	73.7	304	65.8	466	74.7
female	536	26.3	158	34.2	158	25.3
Table A5						
Age						
< 25 years	980	48.1	197	42.6	425	68.1
25 + years	1013	49.7	257	55.6	191	30.6
n/k	44	2.2	8	1.7	8	1.3
Table A6						
Living Status						
alone	201	9.9	52	11.3	73	11.7
with family	1006	49.4	181	39.2	375	60.1
with friends	50	2.5	6	1.3	22	3.5
partner, drug misuser	253	12.4	66	14.3	46	7.4
partner, not drug misuser	266	13.1	70	15.2	60	9.6
institution	54	2.7	40	8.7	9	1.4
homeless/transient	53	2.6	7	1.5	18	2.9
other	84	4.1	32	6.9	10	1.6
n/k	70	3.4	8	1.7	11	1.8

Table A7 **Employment Status**						
regular work	199	9.8	33	7.1	68	10.9
unemployed	1640	80.5	381	82.5	474	76.0
student	62	3.0	11	2.4	44	7.1
housewife	75	3.7	22	4.8	13	2.1
other	29	1.4	6	1.3	18	2.9
n/k	32	1.6	9	1.9	7	1.1
Table A8 **Age Left School**						
< 15 years	696	34.2	197	42.6	167	26.8
15 + years	896	44.0	203	43.9	283	45.4
n/a	51	2.5	8	1.7	37	5.9
n/k	394	19.3	54	11.7	137	22.0
Table A9 **Level Reached**						
primary	404	19.8	125	27.1	72	11.5
secondary	811	39.8	182	39.4	258	41.3
third level	16	0.8	4	0.9	5	0.8
n/a	51	2.5	8	1.7	37	5.9
n/k	755	37.1	143	31.0	252	40.4
Table A10 **Primary Drug of Misuse**						
opiates/opioids	1613	79.2	395	85.5	376	60.3
stimulants	23	1.1	4	0.9	10	1.6
hypnotics/sedatives	74	3.6	15	3.2	36	5.8
hallucinogens	9	0.4	2	0.4	5	0.8
volatile inhalants	49	2.4	11	2.4	29	4.6
cannabis	233	11.4	28	6.1	156	25.0
other	18	0.9	5	1.1	7	1.1
n/a	2	0.1	–	–2	0.3	
n/k	16	0.8	2	0.4	3	0.5
Table All **Age First Used**						
< 20 years	1263	62.0	298	64.5	423	67.8
20 + years	637	31.3	146	31.6	161	25.8
n/a	2	0.1	2	0.3		
n/k	135	6.6	18	3.9	38	6.1

Table A12
Frequency Past Month

drug free	370	18.2	152	32.9	90	14.4
< once weekly	97	4.8	14	3.0	34	5.4
once weekly	47	2.3	6	1.3	20	3.2
twice + weekly	142	7.0	33	7.1	62	9.9
daily	618	30.3	50	10.8	225	36.1
twice + daily	653	32.1	192	41.6	161	25.8
n/k	110	5.4	15	3.2	32	5.1

Table A13
Route

inject	1289	63.3	305	66.0	290	46.5
smoke	273	13.4	37	8.0	166	26.6
eat/drink	263	12.9	57	12.3	102	16.3
sniff	77	3.8	21	4.5	41	6.6
n/a	2	0.1	–	–	2	0.3
n/k	133	6.5	42	9.1	23	3.7

Table A14
Duration in Years

< 5 years	886	43.5	162	35.1	385	61.7
5 – 9 years	610	29.9	164	35.5	137	22.0
10 + years	317	15.6	105	22.7	51	8.2
n/a	2	0.1	–	–	2	0.3
n/k	222	10.9	31	6.7	49	7.9

Table A15
Secondary Drug of Misuse

opiates/opioids	1014	49.8	246	53.2	239	38.3
stimulants	38	1.9	17	3.7	14	2.2
hynotics/sedatives	91	4.5	14	3.0	35	5.6
hallucinogens	19	0.9	2	0.4	12	1.9
volatile inhalants	8	0.4	1	0.2	6	1.0
cannabis	235	11.5	41	8.9	82	13.1
alcohol	215	10.6	64	13.9	94	15.1
other	21	1.0	3	0.6	12	1.9
n/a	362	17.8	53	11.5	126	20.2
n/k	34	1.7	21	4.5	4	0.6

Table A16
Age First Used

< 20 years	975	47.9	256	55.4	307	49.2
20 + years	477	23.4	104	22.5	123	19.7
n/a	362	17.8	53	11.5	126	20.2
n/k	223	10.9	49	10.6	68	10.9

Table A17 **Frequency Past Month**						
drug free	237	11.6	96	20.8	57	9.1
< once weekly	152	7.5	34	7.4	50	8.0
once weekly	95	4.7	21	4.5	28	4.5
twice + weekly	346	17.0	138	29.9	96	15.4
daily	473	23.2	39	8.4	161	25.8
twice + daily	173	8.5	33	7.1	50	8.0
n/a	362	17.8	53	11.5	126	20.2
n/k	199	9.8	48	10.4	56	9.0
Table A18 **Route**						
inject	639	31.4	173	37.4	141	22.6
smoke	243	11.9	38	8.2	83	13.3
eat/drink	561	27.5	121	26.2	215	34.5
sniff	28	1.4	6	1.3	13	2.1
n/a	362	17.8	53	11.5	126	20.2
n/k	204	10.0	71	15.4	46	7.4
Table A19 **Duration in Years**						
< 5 years	692	34.0	131	28.4	285	45.7
5-9 years	449	22.0	135	29.2	85	13.6
10+years	241	11.8	83	18.0	42	6.7
n/a	362	17.8	53	11.5	126	20.2
n/k	293	14.4	60	13.0	86	13.8
Table A20 **Ever Injected**						
yes	1590	78.1	389	84.2	355	56.9
no	394	19.3	64	13.9	248	39.7
n/k	53	2.6	9	1.9	21	3.4
Table A21 **Age First Injected**						
< 25 years	1179	57.9	322	69.7	281	45.0
25 + years	100	4.9	20	4.3	20	3.2
n/a	394	19.3	64	13.9	248	39.7
n/k	364	17.9	56	12.1	75	12.0
Table A22 **Currently injecting**						
yes	991	48.6	206	44.6	223	35.7
no	543	26.7	179	38.7	105	16.8
n/a	394	19.3	64	13.9	248	39.7
n/k	109	5.4	13	2.8	48	7.7

Table A23
Ever Shared

yes	1239	60.8	332	71.9	228	36.5
no	237	11.6	32	6.9	101	16.2
n/a	394	19.3	64	13.9	248	39.7
n/k	167	8.2	34	7.4	47	7.5

Table A24
Currently Sharing

yes	245	12.0	93	20.1	52	8.3
no	1189	58.4	273	59.1	254	40.7
n/a	394	19.3	64	13.9	248	39.7
n/k	209	10.3	32	6.9	70	11.2

APPENDIX B

Population of the Greater Dublin Area
1981 and 1986

Age and Sex
Numbers

	1981			1986		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
>15	133,948	127,618	261,566	124,308	117,674	241,982
15-19	47,469	49,682	97,151	46,232	46,039	92,271
20-29	78,282	84,491	162,773	82,541	88,414	170,955
30-39	55,740	58,092	113,832	59,702	63,715	123,417
40-49	42,863	46,002	88,865	45,474	48,637	94,111
50+	79,736	111,192	190,928	83,828	114,392	198,220
Total	438,038	477,077	915,115	442,085	478,871	920,956

Source: Ireland, Census 1981 and 1986, Central Statistics Office.

APPENDIX C

Dublin Drug Reporting System
Treatment Centres

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

- A statutory out-patient 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 Drug 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 in 1990 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.

St. Patrick's Hospital

- A service offered by psychiatrists in a private facility at in- or out-patient level.

St. John of God Hospital
A service offered by psychiatrists in a private facility at in-or out-patient level.

Mountjoy Prison

- A detoxification, counselling and support service.

St. Patrick's Institution

- A detoxification, counselling and support service. Arbour Hill Prison 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 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.

Wheatfield Prison

- A detoxification, counselling and support service.

Candle Community Trust

- A community based centre for drug free young men providing day, personal development and training workshop facilities.

Merchant's Quay Project

- A voluntary service providing counselling and advice to drug users affected by HIV and also referral to other agencies.

APPENDIX D

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 (Anywhere)
1. never
2. prev. treated
9. n/k

7. Currently in Contact with Other Centres
(a) 1. no (for drug misuse)
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 (99 n/k) ☐☐

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

Instructions for Completion of Form

(to be completed once for each client for the period under review)

1. City or Health Board Area

Enter appropriate 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. 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 drug-related treatment contact anywhere for drug misuse and is therefore making a first ever treatment contact. 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 elsewhere. This is a crucial question and it is essential that accurate information be obtained. (Please note that where a client is recorded as ‘never previously treated’ he/she cannot be coded as ‘old client’ in Q.5, nor as ‘currently in contact with other centres’ in Q.7.)

7. Currently in Contact with other Centres – for a drug problem

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 the start of this treatment 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 family of origin. 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 using the codes in the EIS street index.

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 full time education 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 (refers to the month before presenting for treatment)

Primary

Record the drug name which the client alleges at the time of current treatment 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 the client is misusing a second drug in addition to the primary one specified record the name. If none, write none.

Alcohol may be recorded as a secondary drug of misuse.

Age First Used

Record age in years for the drug recorded.

Frequency Past Month (prior to current treatment contact) 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. (Please note that if 'no' is recorded for this question then Q.I 7, 18 and 19 are not applicable).

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.

Drug Classification

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 Tablets – MST)	09
Opium	10
Pentazocine	11
Pethidine	12
Other opiates/opioid	88

2. STIMULANTS

Amphetamine	01
Dexamphetamine	02
Methamphetamine	03
Methylphenidate	04
Other amphetamine 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
Nitrazepam	07
Temazepam	08
Triazolam	09
Other minor Tranquillizers	10
Major tranquillizers	11
Other hypnotics and Sedatives	88

4. HALLUCINOGENS

Lysergic Acid Diethylamide	01
Amanita Muscaria	02
Psilocybin	03
Phencyclidine	04
MDMA (Ecstasy)	05
MDA	06
Other hallucinogens	88

5. VOLATILE INHALANTS

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