Drug Misuse Research Division

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Trends in Treated Drug Misuse in the Mid Western Health Board Area[1] 1996-2000

contents

Background

Information on problem drug use is collected by the National Drug Treatment Reporting System (NDTRS). The NDTRS is an epidemiological database on treated drug misuse. It was established in 1990 in the Greater Dublin Area only. In 1995 it was extended to other parts of the country including the Mid Western Health Board (MWHB) area. The objectives of the NDTRS are to provide reliable information on the number and characteristics of people who are treated for problem drug use; and to examine trends and patterns of problem drug use. It provides information relevant to the health consequences and social implications of drug misuse and contributes to an understanding of the epidemiology of drug misuse in Ireland. This series of papers presents data by regional health board areas.

NDTRS methodology

Data on treated drug misuse are routinely collected by staff at drug treatment agencies throughout Ireland. In the MWHB area data collection is co-ordinated by a Regional Co-ordinator. Compliance with the NDTRS requires that a form be completed for each person who receives treatment for problematic drug use. At national level, anonymous, aggregated data are compiled by the Drug Misuse Research Division (DMRD), Health Research Board (HRB).

For the purpose of the NDTRS, *treatment* is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems'. Treatment may therefore include non-medical (addiction counselling, group therapy, psychotherapy), as well as medical interventions (detoxification, methadone substitution programmes).

The main elements of the reporting system are:

a) *All Treatment Contacts* – the reporting of *all* clients receiving treatment during a given year, and

b) *First Treatment Contacts* – the reporting of the sub-group of clients who have *never* previously been treated for problem drug use.

In the case of the 'all contact' data there is a possibility of duplication in the database, for example, where a person receives treatment at more than one centre. This is estimated to be small since the introduction of the *Misuse of Drugs Regulations in 1998*, whereby precautions are taken to ensure that treatment by way of medical prescription is available from one source only.

Treatment as an indicator of drug misuse

Drug treatment data are viewed as an indirect indicator of drug misuse and are used at national and European levels to provide information on the characteristics of clients entering treatment, and patterns of drug misuse such as types of drugs used and consumption behaviours. They are 'valuable from a public health perspective to assess needs, … and to plan and evaluate services' (EMCDDA, 1998: 23). Information from the NDTRS is made available to service providers and policy makers and forms an important

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element in informing local and national drug policies. Based on NDTRS data a number of local areas were targeted for special attention in 1996 (Ministerial Task Force, 1996). Initially eleven areas, ten in Dublin and one in Cork, all of which were characterised by social and economic disadvantage, were designated as Local Drug Task Force Areas (Ministerial Task Force, 1996). There are now fourteen areas: twelve in Dublin; one in Cork; and one in Bray (Department of Tourism, Sport & Recreation, 2001). Local Drug Task Forces were established with the aim of providing strategic local responses in areas where drug misuse was a serious problem.

In the Government's *Building on Experience. National Drugs Strategy 2001-2008*, the role of the NDTRS is recognised in ensuring that the overall aims of the strategy are met. NDTRS data collection is one of the actions identified and agreed by Government for implementation by health boards. It is stated that 'all treatment providers should co-operate in returning information on problem drug use to the DMRD of the HRB' (Department of Tourism, Sport & Recreation, 2001: 118).

Treatment provision

The emphasis of drug policy in the MWHB area is on prevention and health promotion

The emphasis of drug policy in the MWHB area is on prevention and health promotion (http://www.mwhb.ie). The Health Promotion team of the MWHB operates the *Sláinte Health Advice Centre* to cater for the health information needs of the general public. A Drug Strategy Co-ordinator was appointed in 1999 to formulate and develop a drug strategy for the region. Training in drug and alcohol related issues is available to teachers, youth workers, community workers, Gardaí and others.

Drug treatment services in the MWHB area are provided through the Drug and Alcohol Counselling Service at *Sláinte Health Advice Centre*; by Addiction Counsellors at day hospitals and residential treatment centres. Data for the NDTRS during 2000 were collected by 10 agencies: 3 residential, including 1 psychiatric hospital; and 7 non-residential centres. Out of a total of 327 contacts during 2000, 197 were treated at residential centres, and 130 at non-residential centres. The type of drug treatment provided/availed of was mainly advice/counselling/support (N=317). The treatment provided to any one individual may include a combination of treatment options. During 2000, as well as addiction counselling, over half of clients (N=195) received 'medicament free/psychosocial therapy'; 18 clients underwent detoxification; and 2 were treated in a drug substitution/maintenance programme.

Extent of the problem

During 2000, 204 MWHB residents were treated for problematic drug use

In 1996 the number of drug users presenting for treatment[2] in the MWHB area was 83 (Table 1a). In 1997 this had increased to 210; and by 2000 the number had reached 327. Each year a high proportion (around half) of people treated in the MWHB for problem drug use are from outside the area. In 2000, for example, out of the total of 327 treated in the region, 151 (46 percent) were not residents of the MWHB catchment area (Table 1a). These clients were mainly from Eastern Regional Health Authority (ERHA) (N=64) and Southern Health Board (SHB) (N=45) areas. This may indicate a preference for the type of treatment services on offer in the area. A relatively small number of people from the MWHB area are treated outside of the region – for example, in 2000, 28 MWHB residents were treated elsewhere (Table 1a).

Table 1a. Number of All Treatment Contacts* by treatment area and area of residence of clients, 1996-2000

Year	Total treated in MWHB	MWHB residents treated in MWHB	MWHB residents treated elsewhere	Others treated in MWHB	Total MWHB residents treated
1996	83	37	8	46	45
1997	210	94	8	116	102
1998	200	79	17	121	96
1999	281	139	21	142	160
2000	327	176	28**	151	204**

* Number of cases, as distinct from individuals, who received treatment for their problem drug use
** Provisional figures due to incomplete returns from the Eastern Regional Health Authority health boards

[1] Counties Clare, Limerick and Tipperary North Riding

[2] The emphasis of this paper is on the illicit drug use of clients who received treatment between 1996 and 2000, in the catchment area covered by the MWHB (Counties Clare, Limerick and Tipperary North Riding)

About half of all those presenting each year in the MWHB are receiving treatment for problematic drug use for the first time (first contacts). The number of first contacts increased from 59 in 1996 to 174 in 2000 (Table 1b). A little less than half of new clients are from elsewhere (78 out of 174 in 2000).

Table 1b. Number of First Treatment Contacts* by treatment area and area of residence of clients, 1996-2000

Year	Total treated in MWHB	MWHB residents treated in MWHB	MWHB residents treated elsewhere	Others treated in MWHB	Total MWHB residents treated
1996	59	30	6	29	36
1997	84	54	3	30	57
1998	110	50	7	60	57
1999	127	74	17	53	91
2000	174	96	16**	78	112**

* Number of people who received treatment for the first time ever
** Provisional figures due to incomplete returns from the Eastern Regional Health Authority health boards

Socio-demographic information

The typical client coming for treatment is male, in his late teens or early twenties and living in the family home. The mean age for all contacts was stable over the five-year period under review, at around 24 years of age (Table 2a). The social conditions of clients improved over the period 1996 to 2000. By 2000 they were less likely to have left school before the official school leaving age of 15 years (20 percent) compared to 1996 (32 percent) (Table 2a). Clients were also less likely to be unemployed, with employment levels improving from 13 percent in 1996 to 21 percent in 2000. This is as might be expected, given the general favourable economic conditions in the country. However, these statistics are indicative of the social disadvantage of drug users, and present a challenge to policy makers if social exclusion and marginalisation issues are to be addressed.

The typical client coming for treatment is male, in his late teens or early twenties and living in the family home

Table 2a. Socio-demographic characteristics of All Treatment Contacts treated in the MWHB, 1996-2000

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	85:15	67:33	72:28	75:25	81:19
Mean age (years)	23	23	24	25	24
Modal age (years)	18	17	18	23	19
% Under 18 years of age	7	16	5	9	10
% Living with parents/family	46	58	53	67	67
% Early school leavers*	32	26	11	18	20
% Still at school	0	8	2	7	6
% Employed	13	22	18	17	21

* Left school before the age of 15 years

The socio-demographic characteristics of new clients (first contacts) are generally quite similar to those of the overall group of all contacts (Table 2b).

Table 2b. Socio-demographic characteristics of First Treatment Contacts treated in the MWHB, 1996-2000

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	86:14	68:32	74:26	76:24	81:19
Mean age (years)	23	22	23	22	23
Modal age (years)	18	19	18	20	19
% Under 18 years of age	7	14	7	15	12
% Living with parents/family	51	61	61	73	73
% Early school leavers*	26	16	12	13	17
% Still at school	0	10	2	12	6
% Employed	14	23	18	21	23

* Left school before the age of 15 years

Problem drug use

Trends over the period 1996 to 2000 show that cannabis misuse is on the increase

Information on the patterns of drug use, such as the types of drugs used, *how* they are taken, and whether in combination with other drugs, can be useful in assessing and planning drug treatment services. In the MWHB area, drug use patterns are generally similar to those in other regions of the country where cannabis is the main drug causing problems and for which most people present for treatment (O'Brien *et al.* 2000). Trends over the period 1996 to 2000 show that cannabis misuse is on the increase, from 33 percent in 1996 to 53 percent in 2000 (Table 3a). Given that cannabis is smoked, this can have serious implications for the future health of a young population. Unlike most other regions where cannabis is usually followed by ecstasy as the main drug of misuse, in the MWHB cannabis is followed by opiates as the main drug of choice. While the *number* of opiate contacts has increased (from 27 in 1996 to 87 in 2000), the *proportion* has decreased from 33 percent in 1996 to 27 percent in 2000. Over the same period there was a decrease in ecstasy use, from 22 percent to 8 percent (Table 3a).

Table 3a. Main Drug of Misuse of All Treatment Contacts treated in the MWHB, 1996-2000

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
Opiates	27	(33)	68	(33)	69	(35)	84	(30)	87	(27)
Cocaine	1	(1)	4	(2)	13	(7)	3	(1)	12	(4)
Ecstasy	18	(22)	39	(19)	24	(12)	21	(8)	26	(8)
Amphetamines	1	(1)	13	(6)	11	(6)	8	(3)	3	(1)
Benzodiazepines	1	(1)	10	(5)	11	(6)	6	(2)	7	(2)
Volatile Inhalants	1	(1)	6	(3)	1	(1)	7	(3)	8	(2)
Cannabis	27	(33)	57	(27)	66	(33)	146	(52)	172	(53)
Other substances	7	(8)	12	(6)	5	(3)	6	(2)	12	(4)
Total	83		210*		200		281		327	

* Percentages based on valid N of 209

Trends among the sub-group of new clients (first contacts) were similar to those of the overall group (all contacts) (Table 3b). New clients were more likely to be using cannabis than the overall group. This could perhaps be explained in part by the expansion of treatment services, which are more accessible to young cannabis users. Ecstasy use among new clients decreased from 27 percent in 1996 to 9 percent in 2000. Opiate use trends among new clients were similar to those of all contacts (Table 3b).

Table 3b. Main Drug of Misuse of First Treatment Contacts treated in the MWHB, 1996-2000

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
Opiates	15	(25)	19	(23)	39	(35)	28	(22)	36	(21)
Cocaine	1	(2)	1	(1)	1	(1)	1	(1)	6	(3)
Ecstasy	16	(27)	19	(23)	15	(14)	11	(9)	15	(9)
Amphetamines	0	(0)	6	(7)	9	(8)	5	(4)	1	(1)
Benzodiazepines	0	(0)	0	(0)	2	(2)	2	(2)	1	(1)
Volatile Inhalants	0	(0)	1	(1)	0	(0)	2	(2)	4	(2)
Cannabis	22	(37)	34	(41)	43	(39)	76	(60)	102	(59)
Other substances	5	(8)	3	(4)	1	(1)	2	(2)	9	(5)
Total	59		84*		110		127		174	

* Percentages based on valid N of 83

A closer scrutiny of all treatment contacts reveals that heroin was the opiate most likely to be used and that the number is on the increase, from 26 in 1996 to 82 in 2000 (Table 4a). The fact that in 2000 heroin was more likely to be injected (by 50 out of 82 contacts) than smoked has serious health implications.

Table 4a. Opiate as a Main Drug of Misuse for All Treatment Contacts treated in the MWHB, 1996-2000

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	26	60	66	78	82
of whom:					
inject	17	29	48	54	50
smoke	9	24	15	17	29
other route	0	2	1	5	0
not known	0	5	2	2	3
Other Opiates	1	8	3	6	5
Total	27	68	69	84	87

Heroin contacts increased from 26 in 1996 to 82 in 2000

Among new clients the number of heroin users more than doubled from 15 in 1996 to 34 in 2000 (Table 4b). More than half (19 out of 34) had injected the heroin in 2000.

Table 4b. Opiate as a Main Drug of Misuse for First Treatment Contacts treated in the MWHB, 1996-2000

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	15	18	36	28	34
of whom:					
inject	11	8	25	19	19
smoke	4	9	10	7	14
other route	0	0	0	1	0
not known	0	1	1	1	1
Other Opiates	0	1	3	0	2
Total	15	19	39	28	36

Polydrug use is very much a feature of clients' behaviour, with nearly three-quarters of clients (73 percent) in 2000 involved in the use of more than one drug (Table 5a). However, polydrug use seems to be a decreasing trend in the MWHB, from 90 percent in 1996 to 73 percent in 2000. Very few cases of alcohol[3] use are reported, and considering that alcohol use was the main problem highlighted in a survey of teenagers in the Mid West in 1997 (Gleeson *et al.*, 1998), it is somewhat surprising that this is not reflected in returns to the NDTRS.

Polydrug use is very much a feature of clients' behaviour

Table 5a. Secondary Drug of Misuse of All Treatment Contacts treated in the MWHB, 1996-2000

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
No second drug	8	(10)	40	(19)	20	(10)	55	(20)	87	(27)
Opiates	14	(17)	19	(9)	25	(13)	12	(4)	17	(5)
Cocaine	3	(4)	9	(4)	9	(5)	18	(6)	12	(4)
Ecstasy	14	(17)	46	(22)	46	(23)	72	(26)	71	(22)
Amphetamines	6	(7)	18	(9)	29	(15)	24	(9)	13	(4)
Benzodiazepines	2	(2)	10	(5)	6	(3)	4	(1)	4	(1)
Volatile Inhalants	1	(1)	2	(1)	0	(0)	2	(1)	3	(1)
Cannabis	11	(13)	44	(21)	27	(14)	50	(18)	76	(23)
Alcohol	9	(11)	9	(4)	18	(9)	11	(4)	8	(2)
Other substances	15	(18)	11	(5)	20	(10)	33	(12)	36	(11)
Total	83		210*		200		281		327	

* Percentages based on valid N of 208

There are similar trends in polydrug use among new clients (Table 5b).

[3] Alcohol may be included as a secondary drug of misuse in the NDTRS. It is NOT included as a main drug

Table 5b. Secondary Drug of Misuse of First Treatment Contacts treated in the MWHB, 1996-2000

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
No second drug	6	(10)	20	(24)	8	(7)	24	(19)	41	(24)
Opiates	8	(14)	5	(6)	15	(14)	2	(2)	9	(5)
Cocaine	2	(3)	0	(0)	2	(2)	8	(6)	6	(3)
Ecstasy	10	(17)	22	(27)	29	(26)	41	(32)	49	(28)
Amphetamines	6	(10)	7	(8)	20	(18)	13	(10)	7	(4)
Benzodiazepines	1	(2)	1	(1)	0	(0)	3	(2)	3	(2)
Volatile Inhalants	1	(2)	1	(1)	0	(0)	2	(2)	1	(1)
Cannabis	7	(12)	17	(20)	14	(13)	19	(15)	37	(21)
Alcohol	8	(14)	5	(6)	14	(13)	5	(4)	3	(2)
Other substances	10	(17)	5	(6)	8	(7)	10	(8)	18	(10)
Total	59		84*		110		127		174	

* Percentages based on valid N of 83

Risk behaviour

Mean age of initial drug use remained consistently young at 15 years of age

Over the five-year period the mean age of initial drug use remained consistently young at 15 years of age (Tables 6a, 6b). The *number* of clients who had injected at some time was relatively low, but increased from 19 in 1996 to 64 in 2000 (Table 6a). While the *numbers* who had ever injected are increasing, there is a *proportional* decrease in those involved in high risk behaviour. The *number* who had ever shared injecting equipment dropped from 15 in 1996 to 10 in 2000 (Table 6a). However, those currently involved in injecting drug use increased from 15 in 1996 to 29 in 2000, indicating that there is no room for complacency.

Table 6a. Risk Behaviours of All Treatment Contacts treated in the MWHB, 1996-2000

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	15	15	15	15	15
Mean age 1st injected (years)	19	19	18	18	18
Ever Injected N	19	36	58	69	64
of whom:					
'ever shared' N	15	29	28	13	10
'currently injecting' N	15	29	14	29	29
'currently sharing' N	6	14	6	2	4

Among the first contact sub-group the *number* who had ever injected is relatively small. However, it is increasing (from 12 in 1996 to 23 in 2000), and the fact that they are involved in high risk behaviour such as injecting drugs cannot be ignored (Table 6b).

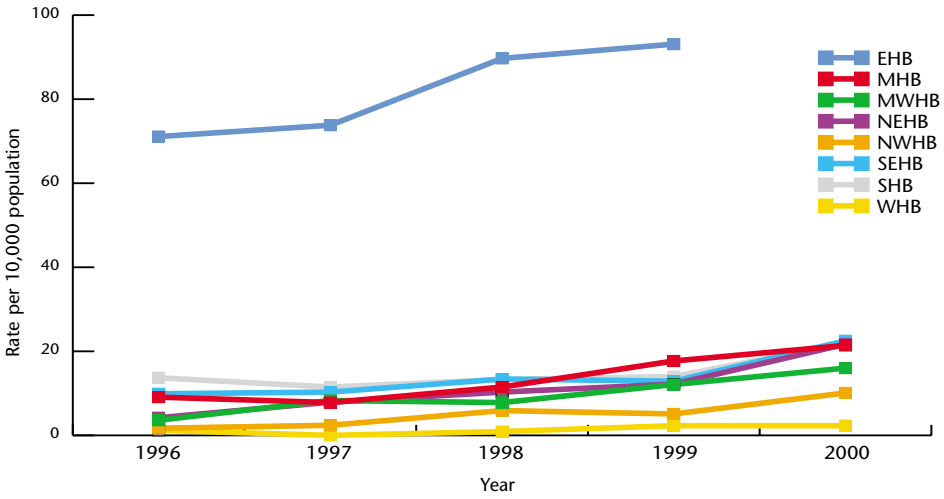
Table 6b. Risk Behaviours of First Treatment Contacts treated in the MWHB, 1996-2000

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	15	15	15	15	15
Mean age 1st injected (years)	20	18	17	17	18
Ever Injected N	12	10	31	22	23
of whom:					
'ever shared' N	10	8	12	4	3
'currently injecting' N	8	9	4	8	12
'currently sharing' N	3	5	1	1	2

Regional trends

Figures 1a and 1b provide a comparison of the rates of treated drug misuse among residents in different health board areas of Ireland for all and first treatment contacts respectively. As the majority of people treated for problem drug use are in the 15-39 year age group, the rates were based on this age group of the population in each health board area. It is immediately obvious that in the ERHA health board areas (formerly EHB) the rate is much higher than in other regions of the country. However, there is not great variation in regional trends. In all cases the trend shows an increase in those presenting to drug treatment services (Figure 1a).

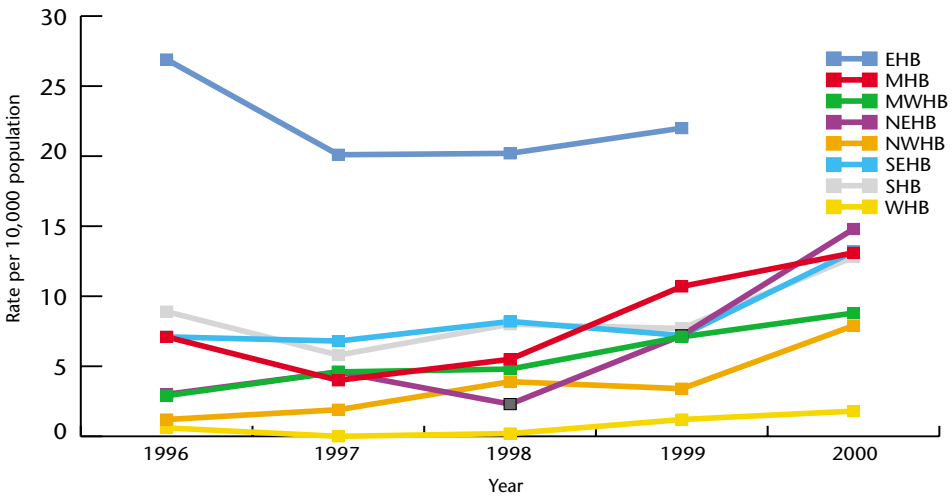
Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* Trends for 1996-1999 only in the EHB due to incomplete returns for 2000
** Population figures for each health board are based on the Census for Population 1996, Central Statistics Office

There was an upward trend in first treatment contacts between 1996 and 2000 in all regions (Figure 1b). Increased provision of services at individual health board level is of course a factor that must be borne in mind when considering such trends. Where there are accessible drug user oriented services provided, people are more likely to approach them. However, it would appear that the upward trends also indicate a real increase in drug misuse.

Figure 1b. Trends in First Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* Trends for 1996-1999 only in the EHB due to incomplete returns for 2000
** Population figures for each health board are based on the Census for Population 1996, Central Statistics Office

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Value of NDTRS

- Data from the NDTRS provide a profile of drug users presenting to the treatment services. This gives planners and service providers an insight into the number and type of clients availing of treatment services.
- Data on clients receiving treatment for the first time can indicate, over time, changing patterns and trends in problematic drug use. It is thus possible to distinguish new populations of drug users coming for treatment, from more long term chronic drug users.
- A particular benefit of this database is that it provides a foundation for carrying out other more detailed investigations. The value increases over time if data are collected systematically for a number of years. Examples include studies of changes in behaviour patterns in different subgroups, or comparisons with samples of untreated drug users. The DMRD welcomes collaborative research using the NDTRS database.
- The DMRD will provide to the agency, if required, an analysis of returns made to the NDTRS. This can be very useful to the agency for end of year appraisal of clients, or for research purposes.

General information

The Drug Misuse Research Division of the Health Research Board is involved in national and international research, information gathering and dissemination activities in relation to drugs and drug misuse.

National activities include drug misuse research; maintenance and development of the National Drug Treatment Reporting System; and development of a National Documentation Centre on drug misuse issues in Ireland. The documentation centre will serve as an information resource in the area of drug misuse and will consist of a bibliographic database comprising records and registers of published and unpublished current research; an electronic library containing full texts of research reports included in the bibliography; and a library containing hard copies of material cited in the bibliography.

At European level the DMRD is the designated Irish Focal Point for the European Information Network on Drugs and Drug Addiction (REITOX) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Work with the EMCDDA includes the development and harmonisation of key indicators of drug misuse, and participation in the European Database on Demand Reduction Activities (EDDRA). This work is designed to meet the needs of health professionals, researchers and policy makers involved in the planning and implementation of activities to reduce the demand for drugs. The DMRD also participates in the Pompidou Group of the Council of Europe in developing methodological approaches in the field of drug misuse research.

Through its research, information and dissemination activities the DMRD provides a picture of drug misuse, its health consequences and initiatives underway in the field of drug misuse research and policy.

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