Drug Misuse Research Division

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Trends in Treated Drug Misuse in the North Eastern 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; the North Eastern Health Board (NEHB) began making full data returns in 1998. 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 NEHB 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, aggregated anonymous 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 element in

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informing local and national drug policies. Based on NDTRS data a number of local areas were targeted for special attention in 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 NEHB area is on prevention, health promotion and drug education

In 1997 financial resources were allocated for the improvement of drug treatment services in the NEHB area. Consequently over the past three years a number of initiatives have been undertaken to improve services in the area. In recognising drug misuse as a serious problem, the NEHB established a *Regional Advisory Committee on Drugs.* Partnerships were developed with voluntary groups and parent groups willing to participate with the Board in implementing its policies. The emphasis of drug policy in the NEHB area is on prevention, health promotion and drug education. Particular importance is attached to providing services for drug users and their families (http://www.nehb.ie).

Following the initiatives taken in 1997, reporting to the NDTRS commenced in 1998. Data for NDTRS during 2000 were collected by 8 agencies: all were non-residential. The type of drug treatment provided/availed of was mainly advice/counselling/support, that is, in 243 out of 250 cases.

Extent of the problem

During 2000, 265 NEHB residents were treated for problem drug use

Prior to 1998 all NEHB residents recorded in the NDTRS were receiving treatment for problem drug use outside of the NEHB area (49 in 1996; 94 in 1997), mainly in the then Eastern Health Board area. In 1998 the number of drug users presenting for treatment[2] in the NEHB area was 71 (Table 1a). By 2000 the number had increased to 250 which was double that of the previous year. In 2000 a total of 264 residents of the NEHB received treatment for problem drug use, and of these the majority (N=250) received treatment in the NEHB area (Table 1a). Only 22 NEHB residents were treated elsewhere, probably as a result of increasing improvements in service provision in the NEHB catchment area. However, this figure (N=22) may be an under-estimation of the situation due to incomplete data returns from Eastern Regional Health Authority (ERHA) health board areas to date.

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

Year	Total treated in NEHB	NEHB residents treated in NEHB	NEHB residents treated elsewhere	Others treated in NEHB	Total NEHB residents treated
1996	Na	Na	49	Na	49
1997	Na	Na	94	Na	94
1998	71	69	59	2	128
1999	123	123	32	0	155
2000	250	243	22**	7	265**

* 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
Na: Not available

[1] Counties Louth, Meath, Cavan and Monaghan

[2] The emphasis of this paper is on the illicit drug use of clients who received treatment between 1998 and 2000, in the catchment area covered by the NEHB (Counties Louth, Meath, Cavan and Monaghan)

A sizeable proportion of those treated in the NEHB are receiving treatment for the first time (first contacts). The number of first contacts increased from 78 in 1999 to 172 in 2000 (Table 1b).

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

Year	Total treated in NEHB	NEHB residents treated in NEHB	NEHB residents treated elsewhere	Others treated in NEHB	Total NEHB residents treated
1996	Na	Na	35	Na	35
1997	Na	Na	53	Na	53
1998	Na	Na	27	Na	27
1999	78	78	14	0	92
2000	172	165	16**	7	181**

* 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
Na: Not available

Socio-demographic information

The typical client presenting for treatment is male, around 20 years of age and living in the family home (Table 2a). Clients treated in 2000 were less likely to have left school before the official school leaving age of 15 years (11 percent) compared to 21 percent the year before (Table 2a). Employment levels did not change much over the three-year period with a little less than half in employment (Table 2a). Although these levels are comparatively higher than in other areas of the country, nonetheless they are indicative of social disadvantage of drug users, especially in a climate of favourable economic conditions.

The typical client presenting for treatment is male, around 20 years of age and living in the family home

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

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	Na	Na	82:18	74:26	85:15
Mean age (years)	Na	Na	22	23	21
Modal age (years)	Na	Na	19	21	19
% Under 18 years of age	Na	Na	20	17	25
% Living with parents/family	Na	Na	Na	68	80
% Early school leavers*	Na	Na	Na	20	11
% Still at school	Na	Na	Na	11	18
% Employed	Na	Na	47	44	45

* Left school before the age of 15 years
Na: Not available

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 NEHB, 1996-2000

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	Na	Na	Na	78:22	87:13
Mean age (years)	Na	Na	Na	23	21
Modal age (years)	Na	Na	Na	21	20
% Under 18 years of age	Na	Na	Na	17	30
% Living with parents/family	Na	Na	Na	74	83
% Early school leavers*	Na	Na	Na	23	10
% Still at school	Na	Na	Na	13	22
% Employed	Na	Na	Na	51	47

* Left school before the age of 15 years
Na: Not available

Problem drug use

Trends over the period 1998 to 2000 show that treated cannabis misuse has increased

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 NEHB 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). Given that cannabis is smoked, this can have serious implications for the future health of a young population. Trends over the period 1998 to 2000 show that cannabis misuse has increased. The numbers presenting for treatment of cannabis use increased from 31 in 1998 to 153 in 2000 (Table 3a). However this increase could partly be attributed to the increase in service provision. There was an increase in ecstasy use, from 10 percent (N=7) in 1998 to 17 percent (N=42) in 2000. While the number of those treated for opiate problems increased from 21 in 1998 to 36 in 2000, the relative proportion decreased from 30 percent in 1998 to 14 percent in 2000 (Table 3a).

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

Main Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)	2000 N	(%)
Opiates	Na		Na		21	(30)	29	(24)	36	(14)
Cocaine	Na		Na		0	(0)	1	(1)	5	(2)
Ecstasy	Na		Na		7	(10)	15	(12)	42	(17)
Amphetamines	Na		Na		8	(11)	7	(6)	2	(1)
Benzodiazepines	Na		Na		1	(1)	3	(2)	2	(1)
Volatile Inhalants	Na		Na		3	(4)	9	(7)	9	(4)
Cannabis	Na		Na		31	(44)	58	(47)	153	(61)
Other substances	Na		Na		0	(0)	1	(1)	1	(0)
Total	Na		Na		71		123		250	

Na: Not available

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 however, more likely to be using cannabis and ecstasy, and less likely to be using an opiate. The use of opiates is relatively low, 15 new clients were treated in 2000 (Table 3b).

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

Main Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)	2000 N	(%)
Opiates	Na		Na		Na		11	(14)	15	(9)
Cocaine	Na		Na		Na		0	(0)	3	(2)
Ecstasy	Na		Na		Na		11	(14)	32	(19)
Amphetamines	Na		Na		Na		4	(5)	2	(1)
Benzodiazepines	Na		Na		Na		2	(3)	1	(1)
Volatile Inhalants	Na		Na		Na		6	(8)	8	(5)
Cannabis	Na		Na		Na		44	(56)	110	(64)
Other substances	Na		Na		Na		0	(0)	1	(1)
Total	Na		Na		Na		78		172	

Na: Not available

A closer scrutiny of all treatment contacts reveals that heroin was the opiate most likely to be used and that the number of users is on the increase, from 14 in 1998 to 32 in 2000 (Table 4a). In 2000 the heroin was smoked and injected in equal measure; half (N=16) smoked and half (N=16) injected.

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	Na	Na	14	26	32
of whom:					
inject	Na	Na	7	11	16
smoke	Na	Na	7	14	16
other route	Na	Na	0	0	0
not known	Na	Na	0	1	0
Other Opiates	Na	Na	7	3	4
Total	Na	Na	21	29	36

Na: Not available

Among new clients, the number using heroin is relatively low, increasing from 9 in 1999 to 15 in 2000. In contrast to all contacts, new clients were more likely to be smoking rather than injecting heroin (Table 4b).

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	Na	Na	Na	9	15
of whom:					
inject	Na	Na	Na	3	5
smoke	Na	Na	Na	6	10
other route	Na	Na	Na	0	0
Other Opiates	Na	Na	Na	2	0
Total	Na	Na	Na	11	15

Na: Not available

Trends in secondary drug use indicate that polydrug use is prevalent, with more than two-thirds of clients in 2000 likely to be involved in the use of more than one drug (Table 5a). Ecstasy, cannabis and amphetamines were the drugs most likely to be reported. Very few people were reported with alcohol[3] problems, which is surprising given that regular use of alcohol is reported to be high among adolescents (Department of Public Health, 1999).

Clients are likely to be involved in polydrug use

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

Secondary Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)	2000 N	(%)
No second drug	Na		Na		21	(30)	62	(50)	79	(32)
Opiates	Na		Na		10	(14)	3	(2)	8	(3)
Cocaine	Na		Na		0	(0)	2	(2)	2	(1)
Ecstasy	Na		Na		14	(20)	21	(17)	59	(24)
Amphetamines	Na		Na		15	(21)	10	(8)	33	(13)
Benzodiazepines	Na		Na		0	(0)	1	(1)	4	(2)
Volatile Inhalants	Na		Na		0	(0)	2	(2)	7	(3)
Cannabis	Na		Na		8	(11)	20	(16)	39	(16)
Alcohol	Na		Na		2	(3)	0	(0)	7	(3)
Other substances	Na		Na		1	(1)	2	(2)	12	(5)
Total	Na		Na		71		123		250	

Na: Not available

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

New clients (first contacts) were as likely to be polydrug users as all contacts (Table 5b).

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

Secondary Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)	2000 N	(%)
No second drug	Na		Na		Na		43	(55)	54	(31)
Opiates	Na		Na		Na		2	(3)	5	(3)
Cocaine	Na		Na		Na		2	(3)	1	(1)
Ecstasy	Na		Na		Na		14	(18)	44	(26)
Amphetamines	Na		Na		Na		6	(8)	22	(13)
Benzodiazepines	Na		Na		Na		0	(0)	2	(1)
Volatile Inhalants	Na		Na		Na		1	(1)	7	(4)
Cannabis	Na		Na		Na		10	(13)	28	(16)
Alcohol	Na		Na		Na		0	(0)	3	(2)
Other substances	Na		Na		Na		0	(0)	6	(3)
Total	Na		Na		Na		78		172	

Na: Not available

Risk behaviour

The mean age of initial drug use was very young at 15 years of age

The mean age of initial drug use was very young at 15 years of age (Tables 6a, 6b). The *number* of clients who had ever injected increased from 20 in 1998 to 30 in 2000. Of these, a sizeable proportion engaged in high risk behaviours: in 2000, nearly half (N=14) had shared injecting equipment, and over a third (N=11) were currently injecting (Table 6a). Although data are available only for three years the trends over this period present issues of particular concern for the health of drug users and a challenge to service providers.

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

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	Na	Na	Na	15	15
Mean age 1st injected (years)	Na	Na	Na	21	21
Ever Injected N	Na	Na	20	21	30
of whom:					
'ever shared' N	Na	Na	11	8	14
'currently injecting' N	Na	Na	12	7	11
'currently sharing' N	Na	Na	1	3	3

Na: Not available

Among the first contact sub-group the *number* who had ever injected increased from 6 in 1999 to 9 in 2000 (Table 6b). Because data are available for only two years it is difficult to review risk behaviour trends among new clients.

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

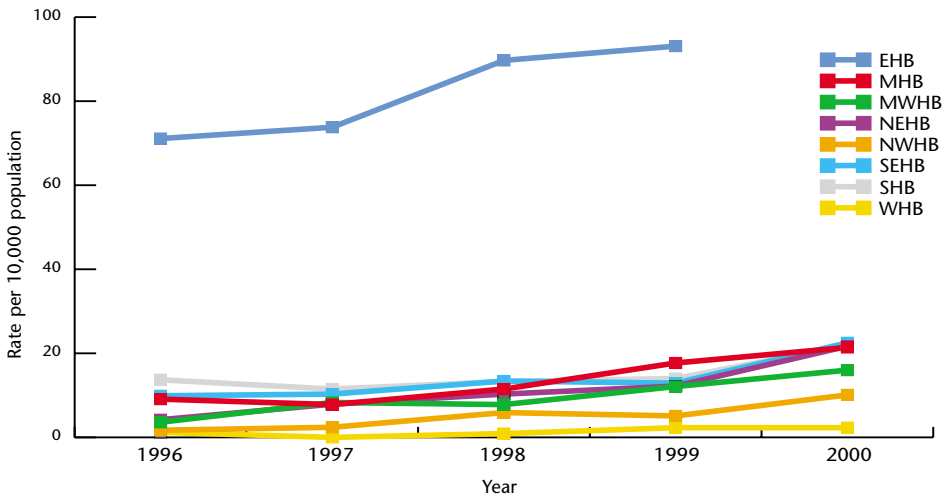
Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	Na	Na	Na	16	15
Mean age 1st injected (years)	Na	Na	Na	21	20
Ever Injected N	Na	Na	Na	6	9
of whom:					
'ever shared' N	Na	Na	Na	2	4
'currently injecting' N	Na	Na	Na	2	3
'currently sharing' N	Na	Na	Na	1	3

Na: Not available

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).

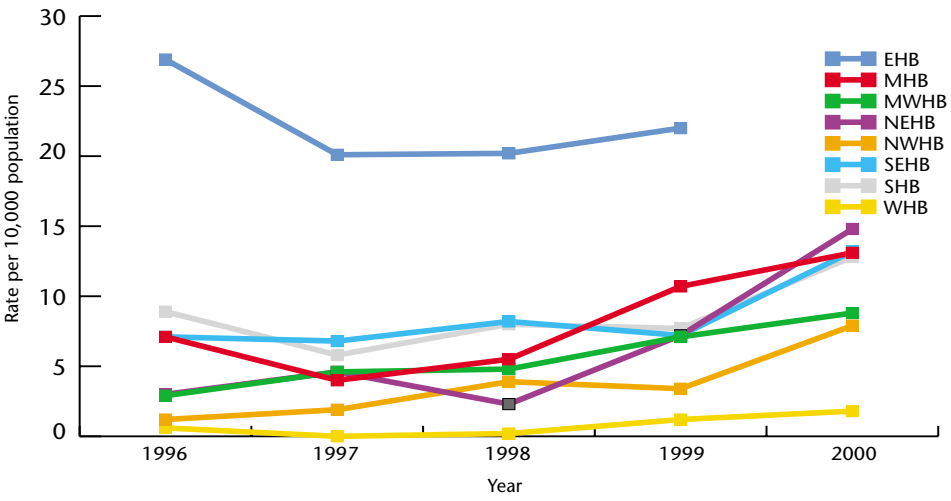
Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* 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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