Treatment demand in the seven health board areas outside the Eastern Regional Health Authority: 1998 to 2002 / Jean Long, Tracey Kelleher, Fionnola Kelly, Hamish Sinclair

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Treatment demand in the seven health board areas outside the Eastern Regional Health Authority, 1998 to 2002

Summary

The data presented in this paper provide a description of demand for drug treatment services in seven health boards, namely: the Midland, Mid-Western, North Eastern, North Western, Southern, South Eastern and Western Health Boards. This paper will help inform service planning and provision.

The analysis presented in this paper is based on data reported to the National Drug Treatment Reporting System.

The main findings and their implications are:

- The number of new and previously treated cases in the seven health boards (outside the Eastern Regional Health Authority area) almost trebled between 1998 and 2002.
- Both new and previously treated cases in the seven health board areas most frequently reported that cannabis was their main problem drug between 1998 and 2002. The total number of cases reporting cannabis as their main problem drug trebled, increasing from 409 in 1998 to 1,359 in 2002. The numbers reporting problem opiate use almost trebled, from 184 in 1998 to 532 in 2002. Opiate use was more common in the health board areas bordering the Eastern Regional Health Authority area. Though small, the numbers reporting cocaine use increased consistently, indicating the early years of an epidemic. The wide spectrum of problem drugs reported indicates that treatment services need to cater for a number of licit and illicit drugs used rather than focusing on one or two drugs.
- Although there was a small decrease in the proportion of cases taking more than one drug (polydrug use), from 84 per cent in 1998 to 77 per cent in 2002, it remained a common practice and is associated with poorer treatment outcomes. Polydrug use is an issue that needs to be addressed in a client's treatment plan.
- The number of cases who reported injecting more than doubled, from 148 in 1998 to 342 in 2002. Half of the injector cases had started injecting before they were 20 years old. Injectors have a higher risk of acquiring blood-borne viral infections and experiencing overdose than non-injectors. This suggests that the drug treatment services outside the ERHA require prevention and treatment interventions to deal with blood-borne viruses (in particular HIV, hepatitis B, and hepatitis C) and drug overdose (in particular opiate-related overdoses).
- The proportion of cases under 18 years old increased by four per cent over the reporting period and, as expected, was much higher for new cases than for those previously treated. Those under 18 years old require different approaches to treatment and it is important that this is recognised in service planning.
- The low levels of educational achievement and employment among chronic problem drug users emphasises the importance of close links between treatment interventions and social and occupational reintegration programmes.

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Glossary of terms

- Incidence is a term used to describe the number of new cases of disease or events that develop among a population during a specified time interval. For example, in 2001, ten opiate users living in a specific county sought treatment for the first time. The incidence is the number of opiate cases divided by the population living in the county (say 31,182 persons in this example) expressed per given number of the population, i.e., per 100, per 1,000, per 10,000, etc.
  - The calculation in this case is as follows: (10/31,182) x 10,000, which gives an incidence rate of 3.2 per 10,000 of the specific county population in 2001.

- Prevalence is a term used to describe the proportion of people in a population who have a disease or condition at a specific point or period in time. For example, in 2001, ten opiate users living in a specific county sought treatment for the first time, 20 opiate users returned to treatment in the year and five opiate users continued in treatment from the previous year; in total there are 35 people treated for problem opiate use in 2001. The prevalence is the total number of cases (35) divided by the population living in the county (31,182 persons) expressed per given number of the population, i.e., per 100, per 1,000, per 10,000, etc.
  - The calculation in this case is as follows: (35/31,182) x 10,000, which gives a prevalence rate of 11.2 per 10,000 of the specific county population in 2001.

- The median is the value at the mid-point in a sequence of numerical values ranged in ascending or descending order. It is defined as the value above or below which half of the values lie. Unlike the mean (average), the median is not influenced by extreme values (or outliers). For example, in the case of five drug users aged 22, 23, 24, 24 and 46 years respectively, the median (middle value) is 24 years, whereas the mean is 27.8 years. While both the median and the mean describe the central value of the data, the median is more useful since the mean is influenced by the one older person in this example.

Introduction

The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug use in Ireland. It was established in 1990 in the Greater Dublin Area and was extended in 1995 to cover other areas of the country. The reporting system was originally developed in line with the Pompidou Group's Definitive Protocol (Hartnoll 1994) and subsequently refined in accordance with the Treatment Demand Indicator Protocol (EMCDDA and Pompidou Group 2000). The NDTRS is co-ordinated by staff at the Drug Misuse Research Division (DMRD) of the Health Research Board (HRB) on behalf of the Department of Health and Children.

Drug treatment data are viewed as an indirect indicator of drug misuse as well as a direct indicator of demand for treatment services. These data 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 is used to inform local and national drug policy and planning. For example, in 1996 NDTRS data were used to identify a number of local areas with problematic heroin use (Ministerial Task Force 1996). These areas were later designated as Local Drugs Task Force Areas and are continuing to provide strategic responses to drug misuse in their communities.

The monitoring role of the NDTRS is recognised by the Government in its document *Building on Experience: National Drugs Strategy 2001–2008.* Data collection for the NDTRS is one of the actions identified and agreed by Government for implementation by health boards: 'All treatment providers should co-operate in returning information on problem drug use to the DMRD of the HRB' (Department of Tourism, Sport and Recreation 2001: 118).

Methods

Compliance with the NDTRS requires that one form be completed for each person who receives treatment for problematic drug use at each treatment centre in a calendar year. Service providers at drug treatment centres throughout Ireland collect data on each individual treated for drug misuse. At national level, staff at the DMRD of the HRB compile anonymous, aggregated data.

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'. Clients who attend needle-exchange services are not included in this reporting system. Up to 2004, clients who reported alcohol as their main problem drug were not included in this reporting system. Treatment options include one or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training. Treatment is provided in both residential and non-residential settings. In the seven health board areas, data returns to the NDTRS for clients attending treatment services during 2002 were provided by 79 treatment services: 63 non-residential and 16 residential (Table 1).

The main elements of the reporting system are defined as follows:

- *All cases treated* – describes individuals who receive treatment for problematic drug use at each treatment centre in a calendar year, and includes both

    (a) *Previously treated cases* – describes individuals who were treated previously for problematic drug use at any treatment centre and have returned to treatment in the reporting year, and also those individuals continuing in treatment from the preceding calendar year; and
    (b) *New cases treated* – describes individuals who have never been treated for problem drug use.

In the case of the data for 'previously treated cases' there is a possibility of duplication in the database; for example, where a person receives treatment at more than one centre. For those receiving methadone maintenance or detoxification, this possibility is considered to be small since the introduction of the Misuse of Drugs Regulations in 1998, whereby precautions are taken to ensure that methadone treatment is available from one source only.

As a result of small numbers in 1998 and a high rate (13%) of treatment status unknown, some of the comparisons are limited to the time period 1999 to 2000.

The data presented in this paper provide a description of demand for drug treatment services in seven health boards, namely: the Midland, Mid-Western, North Eastern, North Western, Southern, South Eastern and Western Health Boards. The total numbers treated in the seven health boards include cases resident the Eastern Regional Health Authority and cases not resident in Ireland who sought treatment in one of the seven health boards between 1998 and 2002.

Analysis of treatment data

The analysis presented provides an overview of service provision for problem drug use, initial treatment provided, main problem drugs, risk behaviours, and socio-demographic characteristics of cases.

Service provision

The total number of treatment outlets for problem drug use available in the seven health boards outside the Eastern Regional Health Authority area and participating in the NDTRS increased between 1998 and 2002 (Table 1). The largest increase was in outpatient treatment services, while there was a small increase in the number of residential treatment services. The number of general practitioners participating in the NDTRS was very low. In 2002, there were 49 general practitioners prescribing methadone treatment outside the Eastern Regional Health Authority area but only four of these provided returns to the NDTRS. There are no low-threshold services providing low-dose methadone therapy outside Counties Dublin, Kildare and Wicklow. The prison service does not participate in the NDTRS, although it does provide drug treatment services.

Table 1 Number and type of services providing treatment for problem drug use, and number of cases* treated (in brackets) in the seven health board† areas and reported to the NDTRS, 1998 to 2002

Drug services	1998		1999		2000		2001		2002	
Outpatient	36	(598)	35	(762)	50	(1272)	60	(1339)	59	(1519)
Residential	12	(290)	10	(293)	13	(395)	13	(745)	16	(872)
Low threshold	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
General practitioner	0	(0)	5	(8)	3	(4)	5	(14)	4	(6)
Prison	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)

* Numbers include cases living in the Eastern Regional Health Authority but treated in another health board area, and exclude cases living in one of the seven health board areas but treated in the Eastern Regional Health Authority and recorded in the NDTRS.
† Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.

Numbers treated

Overall, the number of new and previously treated cases in the seven health boards (outside the Eastern Regional Health Authority area) and reported to the NDTRS trebled between 1998 and 2002 (Table 2). Each year, over half of cases were treated for the first time during the period under review.

Table 2 Number (%) of cases* treated in the seven health board† areas by treatment status reported to the NDTRS, 1998 to 2002

Treatment status	1998		1999		2000		2001		2002	
					Number (%)					
All cases	**888**		**1063**		**1671**		**2098**		**2397**	
Previously treated cases	306	(34.5)	441	(41.5)	618	(37.0)	787	(37.5)	917	(38.3)
New cases	472	(53.2)	595	(56.0)	1013	(60.6)	1205	(57.4)	1341	(55.9)
Status unknown	110	(12.4)	27	(2.5)	40	(2.4)	106	(5.1)	139	(5.8)

* Numbers include cases living in the Eastern Regional Health Authority but treated in another health board area, and exclude cases living in one of the seven health board areas but treated in the Eastern Regional Health Authority and recorded in the NDTRS.
† Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.

Of the 8,117 cases treated in the seven health boards and reported to the NDTRS between 1998 and 2002, the highest number of cases were treated in the Southern Health Board (2,164, 26%); followed closely by the South Eastern Health Board (1,931, 24%) and the Mid-Western Health Board (1,655, 20%). The North Eastern Health Board treated 1,109 (14%) cases during the period under review, while the Midland, North Western and Western Health Boards treated smaller numbers of all cases, 646 (8%), 391 (5%) and 239 (3%) respectively.

Table 3 presents a breakdown of the total number of cases reported to the NDTRS by health board where treated between 1998 and 2002. In 2002, the number of cases treated in the North Eastern Health Board area decreased by almost 14 per cent. According to staff at that health board, the reduction in numbers reported to the NDTRS in 2002 was due to a reduction in returns to the reporting system rather than to an actual reduction in the demand for services. Staff at the North Eastern Health Board's Public Health Department have addressed the reduction in returns to the NDTRS for the area for 2003.

As a proportion of all cases treated in each of the seven health boards and reported to the NDTRS during the reporting period, 40 per cent of cases treated in the Mid-Western Health Board lived in other health board areas, while 16 per cent of cases treated in the South Eastern Health Board lived in other health board areas. This observation is explained by the fact that there are residential treatment services located in these two health boards that are used by individuals with problem drug use from all parts of the country. In the remaining health boards, 2.5 per cent or less of the cases treated were living in health board areas other than the one in which they were treated.

Previously treated cases are an indicator of continued demand for treatment by chronic drug users in the seven health board areas. From 1998 to 2002, the number of previously treated cases returning to or continuing in treatment in one of the seven health boards increased each year for five of the health board areas (Table 3). The number of previously treated cases in the North Eastern Health Board area decreased by 10 per cent in 2002 compared to 2001; the reason for this has been mentioned above. The number of previously treated cases in the Mid-Western Health Board area decreased by 23 per cent between 2000 and 2002; the reason for this is not clear.

New cases are an indicator of new trends in treated problem drug use. From 1998 to 2002, the number of new cases treated increased each year for five of the health board areas (Table 3). For the same reason given above, the number of new cases treated in the North Eastern Health Board area decreased by 18 per cent in 2002 compared to 2001. The number of new cases treated in the Midland Health Board area fell by 31 per cent between 2000 and 2002; the reason for this is not clear. Anecdotal reports suggest that there was not an adequate number of methadone places for problem opiate users available in this health board area and the reduction in numbers of new cases may indicate a significant delay in entering treatment.

Table 3 Number of cases* treated in each health board by treatment status reported to the NDTRS, 1998 to 2002

Health Board where treated	1998		1999		2000		2001		2002	
	Number (%)									
All cases	**888**		**1063**		**1671**		**2098**		**2397**	
Midland Health Board	85	(9.6)	128	(12.0)	150	(9.0)	123	(5.9)	160	(6.7)
Mid-Western Health Board	200	(22.5)	281	(26.4)	327	(19.6)	423	(20.2)	424	(17.7)
North Eastern Health Board	71	(8.0)	123	(11.6)	250	(15.0)	358	(17.1)	307	(12.8)
North Western Health Board	45	(5.1)	39	(3.7)	77	(4.6)	99	(4.7)	131	(5.5)
Southern Health Board	263	(29.6)	258	(24.3)	429	(25.7)	555	(26.5)	641	(26.7)
South Eastern Health Board	216	(24.3)	212	(19.9)	424	(25.4)	474	(22.6)	605	(25.2)
Western Health Board	8	(0.9)	22	(2.1)	14	(0.8)	66	(3.1)	129	(5.4)
Previously treated cases	**306**		**441**		**618**		**787**		**917**	
Midland Health Board	45	(14.7)	47	(10.7)	55	(8.9)	58	(7.4)	83	(9.1)
Mid-Western Health Board	63	(20.6)	148	(33.6)	142	(23.0)	138	(17.5)	110	(12.0)
North Eastern Health Board	1	(0.3)	37	(8.4)	73	(11.8)	138	(17.5)	124	(13.5)
North Western Health Board	14	(4.6)	13	(2.9)	15	(2.4)	27	(3.4)	58	(6.3)
Southern Health Board	91	(29.7)	108	(24.5)	167	(27.0)	182	(23.1)	256	(27.9)
South Eastern Health Board	86	(28.1)	79	(17.9)	165	(26.7)	217	(27.6)	236	(25.7)
Western Health Board	6	(2.0)	9	(2.0)	1	(0.2)	27	(3.4)	50	(5.5)
New cases	**472**		**595**		**1013**		**1205**		**1341**	
Midland Health Board	39	(8.3)	76	(12.8)	87	(8.6)	65	(5.4)	60	(4.5)
Mid-Western Health Board	109	(23.1)	127	(21.3)	174	(17.2)	208	(17.3)	223	(16.6)
North Eastern Health Board	0	(0.0)	78	(13.1)	171	(16.9)	202	(16.8)	166	(12.4)
North Western Health Board	29	(6.1)	26	(4.4)	60	(5.9)	70	(5.8)	71	(5.3)
Southern Health Board	169	(35.8)	148	(24.9)	262	(25.9)	368	(30.5)	380	(28.3)
South Eastern Health Board	124	(26.3)	127	(21.3)	246	(24.3)	253	(21.0)	363	(27.1)
Western Health Board	2	(0.4)	13	(2.2)	13	(1.3)	39	(3.2)	78	(5.8)
Treatment status unknown	110		27		40		106		138	

* Numbers include cases living in the Eastern Regional Health Authority but treated in another health board area, and exclude cases living in one of the seven health board areas but treated in the Eastern Regional Health Authority and recorded in the NDTRS.

Treatment provision

Given the complex nature of problems associated with drug misuse, it is recognised that there is no single treatment modality for problem drug use. Consequently, a broad range of services covering treatment and rehabilitation is provided throughout the country. A question ascertaining the type of treatment provided on admission to treatment was introduced to the NDTRS form in 1999. Of the 7,217 cases who received treatment in the seven health board areas between 1999 and 2002 and were reported to the NDTRS, 7,086 had an initial treatment recorded and 131 had no treatment recorded. Of the 7,086 cases for whom initial treatment was documented, 89 per cent (6,314) received counselling or advice, 21 per cent (1,514) had medication-free therapy, 6 per cent (451) attended a social or occupational rehabilitation programme, 5 per cent (351) commenced medically assisted detoxification and 4 per cent (300) commenced methadone maintenance at their first treatment visit. Of the 7,086 cases for whom initial treatment was documented, 1,913 (27%) had more than one type of initial treatment, therefore the total number of treatments is greater than the number of cases (7,086).

Main problem drugs

Overall, cases treated in the seven health board areas most frequently reported that cannabis was their main problem drug between 1998 and 2002 (Table 4). The number of cases reporting cannabis as their main problem drug increased substantially, from 409 in 1998 to 1,359 in 2002. The same trend in cannabis use was noted for both new and previously treated cases. The numbers reporting problem opiate use trebled during the same period. The second most frequently reported main problem drug was ecstasy for new cases and opiates for previously treated cases between 1998 and 2001. In 2002, the second most frequently reported main problem drug was an opiate for both new and previously treated cases. The numbers reporting amphetamines as their main problem drug decreased, while the numbers reporting cocaine, though small, increased consistently, indicating the early years of an epidemic. The number of cases reporting benzodiazepines use also increased during the period under review.

Table 4 Main problem drug reported by cases* treated in the seven health board† areas by treatment status and reported to the NDTRS, 1998 to 2002

Main problem drug	1998		1999		2000		2001		2002	
	Number (%)									
All cases	**888**		**1063**		**1671**		**2098**		**2397**	
Cannabis	409	(46.1)	559	(52.6)	959	(57.4)	1161	(55.3)	1359	(56.7)
Opiates	184	(20.7)	225	(21.2)	288	(17.2)	447	(21.3)	532	(22.2)
Ecstasy	145	(16.3)	156	(14.7)	254	(15.2)	271	(12.9)	245	(10.2)
Amphetamines	45	(5.1)	42	(4.0)	28	(1.7)	19	(0.9)	28	(1.2)
Benzodiazepines	37	(4.2)	22	(2.1)	42	(2.5)	51	(2.4)	63	(2.6)
Cocaine	24	(2.7)	19	(1.8)	35	(2.1)	57	(2.7)	82	(3.4)
Volatile Inhalants	18	(2.0)	24	(2.3)	30	(1.8)	37	(1.8)	43	(1.8)
Other substances	26	(2.9)	16	(1.5)	35	(2.1)	55	(2.6)	45	(1.9)
Previously treated cases	**306**		**441**		**618**		**787**		**917**	
Cannabis	116	(37.9)	186	(42.2)	315	(51.0)	367	(46.6)	438	(47.8)
Opiates	78	(25.5)	148	(33.6)	165	(26.7)	256	(32.5)	279	(30.4)
Ecstasy	45	(14.7)	49	(11.1)	67	(10.8)	85	(10.8)	85	(9.3)
Benzodiazepines	20	(6.5)	14	(3.2)	22	(3.6)	24	(3.0)	45	(4.9)
Amphetamines	16	(5.2)	18	(4.1)	11	(1.8)	14	(1.8)	15	(1.6)
Cocaine	15	(4.9)	8	(1.8)	18	(2.9)	20	(2.5)	28	(3.1)
Volatile inhalants	6	(2.0)	8	(1.8)	8	(1.3)	2	(0.3)	8	(0.9)
Other substances	10	(3.3)	10	(2.3)	12	(1.9)	19	(2.4)	19	(2.1)
New cases	**472**		**595**		**1013**		**1205**		**1341**	
Cannabis	251	(53.2)	364	(61.2)	623	(61.5)	742	(61.6)	862	(64.3)
Ecstasy	90	(19.1)	102	(17.1)	181	(17.9)	180	(14.9)	156	(11.6)
Opiates	71	(15.0)	70	(11.8)	113	(11.2)	157	(13.0)	195	(14.5)
Amphetamines	21	(4.4)	21	(3.5)	17	(1.7)	5	(0.4)	13	(1.0)
Benzodiazepines	12	(2.5)	8	(1.3)	19	(1.9)	25	(2.1)	18	(1.3)
Volatile Inhalants	9	(1.9)	15	(2.5)	21	(2.1)	34	(2.8)	34	(2.5)
Cocaine	6	(1.3)	10	(1.7)	16	(1.6)	30	(2.5)	43	(3.2)
Other substances	12	(2.5)	5	(0.8)	23	(2.3)	32	(2.7)	20	(1.5)

* Numbers include cases living in the Eastern Regional Health Authority but treated in another health board area, and exclude cases living in one of the seven health board areas but treated in the Eastern Regional Health Authority and recorded in the NDTRS.
† Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.

Although there was a small decrease in the proportion of cases taking more than one drug (polydrug use), from 84 per cent in 1998 to 77 per cent in 2002 (Table 5), it remained a common practice and is associated with poorer treatment outcomes. Polydrug use is an issue that needs to be addressed in the client's treatment plan.

Table 5 Use of more than one drug reported by cases* treated in the seven health board† areas by treatment status and reported to the NDTRS, 1998 to 2002

Used more than one drug	1998		1999		2000		2001		2002	
	Number (%)									
All cases	**749**	**(84.3)**	**831**	**(78.2)**	**1360**	**(81.4)**	**1641**	**(78.2)**	**1849**	**(77.1)**
Previously treated cases	269	(87.9)	361	(81.9)	511	(82.7)	602	(76.5)	731	(79.7)
New cases	401	(85.0)	448	(75.3)	819	(80.8)	961	(79.8)	1023	(76.3)
Unknown	79		22		30		78		95	

* Numbers include cases living in the Eastern Regional Health Authority but treated in another health board area, and exclude cases living in one of the seven health board areas but treated in the Eastern Regional Health Authority and recorded in the NDTRS.
† Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.

Among the cases treated in the seven health board areas between 1998 and 2002 who reported use of a second problem drug, alcohol, ecstasy and cannabis were the second problem drugs most frequently reported (Table 6). The number of cases reporting either alcohol or ecstasy as their second problem drug increased substantially during the period under review. The numbers reporting amphetamines as their second problem drug decreased, while the numbers reporting benzodiazepines, cocaine and opiates increased. Benzodiazepines and opiates as second problem drugs were more frequently reported by previously treated cases than by new cases; cocaine as a second drug was more frequently reported by new cases than by previously treated cases.

Table 6 Second problem drug reported by cases* treated in the seven health board† areas by treatment status and reported to the NDTRS, 1998 to 2002

Second problem drug	1998		1999		2000		2001		2002	
	Number (%)									
All cases	**749**		**831**		**1360**		**1641**		**1848**	
Ecstasy	190	(25.4)	244	(29.4)	406	(29.9)	484	(29.5)	474	(25.6)
Cannabis	169	(22.6)	194	(23.3)	293	(21.5)	379	(23.1)	363	(19.6)
Alcohol	127	(17.0)	138	(16.6)	306	(22.5)	410	(25.0)	620	(33.5)
Amphetamines	118	(15.8)	112	(13.5)	111	(8.2)	70	(4.3)	87	(4.7)
Opiates	45	(6.0)	25	(3.0)	56	(4.1)	53	(3.2)	62	(3.4)
Cocaine	20	(2.7)	38	(4.6)	59	(4.3)	94	(5.7)	106	(5.7)
Benzodiazepines	19	(2.5)	24	(2.9)	40	(2.9)	51	(3.1)	59	(3.2)
Volatile inhalants	2	(0.3)	8	(1.0)	13	(1.0)	18	(1.1)	20	(1.1)
Other substances	59	(7.9)	48	(5.8)	76	(5.6)	82	(5.0)	57	(3.1)
Previously treated cases	**269**		**361**		**511**		**602**		**731**	
Cannabis	70	(26.0)	92	(25.5)	121	(23.7)	163	(27.1)	162	(22.2)
Ecstasy	58	(21.6)	82	(22.7)	126	(24.7)	152	(25.2)	158	(21.6)
Alcohol	41	(15.2)	56	(15.5)	102	(20.0)	131	(21.8)	228	(31.2)
Amphetamines	33	(12.3)	38	(10.5)	42	(8.2)	23	(3.8)	31	(4.2)
Opiates	19	(7.1)	19	(5.3)	28	(5.5)	35	(5.8)	40	(5.5)
Benzodiazepines	14	(5.2)	15	(4.2)	25	(4.9)	34	(5.6)	44	(6.0)
Cocaine	9	(3.3)	23	(6.4)	29	(5.7)	35	(5.8)	35	(4.8)
Volatile inhalants	0	(0.0)	3	(0.8)	4	(0.8)	5	(0.8)	9	(1.2)
Other substances	25	(9.3)	33	(9.1)	34	(6.7)	24	(4.0)	24	(3.3)
New cases	**401**		**448**		**819**		**961**		**1022**	
Ecstasy	106	(26.4)	155	(34.6)	268	(32.7)	306	(31.8)	297	(29.1)
Cannabis	86	(21.4)	98	(21.9)	166	(20.3)	200	(20.8)	181	(17.7)
Alcohol	82	(20.4)	77	(17.2)	197	(24.1)	271	(28.2)	365	(35.7)
Amphetamines	70	(17.5)	70	(15.6)	67	(8.2)	44	(4.6)	53	(5.2)
Opiates	14	(3.5)	5	(1.1)	27	(3.3)	17	(1.8)	21	(2.1)
Cocaine	9	(2.2)	15	(3.3)	30	(3.7)	50	(5.2)	62	(6.1)
Benzodiazepines	4	(1.0)	8	(1.8)	13	(1.6)	15	(1.6)	14	(1.4)
Volatile inhalants	2	(0.5)	5	(1.1)	9	(1.1)	13	(1.4)	10	(1.0)
Other substances	28	(7.0)	15	(3.3)	42	(5.1)	45	(4.7)	19	(1.9)

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Risk behaviours

The number of cases who reported injecting more than doubled, increasing from 148 in 1998 to 342 in 2002 (Table 7). This increase was noted among both new and previously treated cases. Fifty per cent of cases had started injecting before they were 20 years old. Over two-fifths of injector cases had shared injecting equipment. A higher proportion of previously treated injector cases shared injecting equipment than the new cases who injected. Injectors have a higher risk of acquiring blood-borne viral infections and experiencing overdose than non-injectors. This suggests that the drug treatment services require prevention and treatment interventions to deal with blood-borne viruses (in particular HIV, hepatitis B, and hepatitis C) and drug overdose (in particular opiate-related overdoses).

Table 7 Risk behaviours reported by cases* treated in the seven health board† areas by treatment status and reported to the NDTRS, 1998 to 2002

Injecting and sharing status	1998		1999		2000		2001		2002	
All cases injector status known	**766**		**1006**		**1606**		**2028**		**2309**	
Median age (range)‡ started drug use, in years	15	(12-22)	15	(12-22)	15	(11-22)	15	(12-22)	15	(11-22)
Median age (range)‡ started injecting, in years	19	(15-27)	18	(14-28)	19	(14-30)	20	(15-34)	19	(15-28)
Number (%) ever injected	148	(19.3)	181	(18.0)	237	(14.8)	311	(15.3)	342	(14.8)
Of whom:§										
'ever shared'	66	(44.6)	62	(34.3)	101	(42.6)	139	(44.7)	142	(41.5)
'currently injecting'	44	(29.7)	59	(32.6)	88	(37.1)	139	(44.7)	143	(41.8)
'currently sharing'	14	(9.5)	7	(3.9)	20	(8.4)	31	(10.0)	19	(5.6)
Previously treated cases injector status known	**275**		**416**		**593**		**760**		**891**	
Median age (range)‡ started drug use, in years	15	(11-22)	15	(12-23)	15	(11-22)	15	(12-21)	15	(11-23)
Median age (range)‡ started injecting, in years	20	(14-32)	19	(14-27)	19	(14-29)	20	(15-34)	20	(15-29)
Number (%) ever injected	69	(25.1)	123	(29.6)	147	(24.8)	201	(26.4)	204	(22.9)
Of whom:§										
'ever shared'	32	(46.4)	47	(38.2)	67	(45.6)	109	(54.2)	104	(51.0)
'currently injecting'	20	(29.0)	39	(31.7)	49	(33.3)	81	(40.3)	67	(32.8)
'currently sharing'	7	(10.1)	4	(3.3)	12	(8.2)	22	(10.9)	13	(6.4)
New cases injector status known	**439**		**574**		**985**		**1182**		**1299**	
Median‡ age (range)‡ started drug use, in years	15	(12-21)	15	(11-21)	15	(12-22)	15	(12-22)	15	(11-22)
Median age (range)‡ started injecting, in years	17	(15-26)	18	(14-29)	20	(14-30)	21	(15-35)	20	(15-29)
Number (%) ever injected	52	(11.8)	52	(9.1)	80	(8.1)	87	(7.4)	101	(7.8)
Of whom:§										
'ever shared'	18	(34.6)	14	(26.9)	30	(37.5)	27	(31.0)	35	(34.7)
'currently injecting'	9	(17.3)	18	(34.6)	34	(42.5)	40	(46.0)	51	(50.5)
'currently sharing'	3	(5.8)	2	(3.8)	8	(10.0)	9	(10.3)	6	(5.9)

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† Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.
‡ Age range presented is the 5th to 95th percentile (90% of all cases age are within this range).
§ From the data presented in this table, it is not possible to ascertain the exact percentage of injectors with each risk factor of interest because not all declared injectors were asked the subsequent injecting questions.

Socio-demographic characteristics

The median age of previously treated cases attending drug treatment services in the seven health boards increased by two years in the period under review. The median age of new cases showed no particular trend but was lower than the median age of previously treated cases between 1998 and 2002 (Table 8). The proportion of cases less than 18 years of age increased by four per cent over the reporting period. As expected, the proportion of cases less than 18 years of age was much higher among new cases than among those previously treated. Overall, 79 per cent of cases who attended drug treatment services were male. From 1998 to 2002, there was a marginal increase in the proportion of male cases treated for problem drug use. From 2000 to 2002, the proportion of previously treated cases who lived with their parents or family decreased, while the proportion of new cases who lived with parents or family remained similar. The proportion of new and previously treated cases reporting that they were homeless decreased between 1999 and 2002. Overall, 19 per cent of cases left school early during the period under review. The proportions were marginally higher among previously treated cases when compared to new cases. It is clear that early school leavers are over-represented among those seeking treatment for problem drug use but the direct relationship is unclear. From 1999 to 2002, the proportion reporting that they were employed followed national trends, with rates increasing up to 2001 and decreasing by just over three per cent in 2002. Of note, employment rates were higher among new cases compared to their previously treated counterparts, indicating that those with chronic drug problems may be less likely to find or retain employment. This emphasises the importance of close linkages between treatment interventions and social, educational and occupational reintegration programmes.

Table 8 Socio-demographic characteristics of cases* treated in the seven health board† areas by treatment status and reported to the NDTRS, 1998 to 2002

Characteristics‡	1998		1999		2000		2001		2002	
All cases‡	**888**		**1063**		**1671**		**2098**		**2397**	
Median age (range)§ in years	21.7	(16.6-39.1)	22.0	(16.4-38.3)	22.2	(16.0-39.8)	22.8	(15.9-40.9)	23.1	(15.7-42.0)
Number (%) under 18 years of age	123	(14.0)	165	(15.6)	284	(17.0)	354	(16.9)	432	(18.2)
Number (%) of males	666	(77.1)	817	(77.4)	1323	(79.6)	1624	(78.0)	1851	(79.7)
Number (%) living with parents/family	485	(54.6)	675	(63.5)	1038	(62.1)	1216	(58.0)	1405	(58.6)
Number (%) homeless	**		66	(6.2)	90	(5.4)	83	(4.2)	77	(3.4)
Number (%) of early school leavers††	80	(14.5)	138	(19.2)	248	(19.4)	328	(20.8)	308	(17.6)
Number (%) still in school	58	(9.5)	76	(9.6)	143	(10.1)	186	(10.5)	293	(14.3)
Number (%) aged 16 to 64 years employed	252	(30.1)	281	(28.1)	525	(34.0)	660	(34.2)	670	(30.9)
Previously treated cases‡	**306**		**441**		**618**		**787**		**917**	
Median age (range)§ in years	23.5	(16.9-41.5)	24.4	(17.3-43.9)	23.6	(16.8-41.3)	25.0	(17.1-42.2)	25.5	(16.8-46.6)
Number (%) under 18 years of age	30	(9.8)	35	(8.0)	66	(10.7)	68	(8.7)	84	(9.2)
Number (%) of males	225	(75.8)	326	(74.6)	478	(77.3)	599	(76.6)	694	(78.3)
Number (%) living with parents/family	167	(54.6)	240	(54.4)	345	(55.8)	379	(48.2)	447	(48.7)
Number (%) homeless	**		36	(8.2)	38	(6.1)	37	(5.0)	33	(3.9)
Number (%) of early school leavers††	34	(16.3)	58	(19.8)	98	(20.1)	144	(23.5)	142	(20.2)
Number (%) still in school	14	(6.3)	9	(3.0)	27	(5.3)	27	(4.2)	51	(6.7)
Number (%) aged 16 to 64 years employed	70	(23.5)	88	(20.8)	164	(28.2)	217	(29.0)	245	(28.5)
New cases‡	**472**		**595**		**1013**		**1205**		**1341**	
Median age (range)§ in years	20.8	(16.4-37.4)	20.9	(16.1-34.1)	21.3	(15.8-38.3)	21.2	(15.3-38.2)	21.3	(15.3-38.0)
Number (%) under 18 years of age	80	(17.0)	125	(21.1)	215	(21.2)	279	(23.2)	342	(25.7)
Number (%) of males	364	(78.1)	470	(79.3)	812	(80.6)	936	(78.4)	1043	(80.8)
Number (%) living with parents/family	306	(64.8)	442	(70.9)	668	(65.9)	800	(66.4)	891	(66.4)
Number (%) homeless	**		25	(4.2)	47	(4.6)	31	(2.6)	26	(2.0)
Number (%) of early school leavers††	44	(13.2)	75	(18.2)	143	(18.6)	164	(18.4)	150	(15.5)
Number (%) still in school	35	(9.5)	66	(13.8)	113	(12.8)	157	(15.0)	239	(19.8)
Number (%) aged 16 to 64 years employed	145	(32.5)	189	(34.2)	354	(38.1)	416	(38.2)	392	(33.0)

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‡ It is not possible to ascertain the percentage with each characteristic of interest from the total number because not all forms had complete data.
§ Age range presented is the 5th to 95th percentile (90% of all cases age are within this range).
** Data not available
†† Left school before the age of 15 years.

Conclusions

The number of new and previously treated cases in the seven health board areas and reported to the NDTRS trebled between 1998 and 2002. For each of the years under review, more than half of those treated were being treated for the first time. Both new and previously treated cases in the seven health board areas most frequently reported that cannabis was their main problem drug between 1998 and 2002. Opiate use was common in the health board areas in close proximity to the Eastern Regional Health Authority area. The wide spectrum of problem drug types reported indicates that treatment services need to cater for a number of licit and illicit drugs used rather than focusing on one or two drugs. Alcohol and ecstasy are important second drugs, and as such need to be addressed in treatment programmes. Polydrug use remained a common practice that needs to be addressed in a client's treatment plan. The number of cases who reported injecting trebled and this suggests that the drug treatment services outside the ERHA require prevention, harm reduction and treatment interventions to deal with blood-borne viruses (in particular HIV, hepatitis B, and hepatitis C) and drug overdose (in particular opiate-related overdoses). A sizeable number of cases in the seven health board areas were under 18 years old and these require different approaches to treatment; it is important that this is recognised in service planning. The low levels of educational achievement and employment among chronic problem drug users emphasises the importance of close links between treatment interventions and social, educational and occupational reintegration programmes.

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