Drug Misuse Research Division

Occasional Paper No. 3/ 2002

# Trends in Treated Drug Misuse in the Midland 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 Midland Health Board (MHB) 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. Compliance with the NDTRS requires that a form be completed for each person who receives treatment for problematic drug use. At national level, aggregated anonymous data are compiled by the Drug Misuse Research Division (DMRD), Health Research Board (HRB).

For the purpose of the NDTRS, *treatment* is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems'. Treatment may therefore include non-medical (addiction counselling, group therapy, psychotherapy), as well as medical interventions (detoxification, methadone substitution programmes).

The main elements of the reporting system are:

a) *All Treatment Contacts* – the reporting of *all* clients receiving treatment during a given year, and

b) *First Treatment Contacts* – the reporting of the sub-group of clients who have *never* previously been treated for problem drug use.

In the case of the 'all contact' data there is a possibility of duplication of individuals 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).

The MHB is committed to the establishment and development of standardised mechanisms for data collection relevant to ongoing monitoring of service delivery levels, needs assessment and service planning (Midland Health Board, 1999).

# Treatment provision

With the recognition that there can be serious risk of damage to the health and well being of individuals by the misuse of psychoactive substances, the emphasis of drug policy in the MHB area is on education and prevention (Department of Public Health, 1999). The policy, which is set in the wider context of health promotion, aims to adopt a multi-stranded, multi-agency approach involving mainstream health services, an Garda Siochána, parents and youth and community services (http://www.mhb.ie).

The emphasis of drug policy in the MHB area is on education and prevention

Drug treatment in the MHB area is provided by two main services: the *Community and Alcohol Addiction Service* and the *Laois/Offaly Mental Health Service.* Data for the NDTRS during 2000 were collected at seven locations. All 150 contacts during 2000 were treated in non-residential centres. The type of drug treatment provided/availed of was mainly advice/counselling/support (N=142). The treatment provided to any one individual may include a combination of options. During 2000, as well as addiction counselling, 30 clients participated in a drug substitution/maintenance programme, and 11 clients underwent detoxification from drugs.

# Extent of the problem

The number of drug users presenting for treatment in the MHB has more than doubled in the five-year period 1996 to 2000. In 1996, 63 clients received treatment[2] for problematic drug use in the MHB area. By 2000 the number had increased to 150 (Table 1a). Each year, except 1999, the number treated in the MHB catchment area was less than the total number of MHB residents who received treatment. In 2000, for example, 18 residents of the MHB area were treated elsewhere (Table 1a).

During 2000, 168 MHB residents were treated for problem drug use

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

| Year | Total treated in MHB | MHB residents treated in MHB | MHB residents treated elsewhere | Others treated in MHB | Total MHB residents treated |
|---|---|---|---|---|---|
| 1996 | 63 | 62 | 8 | 1 | 70 |
| 1997 | 61 | 61 | 5 | 0 | 66 |
| 1998 | 85 | 85 | 11 | 0 | 96 |
| 1999 | 128 | 127 | 16 | 1 | 143 |
| 2000 | 150 | 150 | 18** | 0 | 168** |

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

[1] Counties Laois, Longford, Offaly and Westmeath

[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 MHB (Counties Laois, Longford, Offaly and Westmeath)

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 49 in 1996 to 87 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 MHB | MHB residents treated in MHB | MHB residents treated elsewhere | Others treated in MHB | Total MHB residents treated |
|---|---|---|---|---|---|
| 1996 | 49 | 48 | 6 | 1 | 54 |
| 1997 | 34 | 34 | 2 | 0 | 36 |
| 1998 | 39 | 39 | 7 | 0 | 46 |
| 1999 | 76 | 76 | 8 | 0 | 84 |
| 2000 | 87 | 87 | 13** | 0 | 100** |

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

# Socio-demographic information

The typical client coming for treatment is male, in his late teens or early twenties and living in the family home. Clients were slightly older in 2000 than in 1996 - the mean age for all contacts increased from 22 in 1996 to 24 years of age in 2000; the most frequently occurring age (modal age) increased from 19 in 1996 to 23 years of age in 2000 (Table 2a). The educational profile of clients did not improve over the period 1996 to 2000 - in 2000 they were more likely to have left school before the official school leaving age of 15 years (23 percent) compared to 1996 (10 percent) (Table 2a). One aspect of the social condition of clients did improve remarkably - the employment level increased from 13 percent in 1996 to 41 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 late teens or early twenties and living in the family home

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

| Characteristics | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|
| % Males : % Females | 90:10 | 92:08 | 86:14 | 85:15 | 82:18 |
| Mean age (years) | 22 | 24 | 24 | 23 | 24 |
| Modal age (years) | 19 | 19 | 20 | 18, 20 | 23 |
| % Under 18 years of age | 19 | 18 | 13 | 19 | 10 |
| % Living with parents/family | 71 | 66 | 67 | 74 | 63 |
| % Early school leavers* | 10 | 16 | 14 | 17 | 23 |
| % Still at school | 14 | 20 | 14 | 15 | 8 |
| % Employed | 13 | 18 | 24 | 34 | 41 |

* Left school before the age of 15 years

Trends in 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 MHB, 1996-2000**

| Characteristics | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|
| % Males : % Females | 91:09 | 91:09 | 87:13 | 88:12 | 83:17 |
| Mean age (years) | 21 | 22 | 21 | 21 | 22 |
| Modal age (years) | 19 | 19 | 18, 20 | 18 | 20 |
| % Under 18 years of age | 20 | 27 | 19 | 22 | 15 |
| % Living with parents/family | 82 | 74 | 68 | 79 | 67 |
| % Early school leavers* | 8 | 14 | 14 | 15 | 26 |
| % Still at school | 13 | 31 | 19 | 20 | 12 |
| % Employed | 16 | 18 | 21 | 38 | 45 |

* Left school before the age of 15 years

# Problem drug use

Information on 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 MHB 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 67 percent in 1996 to 45 percent in 2000 (Table 3a). Unlike most other regions where cannabis is usually followed by ecstasy as the main drug of misuse, in the MHB cannabis is followed by opiates as the main drug of choice. Since 1997, (after cannabis) opiates are the drugs causing problems and for which people present for treatment. Opiate use shows an increasing trend from 11 percent in 1996 to 38 percent in 2000.

Cannabis is followed by opiates as the main drug of choice

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

| Main Drug of Misuse | 1996 N | (%) | 1997 N | (%) | 1998 N | (%) | 1999 N | (%) | 2000 N | (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Opiates | 7 | (11) | 8 | (13) | 23 | (27) | 35 | (27) | 57 | (38) |
| Cocaine | 0 | (0) | 0 | (0) | 0 | (0) | 0 | (0) | 2 | (1) |
| Ecstasy | 8 | (13) | 6 | (10) | 5 | (6) | 11 | (9) | 19 | (13) |
| Amphetamines | 1 | (2) | 2 | (3) | 2 | (2) | 4 | (3) | 1 | (1) |
| Benzodiazepines | 0 | (0) | 2 | (3) | 2 | (2) | 1 | (1) | 1 | (1) |
| Volatile Inhalants | 4 | (6) | 5 | (8) | 5 | (6) | 1 | (1) | 2 | (1) |
| Cannabis | 42 | (67) | 37 | (61) | 46 | (54) | 74 | (58) | 67 | (45) |
| Other substances | 1 | (2) | 1 | (2) | 2 | (2) | 2 | (2) | 1 | (1) |
| Total | 63 | | 61 | | 85 | | 128 | | 150 | |

There is a trend towards increasing opiate use among new clients

A cause for concern is the fact that there is a similar trend of increasing opiate use among new clients (first contacts). While the numbers are relatively small, the proportion of people presenting for treatment of problematic opiate use increased from 8 percent (N=4) in 1996 to 25 percent (N=22) in 2000 (Table 3b). The increase could be partly explained by an increase in service provision, but undoubtedly also points to an increase in opiate use.

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

| Main Drug of Misuse | 1996 N | (%) | 1997 N | (%) | 1998 N | (%) | 1999 N | (%) | 2000 N | (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Opiates | 4 | (8) | 1 | (3) | 7 | (18) | 8 | (11) | 22 | (25) |
| Cocaine | 0 | (0) | 0 | (0) | 0 | (0) | 0 | (0) | 1 | (1) |
| Ecstasy | 7 | (14) | 4 | (12) | 4 | (10) | 9 | (12) | 13 | (15) |
| Amphetamines | 1 | (2) | 2 | (6) | 0 | (0) | 1 | (1) | 0 | (0) |
| Benzodiazepines | 0 | (0) | 2 | (6) | 0 | (0) | 1 | (1) | 1 | (1) |
| Volatile Inhalants | 3 | (6) | 3 | (9) | 3 | (8) | 1 | (1) | 2 | (2) |
| Cannabis | 33 | (67) | 22 | (65) | 23 | (59) | 55 | (72) | 48 | (55) |
| Other substances | 1 | (2) | 0 | (0) | 2 | (5) | 1 | (1) | 0 | (0) |
| Total | 49 | | 34 | | 39 | | 76 | | 87 | |

A closer scrutiny of all treatment contacts reveals that heroin was the opiate most likely to be used and that the *number* increased from 6 (10 percent of the total number treated) in 1996 to 56 in 2000 (37 percent of the total treated) (Table 4a). The fact that heroin was more likely to be injected than smoked has serious health implications (Table 4a).

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

| Main Drug / Route of Administration | 1996 N | 1997 N | 1998 N | 1999 N | 2000 N |
|---|---|---|---|---|---|
| Heroin | 6 | 7 | 19 | 33 | 56 |
| of whom: | | | | | |
| inject | 3 | 6 | 10 | 22 | 33 |
| smoke | 3 | 1 | 9 | 11 | 22 |
| other | 0 | 0 | 0 | 0 | 0 |
| not known | 0 | 0 | 0 | 0 | 1 |
| Other Opiates | 1 | 1 | 4 | 2 | 1 |
| Total | 7 | 8 | 23 | 35 | 57 |

While heroin use is relatively low among new clients there is a trend towards increasing use, leaving no room for complacency (Table 4b).

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

| Main Drug / Route of Administration | 1996 N | 1997 N | 1998 N | 1999 N | 2000 N |
|---|---|---|---|---|---|
| Heroin | 3 | 1 | 7 | 8 | 22 |
| of whom: | | | | | |
| inject | 1 | 1 | 2 | 3 | 6 |
| smoke | 2 | 0 | 5 | 5 | 16 |
| other route | 0 | 0 | 0 | 0 | 0 |
| Other Opiates | 1 | 0 | 0 | 0 | 0 |
| Total | 4 | 1 | 7 | 8 | 22 |

Polydrug use is very much a feature of drug use patterns. The proportion of clients involved in the use of more than one drug increased over the five-year period, from 59 percent in 1996, to 73 percent in 2000 (Table 5a). Cannabis and ecstasy are the drugs most likely to be reported and show an increasing trend. Very few cases of alcohol[3] use are reported, and considering that 'a high prevalence' of alcohol use was highlighted in a study of midlands youth (Sheerin, 1999: 37), it is surprising that this is not reflected in the returns to the NDTRS. However, the fact that 'there was widespread consensus among young people that drinking is generally 'not a problem'' (Sheerin, 1999: 38), may explain why young people are not presenting for treatment of alcohol 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 MHB, 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 | (41) | 18 | (30) | 23 | (27) | 46 | (36) | 41 | (27) |
| Opiates | 3 | (5) | 3 | (5) | 0 | (0) | 0 | (0) | 0 | (0) |
| Cocaine | 1 | (2) | 0 | (0) | 0 | (0) | 2 | (2) | 6 | (4) |
| Ecstasy | 8 | (13) | 15 | (25) | 18 | (21) | 35 | (27) | 39 | (26) |
| Amphetamines | 2 | (3) | 1 | (2) | 12 | (14) | 13 | (10) | 4 | (3) |
| Benzodiazepines | 1 | (2) | 2 | (3) | 2 | (2) | 2 | (2) | 8 | (5) |
| Volatile Inhalants | 0 | (0) | 0 | (0) | 0 | (0) | 1 | (1) | 1 | (1) |
| Cannabis | 7 | (11) | 10 | (16) | 21 | (25) | 26 | (20) | 46 | (31) |
| Alcohol | 10 | (16) | 6 | (10) | 3 | (4) | 2 | (2) | 3 | (2) |
| Other substances | 5 | (8) | 6 | (10) | 6 | (7) | 1 | (1) | 2 | (1) |
| Total | 63 | | 61 | | 85 | | 128 | | 150 | |

A majority of new clients were polydrug users (Table 5b). Trends among new clients were similar to those among all contacts, except that in 2000 first contacts were more likely than the overall group of all contacts to use ecstasy than cannabis (Table 5b).

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

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

| Secondary Drug of Misuse | 1996 N | 1996 (%) | 1997 N | 1997 (%) | 1998 N | 1998 (%) | 1999 N | 1999 (%) | 2000 N | 2000 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| No second drug | 22 | (45) | 11 | (32) | 10 | (26) | 35 | (46) | 28 | (32) |
| Opiates | 2 | (4) | 2 | (6) | 0 | (0) | 0 | (0) | 0 | (0) |
| Cocaine | 1 | (2) | 0 | (0) | 0 | (0) | 0 | (0) | 2 | (2) |
| Ecstasy | 5 | (10) | 8 | (24) | 8 | (21) | 25 | (33) | 29 | (33) |
| Amphetamines | 2 | (4) | 1 | (3) | 5 | (13) | 7 | (9) | 2 | (2) |
| Benzodiazepines | 0 | (0) | 1 | (3) | 0 | (0) | 0 | (0) | 1 | (1) |
| Volatile Inhalants | 0 | (0) | 0 | (0) | 0 | (0) | 0 | (0) | 0 | (0) |
| Cannabis | 6 | (12) | 5 | (15) | 10 | (26) | 9 | (12) | 24 | (28) |
| Alcohol | 6 | (12) | 2 | (6) | 3 | (8) | 0 | (0) | 0 | (0) |
| Other substances | 5 | (10) | 4 | (12) | 3 | (8) | 0 | (0) | 1 | (1) |
| Total | 49 | | 34 | | 39 | | 76 | | 87 | |

# Risk behaviour

Mean age of initial drug use remained consistently young at 16 or 17 years of age

Over the five-year period the mean age of initial drug use remained consistently young at 16 or 17 years of age (Tables 6a). There was an increase in injecting drug use. The *number* of clients who had ever injected was relatively low, but increased from 6 in 1996 to 45 in 2000. Of these, a sizeable proportion engaged in high risk behaviour: in 2000, more than two-thirds (31 out of 45) had shared injecting equipment, and a third (16 out of 45) were currently injecting drugs (Table 6a). The age at which they started to inject was between 2 years (in 1997) and 4 years (2000) after initial drug use. The increasing trend of injecting drug use 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 MHB, 1996-2000**

| Risk Behaviours | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|
| Mean age of initial drug use (years) | 16 | 17 | 17 | 16 | 16 |
| Mean age 1st injected (years) | 20 | 19 | 22 | 19 | 20 |
| Ever Injected N | 6 | 8 | 12 | 28 | 45 |
| of whom: | | | | | |
| 'ever shared' N | 3 | 5 | 5 | 15 | 31 |
| 'currently injecting' N | 1 | 4 | 6 | 5 | 16 |
| 'currently sharing' N | 1 | 2 | 3 | 1 | 6 |

Among the first contact sub-group the *number* who had ever injected is low, but it is also increasing (from 3 in 1996 to 12 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 MHB, 1996-2000**

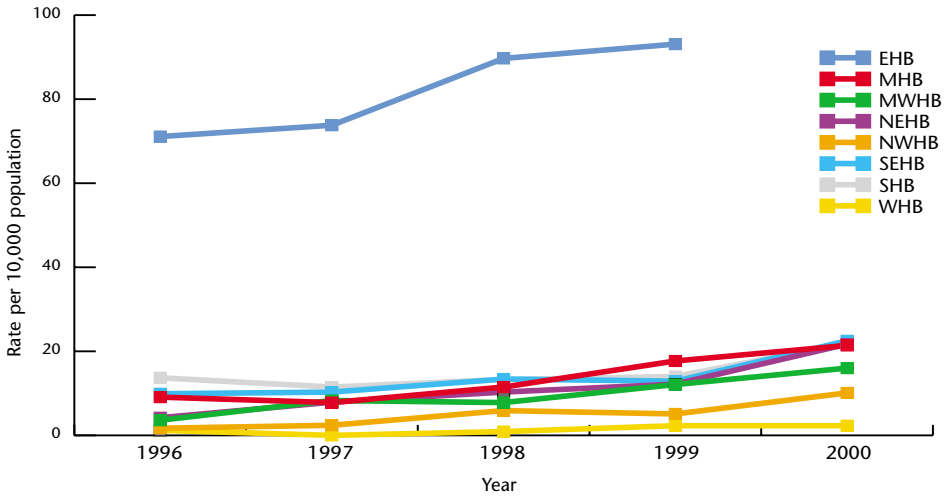
| Risk Behaviours | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|
| Mean age of initial drug use (years) | 16 | 17 | 16 | 16 | 15 |
| Mean age 1st injected (years) | 21 | Na | 16 | 19 | 21 |
| Ever Injected N | 3 | 1 | 3 | 4 | 12 |
| of whom: | | | | | |
| 'ever shared' N | 2 | 1 | 1 | 2 | 5 |
| 'currently injecting' N | 0 | 1 | 0 | 1 | 6 |
| 'currently sharing' N | 0 | 1 | 0 | 0 | 3 |

Na: Not available

# Regional trends

Figures 1a and 1b provide a comparison of the rates of treated drug misuse among residents in different health board areas of Ireland for all and first treatment contacts respectively. As the majority of people treated for problem drug use are in the 15-39 year age group, the rates were based on this age group of the population in each health board area. It is immediately obvious that in the ERHA health board areas (formerly EHB) the rate is much higher than in other regions of the country. However, there is not great variation in regional trends. In all cases the trend shows an increase in those presenting to drug treatment services (Figure 1a).

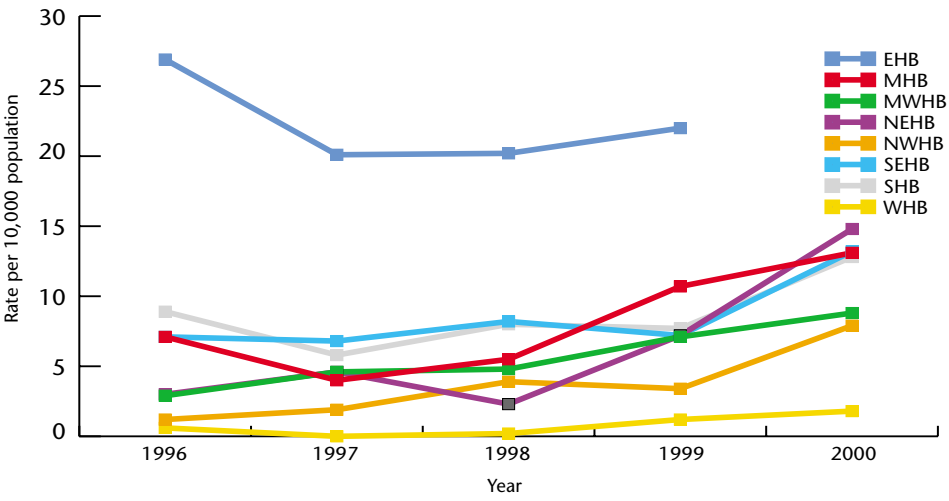
**Figure 1a. Trends in All Treatment Contact rates for 15 - 39 year olds by Health Board of Residence, 1996-2000*. Rates per 10,000 population ****




* Trends for 1996-1999 only in the EHB due to incomplete returns for 2000
** Population figures for each health board are based on the Census for Population 1996, Central Statistics Office

There was an upward trend in first treatment contacts between 1996 and 2000 in all regions (Figure 1b). Increased provision of services at individual health board level is of course a factor that must be borne in mind when considering such trends. Where there are accessible drug user oriented services provided, people are more likely to approach them. However, it would appear that the upward trends also indicate a real increase in drug misuse.

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




* Trends for 1996-1999 only in the EHB due to incomplete returns for 2000
** Population figures for each health board are based on the Census for Population 1996, Central Statistics Office

# References


Department of Public Health (1999). *Substance Misuse. Education and Prevention Policy.* Tullamore, Co. Offaly: Department of Public Health, Midland Health Board.

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

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.

Midland Health Board (1999). *Report of Working Party on Misuse of Drugs and Alcohol.* Tullamore, Co. Offaly: Midland Health Board.

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

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

Sheerin, E. (1999). *Life as it is. Values, attitudes and norms from the perspective of midlands youth.* Midland Health Board & Midland Regional Youth Council.


# 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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