Drug Misuse Research Division

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Trends in Treated Drug Misuse in the South 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 cover other areas of the country including the South Eastern Health Board (SEHB) 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 SEHB 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 SEHB area is on prevention and health promotion, with a recognition that appropriate management is required so that people can address their drug problems (Drug Co-ordination Unit, 2001). In recognising drug misuse as a serious problem, the SEHB established a *Regional Co-ordinating Committee on Demand Reduction Measures for Drugs* in 1996. This Committee has a broad representation from Education, Probation Service, National Parents Council, Garda Siochána, FÁS, and the medical profession. The Drug and Alcohol Misuse Prevention Strategy, which was adopted in 1999, recommended the 'provision of locally based, easy access services, which operate on the principle of best knowledge and practice' (Drug Co-ordination Unit, 2001: 1).

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

Drug treatment services in the SEHB area are provided in each county: statutory, non-residential services include ACCEPT (Alcohol Centre Co-ordinating Education, Prevention and Treatment) in Waterford; CATS (Community Alcohol Treatment Service) in Kilkenny; South Tipperary Alcohol and Addiction Service; Community Counselling Services in Wexford and Carlow. Residential psychiatric services are provided where required, and another statutory service provides methadone maintenance and counselling for those who experience problems with opiate misuse. There are also a number of voluntary residential treatment centres, one of which specialises in treatment for adolescents. Data returns to the NDTRS for 2000 were provided by 22 agencies in all: 7 residential, including 4 psychiatric hospitals; and 15 non-residential. Out of a total of 424 contacts during 2000, 250 were treated in non-residential centres. The type of drug treatment provided/availed of was mainly advice/counselling/support (N=346). The treatment provided to any one individual may include a combination of options. During 2000, as well as addiction counselling, about a quarter of clients (N=126) received 'medicament free/psychosocial therapy'; 6 percent (N=24) of clients underwent detoxification; and 4 percent (N=16) were treated in a drug substitution/maintenance programme.

Extent of the problem

The number of drug users presenting for treatment in the SEHB has more than trebled in the five-year period 1996 to 2000. In 1996 and 1997 the number treated[2] in the SEHB area was less than 150 (Table 1a). In 1998 there was a total of 216 treatment contacts; by 2000 the number had reached 424 which was double that of the previous year. A total of 345 residents of the SEHB were treated in 2000, and of these the majority (N=324) received treatment in the SEHB area. Only a minority (N=21) were treated elsewhere (Table 1a). Each year since 1998, the number treated in the SEHB catchment area has exceeded the total number of SEHB *residents* who received treatment. In 2000, for example, 100 clients from outside the area received treatment in the SEHB – of these, 31 were from the Southern Health Board (SHB) area; 28 from the Eastern Regional Health Authority (ERHA) health boards; and 24 from the Mid Western Health Board (MWHB) area. The proportion of non-residents treated in the SEHB increased from 10 percent (13/131) in 1996 to 24 percent (100/424) in 2000. These data indicate that there is an increasing trend of treating non-residents for problem drug use. This may indicate a preference for the type of treatment services, particularly in the case of a number of voluntary residential services, available in the area.

[1] Counties Waterford, Wexford, Kilkenny, Carlow and Tipperary South 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 SEHB (Counties Waterford, Wexford, Kilkenny, Carlow and Tipperary South Riding)

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

Year	Total treated in SEHB	SEHB residents treated in SEHB	SEHB residents treated elsewhere	Others treated in SEHB	Total SEHB residents treated
1996	131	118	32	13	150
1997	149	128	27	21	155
1998	216	182	19	34	201
1999	212	177	18	35	195
2000	424	324	21**	100	345**

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

During 2000, 345 SEHB residents were treated for problem drug use

A sizeable proportion (over half) of those treated each year are receiving treatment for the first time (first contacts). The number of first contacts increased from 90 in 1996 to 246 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 SEHB	SEHB residents treated in SEHB	SEHB residents treated elsewhere	Others treated in SEHB	Total SEHB residents treated
1996	90	78	26	12	104
1997	98	86	14	12	100
1998	125	104	17	21	121
1999	127	101	8	26	109
2000	246	190	10**	56	200**

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

Socio-demographic information

The typical client coming for treatment is male, in his late teens 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 (15 percent) compared to 1996 (20 percent) (Table 2a). Clients were also less likely to be unemployed, with the employment level improving from 22 percent in 1996 to 30 percent in 2000. This is as might be expected, given the general favourable economic conditions in the country, although it is still very low in comparison to that of the general population.

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

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

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	84:16	86:14	83:17	84:16	80:20
Mean age (years)	23	24	23	25	24
Modal age (years)	20	17	20	19	19
% Under 18 years of age	14	20	12	8	17
% Living with parents/family	63	61	63	59	62
% Early school leavers*	20	19	16	15	15
% Still at school	10	14	5	6	8
% Employed	22	23	36	31	30

* 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 SEHB, 1996-2000

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	86:14	91:9	85:15	83:17	81:19
Mean age (years)	22	23	23	24	23
Modal age (years)	19	17	20	19	19
% Under 18 years of age	16	24	14	13	19
% Living with parents/family	65	58	67	63	63
% Early school leavers*	19	19	14	15	16
% Still at school	13	16	5	8	10
% Employed	26	26	40	38	33

* Left school before the age of 15 years

Problem drug use

Cannabis is the main drug for which most people present for treatment

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 SEHB 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 1996 to 2000 show that while the *number* presenting for treatment for cannabis misuse has increased, the relative proportion has decreased from 70 percent in 1996 to 58 percent in 2000 (Table 3a). Over the same period there was an increase in ecstasy use, from 12 percent to 17 percent. Opiate use also shows an upward trend from 11 percent in 1996 to 14 percent in 2000: the *number* of all (opiate) contacts increased from 14 in 1996 to 58 in 2000 (Table 3a).

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

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
Opiates	14	(11)	12	(8)	29	(13)	32	(15)	58	(14)
Cocaine	3	(2)	5	(3)	8	(4)	6	(3)	8	(2)
Ecstasy	16	(12)	15	(10)	17	(8)	40	(19)	72	(17)
Amphetamines	3	(2)	18	(12)	21	(10)	16	(8)	19	(4)
Benzodiazepines	1	(1)	2	(1)	6	(3)	2	(1)	9	(2)
Volatile Inhalants	2	(2)	0	(0)	1	(0)	0	(0)	2	(0)
Cannabis	92	(70)	92	(62)	134	(62)	113	(53)	247	(58)
Other substances	0	(0)	4	(3)	0	(0)	3	(1)	9	(2)
Total	131		149*		216		212		424	

* Percentages based on valid N of 148

Trends among the sub-group of new clients (first contacts) were similar to those of the overall group (all contacts) (Table 3b). However, first contacts were slightly less likely to be using an opiate than all contacts (Table 3b). Ecstasy use among new clients increased from 8 percent in 1996 to 21 percent in 2000. The use of opiates is relatively low, but the *number* increased from 9 in 1996 to 22 in 2000 (Table 3b).

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

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
Opiates	9	(10)	2	(2)	11	(9)	10	(8)	22	(9)
Cocaine	2	(2)	4	(4)	3	(2)	4	(3)	4	(2)
Ecstasy	7	(8)	8	(8)	11	(9)	25	(20)	52	(21)
Amphetamines	3	(3)	14	(14)	10	(8)	8	(6)	11	(4)
Benzodiazepines	1	(1)	0	(0)	2	(2)	0	(0)	2	(1)
Volatile Inhalants	1	(1)	0	(0)	0	(0)	0	(0)	1	(0)
Cannabis	67	(74)	67	(69)	88	(70)	79	(62)	147	(60)
Other substances	0	(0)	2	(2)	0	(0)	1	(1)	7	(3)
Total	90		98*		125		127		246	

* Percentages based on valid N of 97

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 12 in 1996 to 52 in 2000 (Table 4a). The fact that in 2000 heroin was more likely to be injected than smoked has serious health implications.

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	12	12	27	28	52
of whom:					
inject	4	4	12	16	31
smoke	4	5	13	9	19
other route	1	0	2	3	0
not known	3	3	0	0	2
Other Opiates	2	0	2	4	6
Total	14	12	29	32	58

Among new clients the numbers using heroin is relatively low, but again is increasing, from 8 in 1996 to 18 in 2000 (Table 4b).

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	8	2	10	8	18
of whom:					
inject	1	0	4	5	7
smoke	4	2	6	1	10
other route	1	0	0	2	1
not known	2	0	0	0	0
Other Opiates	1	0	1	2	4
Total	9	2	11	10	22

Polydrug use is very much a feature of drug use patterns. Trends in secondary drug use show that over 80 percent of clients are likely to be involved in the use of more than one drug (Table 5a). Alcohol was the drug most likely to be reported in 2000 showing an increasing trend, from 11 percent in 1996 to 28 percent in 2000. Alcohol[3] was followed by ecstasy (stable), cannabis (stable) and fluctuating amphetamine use.

Polydrug use is very much a feature of drug use patterns

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

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
No second drug	20	(15)	24	(16)	31	(14)	29	(14)	65	(15)
Opiates	4	(3)	4	(3)	7	(3)	0	(0)	10	(2)
Cocaine	4	(3)	6	(4)	5	(2)	6	(3)	20	(5)
Ecstasy	29	(22)	38	(26)	57	(26)	45	(21)	96	(23)
Amphetamines	24	(18)	32	(21)	55	(25)	51	(24)	48	(11)
Benzodiazepines	1	(1)	0	(0)	2	(1)	6	(3)	6	(1)
Volatile Inhalants	1	(1)	1	(1)	0	(0)	0	(0)	1	(0)
Cannabis	17	(13)	21	(14)	31	(14)	33	(16)	53	(13)
Alcohol	14	(11)	10	(7)	22	(10)	34	(16)	117	(28)
Other substances	17	(13)	13	(9)	6	(3)	8	(4)	8	(2)
Total	131		149		216		212		424	

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

New clients are as likely to be polydrug users as the overall group of all contacts. Alcohol use is on the increase among first contacts, rising from 8 percent in 1996 to 29 percent in 2000 (Table 5b).

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

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
No second drug	17	(19)	20	(20)	24	(19)	21	(17)	43	(17)
Opiates	1	(1)	1	(1)	1	(1)	0	(0)	3	(1)
Cocaine	2	(2)	1	(1)	3	(2)	1	(1)	11	(4)
Ecstasy	20	(22)	28	(29)	34	(27)	32	(25)	52	(21)
Amphetamines	17	(19)	24	(25)	39	(31)	34	(27)	30	(12)
Benzodiazepines	1	(1)	0	(0)	1	(1)	3	(2)	2	(1)
Volatile Inhalants	1	(1)	1	(1)	0	(0)	0	(0)	0	(0)
Cannabis	9	(10)	11	(11)	14	(11)	19	(15)	27	(11)
Alcohol	7	(8)	5	(5)	7	(6)	12	(9)	72	(29)
Other substances	15	(17)	7	(7)	2	(2)	5	(4)	6	(2)
Total	90		98		125		127		246	

Risk behaviour

Mean age of initial drug use remained consistently young at around 16 years of age

Over the five-year period the mean age of initial drug use remained consistently young at around 16 years of age (Tables 6a, 6b). The *number* of clients who had ever injected was relatively low, but increased from 13 in 1996 to 66 in 2000. Of these, a sizeable proportion engaged in high risk behaviour - in 2000 nearly half (N=32) had shared injecting equipment, and a third (N=22) were currently injecting drugs (Table 6a). This presents 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 SEHB, 1996-2000

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	16	16	16	16	15
Mean age 1st injected (years)	21	23	21	21	21
Ever Injected N	13	7	28	36	66
of whom:					
'ever shared' N	9	2	11	18	32
'currently injecting' N	1	2	3	10	22
'currently sharing' N	0	1	1	4	5

Among the first contact sub-group the *number* who had ever injected is also increasing (from 7 in 1996 to 23 in 2000), and the fact that they are likely to be involved in high risk behaviour such as sharing injecting equipment cannot be ignored (Table 6b).

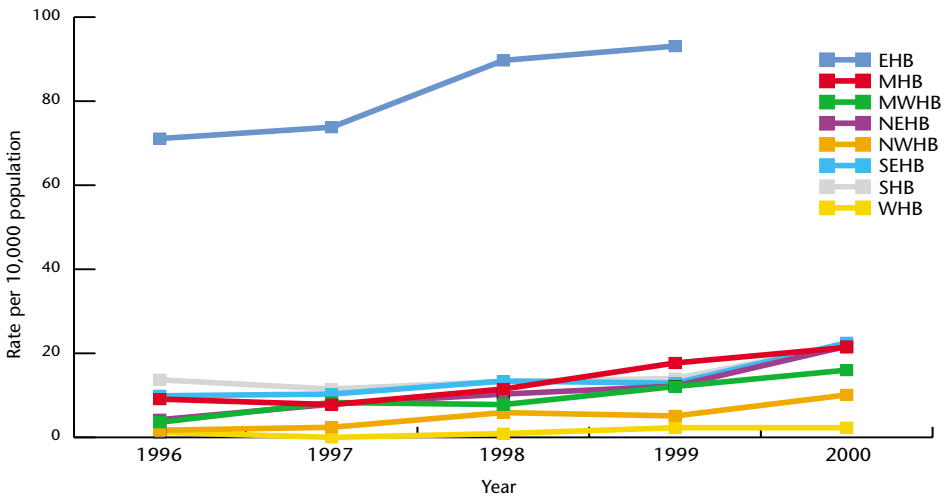
Table 6b. Risk Behaviours of First Treatment Contacts treated in the SEHB, 1996-2000

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	16	16	16	17	16
Mean age 1st injected (years)	22	22	21	24	21
Ever Injected N	7	1	8	13	23
of whom:					
'ever shared' N	4	0	4	6	12
'currently injecting' N	0	0	1	4	9
'currently sharing' N	0	0	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).

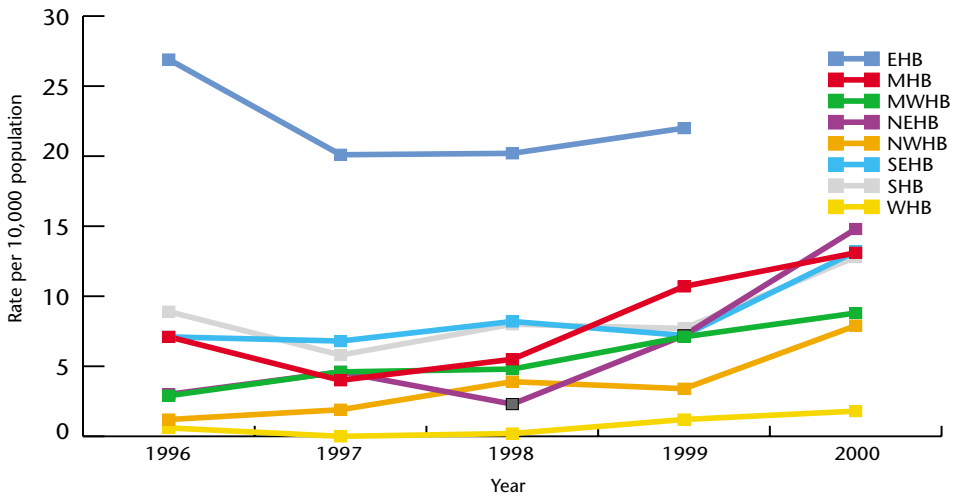
Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* 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 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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