Drug Misuse Research Division

Occasional Paper No. 8/ 2002

Trends in Treated Drug Misuse in the Eastern Health Board Area[1] 1996-1999[2]

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 and in 1995 it was extended to cover other areas of the country. 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. 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 on 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 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;

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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

Drug strategies in the EHB embrace a harm reduction approach

The most serious drug problems in Ireland, associated with the use of heroin, occur mainly in Dublin (National Co-ordinating Committee on Drug Abuse, 1991; O'Hare & O'Brien, 1992; Ministerial Task Force, 1996; Moran *et al.*, 1997; Farrell *et al.*, 2000; O'Brien *et al.*, 2000; Department of Tourism, Sport & Recreation, 2001). In recognition of the fact that there is no single treatment modality for drug misuse given the complex nature of problems associated with drug misuse, drug strategies in the EHB embrace a harm reduction approach. Consequently a broad range of services covering prevention, treatment and rehabilitation is provided to ensure higher levels of treatment access. These include addiction counselling services, syringe exchange programmes[3], drug substitution programmes (opiate detoxification, methadone reduction, methadone maintenance) and rehabilitation programmes. Since 1996, drug services in the EHB have undergone major expansion and have been described as 'one of the more innovative community drug service programmes in Europe' (Farrell *et al.*, 2000: 32).

Data returns to the NDTRS[4] for clients attending treatment services in the EHB during 1999, were provided by 56 agencies: 50 non-residential, 5 residential and 1 prison. Out of a total number of 5380, 82 percent of clients were treated at non-residential centres, mainly specialised treatment centres and satellite clinics; 8 percent were treated by general practitioners; and residential therapeutic communities accounted for 8 percent of clients. A very small proportion (0.1 percent) were in a prison setting. Most clients were participating in drug substitution/maintenance programmes.

Extent of the problem

During 1999, 5390 EHB residents were treated for problematic drug use

Between 1996 and 1999 the number of drug users presenting for treatment increased from 4283 in 1996 to 5380 in 1999 (Table 1a). This was due in part to an increase in service provision, and partly to an increase in drug use. Almost all of those who received treatment in the EHB during 1999 were residents of the area (5304/5380). A relatively small number of people were from outside the EHB catchment area - for example, in 1999, 76 non-residents were treated in the EHB. Altogether in 1999, 5390 EHB residents were treated for their drug use; a small proportion (less than 2 percent) were treated outside of the area (N=86), mainly at residential treatment services in the Mid Western Health Board area (Table 1a).

Table 1a. Number of All Treatment Contacts* by treatment area and area of residence of clients, 1996-1999

Year	Total treated in EHB	EHB residents treated in EHB	EHB residents treated elsewhere	Others treated in EHB	Total EHB residents treated
1996	4283	4173	36	110	4209
1997	4243	4117	95	126	4212
1998	5155	5050	92	105	5142
1999	5380	5304	86	76	5390

* Number of cases, as distinct from individuals, who received treatment for their problem drug use

[1] Counties Dublin, Kildare and Wicklow. The Eastern Health Board (EHB) was dissolved and replaced by the Eastern Regional Health Authority (ERHA) and three new area health boards (the Northern, East Coast and South Western), under the Health *(Eastern Regional Health Authority)* Act, 1999. The ERHA took over formal responsibility for health and personal social services in Dublin, Kildare and Wicklow from 1 March 2000. As this paper refers to data collected prior to this date, the catchment area now covered by the ERHA will be referred to as the EHB area

[2] This paper includes data for 1996 to 1999 only, as a complete dataset was not available for 2000

[3] No NDTRS data returns for syringe exchange programmes

[4] It should be noted that NDTRS figures for those being treated in general practice and prison settings are currently under-represented in data returns. Efforts are being made to improve coverage in these areas

There is a decreasing trend in the proportion of those treated each year for the first time (first contacts) - the number of first contacts fell from 1648 in 1996 to 1255 in 1999 (Table 1b). The explanation for this is not altogether clear but one factor may be the impact of the introduction of the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998*[5] on the structure of treatment services. The regulations placed restrictions on the provision of methadone maintenance services in the general practice setting. Some drug users, who up to then had been attending general practitioners now presented to treatment centres, with the result that places for new clients were limited. This, combined with problems in establishing local drug treatment services meant that there was little scope to provide new treatment places.

Table 1b. Number of First Treatment Contacts* by treatment area and area of residence of clients, 1996-1999

Year	Total treated in EHB	EHB residents treated in EHB	EHB residents treated elsewhere	Others treated in EHB	Total EHB residents treated
1996	1648	1571	24	77	1595
1997	1169	1108	27	61	1135
1998	1151	1107	39	44	1146
1999	1255	1220	38	35	1258

* Number of people who received treatment for the first time ever

Socio-demographic information

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

The typical client coming for treatment is male, in his early twenties and living in the family home. Over the four-year period 1996 to 1999 the modal age (the most frequently occurring age) for all clients was 20 or 21 years of age (Table 2a). Fewer clients are living in the family home - the proportion fell from 70 percent in 1996 to 62 percent in 1999. On closer examination of the data it emerges that more people are living alone (increasing from three percent in 1996 to six percent in 1999). The proportion who were homeless remained stable at around three percent. In educational terms, the proportion of those who had left school before the official school-leaving age of 15 years remained relatively high at 28 or 29 percent (Table 2a). At least one aspect of the social condition of clients in the EHB area is improving - the employment level increased from nine percent in 1996 to 26 percent in 1999. 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. It is indicative of the social disadvantage of drug users and presents a challenge to policy makers, particularly in the area of employment, if social exclusion and marginalisation issues are to be addressed.

Table 2a. Socio-demographic characteristics of All Treatment Contacts treated in the EHB, 1996-1999

Characteristics	1996	1997	1998	1999
% Males : % Females	71:29	69:31	69:31	67:33
Mean age (years)	24	24	25	26
Modal age (years)	20	21	20	21
% Under 18 years of age	13	11	8	4
% Living with parents/family	70	67	67	62
% Early school leavers*	29	28	29	28
% Still at school	4	3	2	2
% Employed	9	13	18	26

* Left school before the age of 15 years

Employment levels are increasing

Trends among new clients are similar to those of the overall group, albeit at different levels (Table 2b). New clients are somewhat younger, with a higher proportion of adolescents (under 18 year olds). In the period under review, the proportion of adolescents fell from 24 percent in 1996 to 10 percent in 1999; and in 1999 they were less likely to be living in the family home - the proportion fell from 78 percent in 1996 to 68 percent in 1999. Employment levels among new clients, which are higher than those of the overall group, also show an improving trend, from 12 percent in 1996 to 30 percent in 1999 (Table 2b).

[5] Statutory Instrument No. 225 of 1998

Table 2b. Socio-demographic characteristics of First Treatment Contacts treated in the EHB, 1996-1999

Characteristics	1996	1997	1998	1999
% Males : % Females	71:29	70:30	73:27	70:30
Mean age (years)	21	22	22	24
Modal age (years)	19	19	20	19
% Under 18 years of age	24	20	20	10
% Living with parents/family	78	75	73	68
% Early school leavers*	24	21	25	23
% Still at school	7	7	7	5
% Employed	12	18	22	30

* Left school before the age of 15 years

Problem drug use

Trends show an increase in the misuse of opiates

Information on the patterns of drug use, such as the types of drugs used, *how* they are taken, and whether they are taken in combination with other drugs, can be useful in assessing and planning drug treatment services. In the EHB area opiates are predominantly the main drugs causing problems and for which most people present for treatment. Trends over the period 1996 to 1999 show an increase in the misuse of opiates (Table 3a), from 88 percent in 1996 to 94 percent in 1999. The *number* of all (opiate) contacts increased from 3774 in 1996 to 5045 in 1999. In comparison, the proportion using other types of drugs is relatively small, and is decreasing. For example, problematic cannabis use decreased from six percent in 1996 to three percent in 1999; and ecstasy use from three percent in 1996 to one percent in 1999.

Table 3a. Main Drug of Misuse of All Treatment Contacts treated in the EHB, 1996-1999

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)
Opiates	3774	(88)	3779	(89)	4688	(91)	5045	(94)
Cocaine	20	(0)	30	(1)	61	(1)	39	(1)
Ecstasy	125	(3)	92	(2)	50	(1)	59	(1)
Amphetamines	10	(0)	15	(0)	28	(1)	20	(0)
Benzodiazepines	42	(1)	37	(1)	58	(1)	27	(1)
Volatile Inhalants	14	(0)	14	(0)	17	(0)	8	(0)
Cannabis	275	(6)	245	(6)	225	(4)	169	(3)
Other substances	16	(0)	18	(0)	15	(0)	13	(0)
Total	4283*		4243**		5155+		5380	

Percentages based on valid Ns of 4276*; of 4230**; of 5142+

Trends among the sub-group of new clients (first contacts) were similar to those of the overall group of all contacts, albeit at a lower level for opiates and a higher level for cannabis and ecstasy use (Table 3b).

Table 3b. Main Drug of Misuse of First Treatment Contacts treated in the EHB, 1996-1999

Main Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)
Opiates	1307	(79)	905	(78)	899	(78)	1056	(84)
Cocaine	14	(1)	15	(1)	26	(2)	18	(1)
Ecstasy	96	(6)	65	(6)	30	(3)	41	(3)
Amphetamines	6	(0)	10	(1)	16	(1)	15	(1)
Benzodiazepines	6	(0)	13	(1)	11	(1)	4	(0)
Volatile Inhalants	11	(1)	6	(1)	13	(1)	5	(0)
Cannabis	199	(12)	143	(12)	146	(13)	110	(9)
Other substances	7	(0)	9	(1)	7	(1)	6	(0)
Total	1648*		1169**		1151+		1255	

Percentages based on valid Ns of 1646*; of 1166**; of 1148+

A closer scrutiny reveals that heroin use is on the increase, from 88 percent (N=3324) in 1996 to 93 percent (N=4685) in 1999; and injection of heroin increased from 52 percent in 1996 to 71 percent in 1999 (Table 4a). The fact that heroin is more likely to be injected than smoked, and that there is an increasing trend in injecting heroin use, has very serious implications for the health of this population of drug users. The use of other opiates such as codeine, dihydrocodeine and methadone was stable

between 1996 and 1998, and then it decreased in 1999, perhaps indicating that heroin as the drug of choice was more readily available.

There is an increasing trend in injecting heroin use

Table 4a. Opiate as a Main Drug of Misuse for All Treatment Contacts treated in the EHB, 1996-1999

Main Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)
Heroin	3324	(88)	3328	(88)	4167	(89)	4685	(93)
of whom:								
injected	1739	(52)	2164	(65)	2736	(66)	3322	(71)
smoked	1507	(45)	1109	(33)	1283	(31)	1288	(27)
other route	23	(1)	19	(1)	22	(1)	16	(0)
not known	55	(2)	36	(1)	126	(3)	59	(1)
Other Opiates	450	(12)	451	(12)	521	(11)	360	(7)
Total	3774		3779		4688		5045	

The pattern of heroin use among new clients in Dublin during the early 1990s was characterised by the emergence of chasing the dragon (Smyth *et al.*, 2000). This coincided with a surge in the number of people entering treatment for the first time. Concern was expressed that the greater acceptability of heroin chasing among new users might attract increasing numbers to heroin use (Smyth *et al.*, 2000). While heroin use has remained very high among new clients, the *numbers* in 1999 (N=1017) were less than in 1996 (N=1266) (Table 4b). In 1996 they were more likely to smoke (61 percent) rather than inject the heroin, then the trend began to change and by 1999 injecting became the most common route of administration (59 percent) for heroin users presenting to treatment services for the first time (Table 4b). It would seem that heroin users, who initially are reluctant to inject the drug, are more likely to do so once their heroin use has become habitual (Cassin *et al.*, 1998; Dillon, 2001; Moran *et al.*, 2001).

Drug users who initially smoke heroin are more likely to inject once their heroin use becomes habitual

Table 4b. Opiate as a Main Drug of Misuse for First Treatment Contacts treated in the EHB, 1996-1999

Main Drug / Route of Administration	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)
Heroin	1266	(97)	872	(96)	849	(94)	1017	(96)
of whom:								
injected	461	(36)	421	(48)	415	(49)	598	(59)
smoked	775	(61)	438	(50)	422	(50)	409	(40)
other route	9	(1)	4	(0)	3	(0)	1	(0)
not known	21	(2)	9	(1)	9	(1)	9	(1)
Other Opiates	41	(3)	33	(4)	50	(6)	39	(4)
Total	1307		905		899		1056	

Drug users presenting for treatment are likely to be involved in the use of more than one drug (Table 5a). Trends in secondary drug use show a high level of polydrug use, although the proportion decreased slightly from 75 percent in 1996 and 1997 to 68 percent in 1998 and 1999 (Table 5a). Opiates, benzodiazepines and cannabis are the drugs most likely to be involved. In 1998 there was a shift towards benzodiazepines which became the most common secondary drug in 1999 (Table 5a).

Trends show high levels of polydrug use

Table 5a. Secondary Drug of Misuse of All Treatment Contacts treated in the EHB, 1996-1999

Secondary Drug of Misuse	1996 N	(%)	1997 N	(%)	1998 N	(%)	1999 N	(%)
No second drug	1020	(25)	1054	(25)	1641	(32)	1734	(32)
Opiates	1011	(25)	1047	(25)	1037	(20)	968	(18)
Cocaine	110	(3)	177	(4)	272	(5)	406	(8)
Ecstasy	278	(7)	198	(5)	183	(4)	195	(4)
Amphetamines	35	(1)	53	(1)	58	(1)	45	(1)
Benzodiazepines	742	(18)	924	(22)	1017	(20)	1067	(20)
Volatile Inhalants	8	(0)	9	(0)	4	(0)	8	(0)
Cannabis	672	(16)	507	(12)	760	(15)	793	(15)
Alcohol	105	(3)	83	(2)	92	(2)	87	(2)
Other substances	104	(3)	111	(3)	91	(2)	77	(1)
Total	4283*		4243**		5155		5380	

Percentages based on valid Ns of 4085*; of 4163**

Among new clients there are also high levels of polydrug use, although with a decreasing trend, from 71 percent in 1996 to 58 percent in 1999 (Table 5b). In the case of new clients the pattern is somewhat different with cannabis as the drug most likely to be involved (in 18 percent of cases in 1999), followed by benzodiazepines and opiates (Table 5b).

Table 5b. Secondary Drug of Misuse of First Treatment Contacts treated in the EHB, 1996-1999

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)
No second drug	450	(29)	378	(33)	450	(39)	523	(42)
Opiates	256	(16)	161	(14)	123	(11)	136	(11)
Cocaine	43	(3)	45	(4)	51	(4)	71	(6)
Ecstasy	148	(9)	82	(7)	67	(6)	72	(6)
Amphetamines	26	(2)	36	(3)	30	(3)	27	(2)
Benzodiazepines	216	(14)	190	(17)	138	(12)	152	(12)
Volatile Inhalants	6	(0)	2	(0)	2	(0)	4	(0)
Cannabis	324	(21)	188	(16)	244	(21)	232	(18)
Alcohol	53	(3)	27	(2)	22	(2)	23	(2)
Other substances	37	(2)	42	(4)	24	(2)	15	(1)
Total	1648*		1169**		1151		1255	

Percentages based on valid Ns of 1559*; of 1151**

Risk behaviour

Mean age of initial drug use was very young at 15 or 16 years of age

Over the four-year period, 1996 to 1999, the mean age of initial drug use was very young at 15 or 16 years of age (Tables 6a, 6b). The mean age at which injecting commenced was about 20 years of age (Tables 6a, 6b). Injecting practices are presenting as a major problem with an increasing high proportion (2501/4283 in 1996 and 4142/5380 in 1999) of clients having ever injected (Table 6a). Over half of those who have injected *have* also engaged in sharing injecting equipment and were currently sharing when they presented for treatment. The prevalence of risk behaviours such as injecting drug use and sharing injecting equipment, has very serious implications for the health of this population of drug users, particularly in relation to the transmission of infectious diseases such as hepatitis C and HIV.

Table 6a. Risk Behaviours of All Treatment Contacts treated in the EHB, 1996-1999

Risk Behaviours	1996	1997	1998	1999
Mean age of initial drug use (years)	15	16	15	15
Mean age 1st injected (years)	19	20	20	20
Ever Injected N	2501	2895	3602	4142
of whom:				
'ever shared' N	1499	1750	2141	2705
'currently injecting' N	1474	1647	1931	1795
'currently sharing' N	375	442	505	488

The prevalence of high risk behaviours has very serious health implications

Levels of risk behaviours are not as high among those attending treatment for the first time, but as is the case among the overall group there is an increasing trend in high risk injecting and sharing practices (Table 6b). In 1996 just over a third (610/1648) had ever injected, and this had increased to over half in 1999 (742/1255). Up to 1999 less than half of these had shared injecting equipment at some time; in 1999 the proportion increased to 57 percent (423/742).

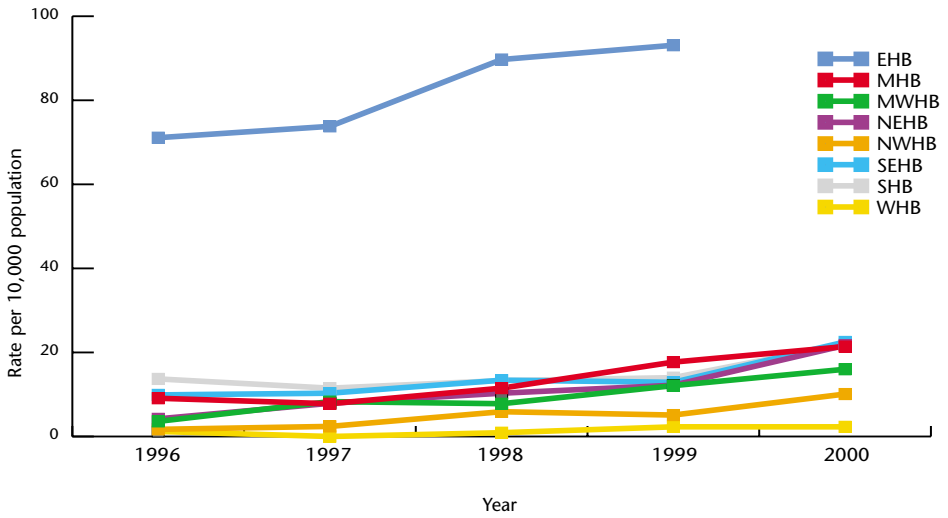
Table 6b. Risk Behaviours of First Treatment Contacts treated in the EHB, 1996-1999

Risk Behaviours	1996	1997	1998	1999
Mean age of initial drug use (years)	15	16	15	16
Mean age 1st injected (years)	20	20	20	20
Ever Injected N	610	525	522	742
of whom:				
'ever shared' N	262	238	235	423
'currently injecting' N	412	356	343	348
'currently sharing' N	115	108	90	108

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[6]. 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 EHB area 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).

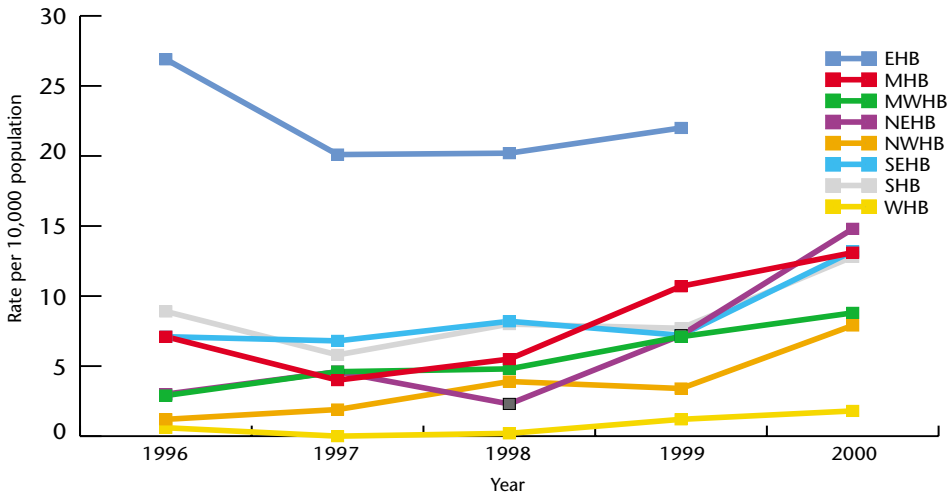
Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* 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 taken into consideration 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

[6] 1999 is the latest date for which complete ERHA (former EHB) data are available

References

Cassin, S., Geoghegan, T. & Cox, G. (1998). Young injectors: A comparative analysis of risk behaviour. *Irish Journal of Medical Science, **167**, 4, 234-237.*

Department of Tourism, Sport & Recreation (2001). *Building on Experience. National Drugs Strategy 2001-2008.* Dublin: The Stationery Office.

Dillon, L. (2001). *Drug Use among Prisoners: an Exploratory Study.* Dublin: Health Research Board.

EMCDDA (1998). *1998 Annual Report on the state of the drugs problem in the European Union.* Luxembourg: Office for Official Publications of the European Communities.

Farrell, M., Gerada, C. & Marsden, J. (2000). *External Review of Drug Services for the Eastern Health Board.* London: National Addiction Centre, Institute of Psychiatry.

Ministerial Task Force (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of the Taoiseach.

Moran, R., O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland. National Report 1996.* Dublin: Health Research Board.

Moran, R., O'Brien, M., Dillon, L., Farrell, E. & Mayock, P. (2001). *Overview of Drug Issues in Ireland 2000. A Resource Document.* Dublin: Health Research Board.

National Co-ordinating Committee on Drug Abuse (1991). *Government strategy to prevent drug misuse.* Dublin: The Department of Health.

O'Brien, M., Moran, R., Kelleher, T. & Cahill, P. (2000). *National Drug Treatment Reporting System. Statistical Bulletin 1997 and 1998.* Dublin: Health Research Board.

O'Hare, A. & O'Brien, M. (1992). *Treated Drug Misuse in the Greater Dublin Area.* Dublin: Health Research Board.

Smyth, B.P., O'Brien, M. & Barry, J. (2000). Trends in treated opiate misuse in Dublin: the emergence of chasing the dragon. *Addiction, **95**, 8, 1217-1223.*

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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