Drug Misuse Research Division

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

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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 Southern Health Board (SHB) 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 SHB 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 drug use problems. At national level, anonymous, aggregated data are compiled by the Drug Misuse Research Division, Health Research Board.

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 informing local and national drug policies. Based on NDTRS data a number of local areas were targeted for special attention in 1996 (Ministerial

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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 objective of drug policy in the SHB area is to strive for abstinence from drug use

The objective of drug policy in the SHB area is to strive for abstinence from drug use (Collins, 1999). Drug strategies promote healthy lifestyles; and the implementation of drug prevention programmes are encouraged and supported in schools and youth clubs throughout the area. Addiction counselling services are provided and where possible family members are involved. Medical treatment services are available through the Community Care Programme, and where necessary, are supported by general practitioners, and psychiatric and general hospital services. In certain circumstances treatment places are purchased elsewhere in order to meet needs, for example, from a specialised treatment centre for adolescents in the South Eastern Health Board area (County Kilkenny) (Collins, 1999).

Drug treatment services in the SHB area, reporting to the NDTRS during 2000, were provided by eight agencies: three residential and five non-residential. Out of a total number of 429, 94 percent of clients were treated in non-residential centres. This is a reflection of drug treatment service provision in the SHB, the aim of which is to offer treatment on an outpatient basis. The *type* of drug treatment provided/availed of was mainly advice/counselling/support (N=404). In fact the treatment provided to any one individual can be a combination of a number of options. During 2000, as well as addiction counselling, about a quarter of clients (N=110) received 'medicament free/psychosocial therapy'; and another quarter (N=98) were involved in 'social/occupational reintegration' programmes. Eighteen people (4 percent) underwent detoxification, of whom 12 had used an opiate as their main drug of misuse. A very small minority of people (N=3) were treated, as part of their treatment, in a drug substitution/maintenance programme.

Extent of the problem

During 2000, 503 SHB residents were treated for problem drug use

In the four years between 1996 and 1999 the number of drug users presenting for treatment[2] in the SHB area remained fairly stable at less than 300, fluctuating between 281 in 1996 and 258 in 1999 (Table 1a). However, this trend changed in 2000 with an increase of 66 percent, from 258 contacts in 1999 to 429 in 2000. This was due in part to an increase in service provision, and partly to an increase in drug use. These statistics include a small number of people from outside the SHB catchment area, for example in 2000, 7 non-residents were treated in the SHB. Almost all of those who received treatment in the SHB during 2000 were residents of the area (422/429) (Table 1a). Altogether, 503 SHB residents were treated for problem drug use; 16 percent of these were treated outside of the area (N=81), mainly at treatment services in the South Eastern and Mid Western Health Board areas.

[1] Counties Cork and Kerry

[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 SHB (Cork & Kerry)

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

Year	Total treated in SHB	SHB residents treated in SHB	SHB residents treated elsewhere	Others treated in SHB	Total SHB residents treated
1996	281	276	30	5	306
1997	230	218	42	12	260
1998	263	252	51	11	303
1999	258	247	61	11	308
2000	429	422	81**	7	503**

* 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

More than half of those treated each year are receiving treatment for the first time (first contacts). The number of first contacts increased from 185 in 1996 to 262 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 SHB	SHB residents treated in SHB	SHB residents treated elsewhere	Others treated in SHB	Total SHB residents treated
1996	185	182	16	3	198
1997	129	122	11	7	133
1998	169	164	20	5	184
1999	149	144	24	5	168
2000	262	257	40**	5	297**

* 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 early twenties and living in the family home. The mean age for all clients was 25 years in 2000, somewhat older than in 1996 when it was 22 years of age (Table 2a). Fewer clients are living with family – the proportion fell from 68 percent in 1996 to 54 percent in 2000. On closer examination of the data it emerges that more people are living alone. In educational terms the proportion of those who had left school before the official school-leaving age of 15 showed an increasing trend from 5 percent in 1996 to 21 percent in 2000 (Table 2a). Some of the social conditions of clients are improving. Employment levels improved from 21 percent in 1996 to 35 percent in 2000. This is as might be expected, given the general favourable economic conditions in the country.

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

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

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	73:27	67:33	72:28	72:28	74:26
Mean age (years)	22	24	24	22	25
Modal age (years)	17	17	19	18	18
% Under 18 years of age	31	24	21	26	19
% Living with parents/family	68	57	64	62	54
% Early school leavers*	5	10	13	19	21
% Still at school	28	21	9	15	10
% Employed	21	22	29	25	35

* Left school before the age of 15 years

Trends among new clients are similar to those of the overall group of all contacts (Table 2b).

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

Characteristics	1996	1997	1998	1999	2000
% Males : % Females	73:27	65:35	75:25	74:26	77:23
Mean age (years)	21	23	23	20	24
Modal age (years)	16	17	17	18	20
% Under 18 years of age	35	29	25	34	24
% Living with parents/family	73	60	66	74	60
% Early school leavers*	7	5	12	18	19
% Still at school	30	27	12	22	13
% Employed	22	25	34	27	38

* Left school before the age of 15 years

Problem drug use

Trends over the period 1996 to 2000 show an increase in the misuse of cannabis

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 Southern Health Board area 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 an increase in the misuse of cannabis (Table 3a), from almost a half of all those receiving treatment in 1996, to nearly two-thirds in 2000. In contrast to this, there was a decrease in ecstasy as the main drug of misuse. Opiate misuse trends fluctuated from 5 percent in 1996 to 15 percent in 1997, and 10 percent in 2000. The *number* of all (opiate) contacts increased from 14 in 1996 to 41 in 2000, indicating an upward trend in opiate misuse.

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

Main Drug of Misuse	1996		1997		1998		1999		2000	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Opiates	14	(5)	35	(15)	31	(12)	33	(13)	41	(10)
Cocaine	0	(0)	3	(1)	3	(1)	9	(3)	8	(2)
Ecstasy	85	(30)	91	(40)	81	(31)	51	(20)	62	(15)
Amphetamines	4	(1)	2	(1)	3	(1)	3	(1)	1	(0)
Benzodiazepines	10	(4)	9	(4)	13	(5)	9	(3)	18	(4)
Volatile Inhalants	4	(1)	1	(0)	7	(3)	7	(3)	7	(2)
Cannabis	138	(49)	79	(34)	109	(41)	142	(55)	278	(65)
Other substances	26	(9)	10	(4)	16	(6)	4	(2)	14	(3)
Total	281		230		263		258		429	

Opiate misuse among first contacts is quite low

Trends were similar among the sub-group of new clients (first contacts), albeit at a slightly higher level for cannabis and ecstasy use (Table 3b). Opiate misuse among first contacts is quite low. The number of opiate users increased from 7 in 1996 to 16 in 2000 (Table 3b).

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

Main Drug of Misuse	1996		1997		1998		1999		2000	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Opiates	7	(4)	11	(9)	15	(9)	11	(7)	16	(6)
Cocaine	0	(0)	2	(2)	2	(1)	5	(3)	2	(1)
Ecstasy	63	(34)	60	(47)	51	(30)	30	(20)	42	(16)
Amphetamines	3	(2)	1	(1)	2	(1)	1	(1)	1	(0)
Benzodiazepines	5	(3)	4	(3)	8	(5)	3	(2)	9	(3)
Volatile Inhalants	3	(2)	1	(1)	5	(3)	6	(4)	4	(2)
Cannabis	95	(51)	45	(35)	78	(46)	92	(62)	182	(69)
Other substances	9	(5)	5	(4)	8	(5)	1	(1)	6	(2)
Total	185		129		169		149		262	

A closer scrutiny reveals that while heroin use is at a low level it is on the increase, from 3 in 1996 to 21 in 2000 (Table 4a). The fact that in 2000 heroin was more likely to be injected than smoked has serious health implications. The use of other opiates increased from 11 in 1996 to 20 in 2000. The 'other opiate' category includes drugs such as codeine, dihydrocodeine, and methadone.

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	3	15	10	16	21
of whom:					
injected	0	9	7	5	12
smoked	3	5	2	11	8
other route	0	1	1	0	1
Other Opiates	11	20	21	17	20
Total	14	35	31	33	41

Among new clients the number using heroin is low, but again is increasing, from 1 in 1996 to 9 in 2000 (Table 4b).

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

Main Drug / Route of Administration	1996 N	1997 N	1998 N	1999 N	2000 N
Heroin	1	5	7	5	9
of whom:					
injected	0	3	4	0	5
smoked	1	2	2	5	3
other route	0	0	1	0	1
Other Opiates	6	6	8	6	7
Total	7	11	15	11	16

Clients are likely to be involved in the use of more than one drug (Table 5a). Trends in secondary drug use present a picture of increasing polydrug use. In 2000 alcohol[3] was reported as a secondary drug in about one-third of cases. Although treatment for ecstasy as a main problem drug was found to be decreasing (Table 3a), secondary drug use trends showed an increase in ecstasy use (Table 5a). In most instances (98 percent) where ecstasy was the secondary drug, the main drug of misuse was cannabis. This suggests an increase in the use of both cannabis and ecstasy.

Clients are likely to be involved in the use of more than one drug

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

Secondary Drug of Misuse	1996 N	1996 (%)	1997 N	1997 (%)	1998 N	1998 (%)	1999 N	1999 (%)	2000 N	2000 (%)
No second drug	26	(9)	16	(7)	27	(10)	24	(9)	16	(4)
Opiates	7	(3)	13	(6)	2	(1)	11	(4)	19	(4)
Cocaine	1	(0)	4	(2)	5	(2)	5	(2)	17	(4)
Ecstasy	51	(18)	40	(17)	45	(17)	60	(23)	121	(28)
Amphetamines	9	(3)	8	(3)	6	(2)	10	(4)	9	(2)
Benzodiazepines	5	(2)	12	(5)	8	(3)	10	(4)	17	(4)
Volatile Inhalants	1	(0)	0	(0)	1	(0)	2	(1)	1	(0)
Cannabis	63	(22)	58	(25)	68	(26)	50	(19)	52	(12)
Alcohol	101	(36)	60	(26)	76	(29)	82	(32)	163	(38)
Other substances	17	(6)	18	(8)	25	(10)	4	(2)	14	(3)
Total	281		230*		263		258		429	

* Percentages based on valid N of 229

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

The same trends are true for new clients (Table 5b).

Table 5b. Secondary Drug of Misuse of First Treatment Contacts treated in the SHB, 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	(11)	12	(9)	21	(12)	15	(10)	10	(4)
Opiates	4	(2)	3	(2)	0	(0)	1	(1)	10	(4)
Cocaine	1	(1)	2	(2)	4	(2)	3	(2)	7	(3)
Ecstasy	32	(17)	22	(17)	26	(15)	38	(26)	77	(29)
Amphetamines	6	(3)	3	(2)	5	(3)	6	(4)	5	(2)
Benzodiazepines	2	(1)	4	(3)	3	(2)	2	(1)	4	(2)
Volatile Inhalants	1	(1)	0	(0)	1	(1)	1	(1)	1	(0)
Cannabis	43	(23)	38	(30)	40	(24)	29	(19)	29	(11)
Alcohol	65	(35)	35	(27)	55	(33)	54	(36)	112	(43)
Other substances	11	(6)	9	(7)	14	(8)	0	(0)	7	(3)
Total	185		129*		169		149		262	

* Percentages based on valid N of 128

Risk behaviour

Over the five-year period the mean age of initial drug use was very young at 15 or 16 years of age (Tables 6a, 6b). A relatively small number of clients (26 in 2000) had injected at some time. Injecting practices were not presenting as a major problem – in 2000, 8 all contacts and 5 first contacts were 'currently injecting' (Table 6a, 6b).

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

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	15	16	16	15	16
Mean age 1st injected (years)	24	21	21	18	22
Ever Injected N	14	29	22	15	26
of whom:					
'ever shared' N	6	9	6	3	10
'currently injecting' N	1	10	7	3	8
'currently sharing' N	0	2	2	0	2

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

However, while the numbers who had ever injected are relatively small, the fact that an increasing proportion of new clients are involved in injecting and sharing practices raises cause for concern and cannot be ignored (Table 6b).

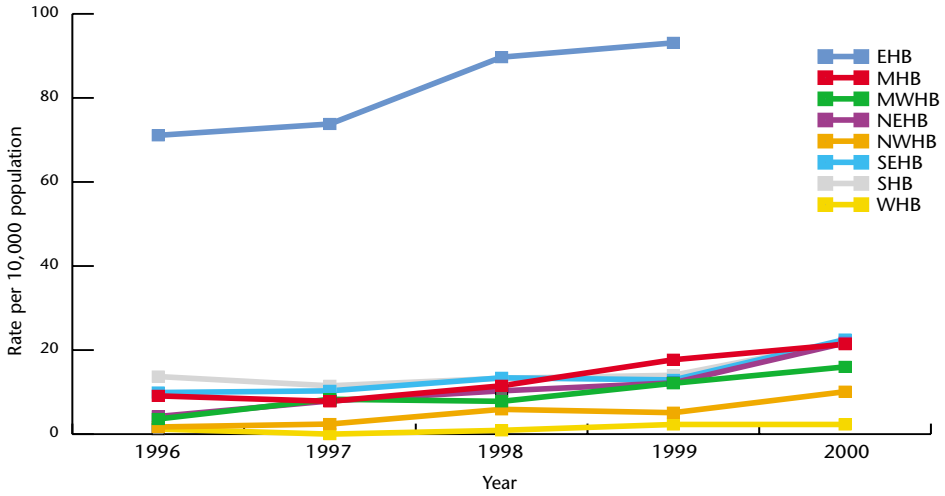
Table 6b. Risk Behaviours of First Treatment Contacts treated in the SHB, 1996-2000

Risk Behaviours	1996	1997	1998	1999	2000
Mean age of initial drug use (years)	15	16	16	15	16
Mean age 1st injected (years)	21	25	19	20	24
Ever Injected N	5	8	11	4	12
of whom:					
'ever shared' N	4	3	3	0	5
'currently injecting' N	1	1	4	1	5
'currently sharing' N	0	0	1	0	1

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).

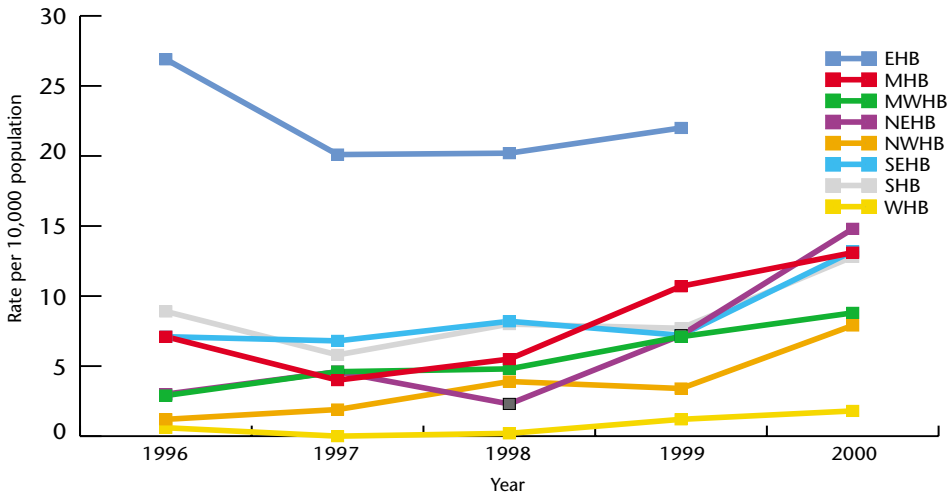
Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population **



* 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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