

Trends in treated problem drug use in Ireland 2005 to 2010

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National Drug
Treatment
Reporting System

Summary

This paper describes trends in treated problem drug use in Ireland between 2005 and 2010. The analysis presented is based on data reported to the National Drug Treatment Reporting System (NDTRS) and to the Central Treatment List (CTL).

It is important to note that each record in the NDTRS database relates to a treatment episode (a case), and not to a person. This means that the same person could be counted more than once in the same calendar year if he/she had more than one treatment episode in that year.

The main findings of the analysis are:

The **total number of cases in treatment** for problem drug use increased over the reporting period, from 12,101 in 2005 to 16,429 in 2010.

The number of cases **entering** drug treatment each year and reported to the NDTRS increased by 52%, from 5,176 in 2005 to 7,878 in 2010. The clear spread and increase in treated drug use throughout the country reflect not only the extent of problem drug use but also an increase in treatment availability and compliance with the NDTRS.

Both the incidence (new cases) and the prevalence (all cases) of treated problem drug use among 15–64-year-olds living in Ireland increased consistently over the reporting period. The incidence increased from 70 cases per 100,000 in 2005 to 106 cases in 2010. The number of new cases entering treatment is an indirect indicator of recent trends in problem drug use. The prevalence increased from 423 cases per 100,000 in 2005 to 544 cases in 2010.

There was an increase in the total number of drug treatment services available in Ireland and participating in the NDTRS between 2005 and 2010. In the six-year period, the majority (68%) of cases received treatment in outpatient settings. Of the 7,878 cases who entered treatment in 2010, the majority (58%) received counselling, 32% received a brief intervention, 25% received methadone substitution and 23% attended education/awareness programmes.

For the six-year period, the highest proportion (35%) of cases lived in the HSE Dublin Mid-Leinster Region; 27% lived in the Dublin North East Region, 25% in the South and 13% in the West. There was a decrease in the proportions of cases in both Dublin regions and a parallel increase in the South and West regions, especially among previously treated cases.

Analysis by regional drugs task force (RDTF) area shows that the average annual incidence of treated drug use per 100,000 15–64-year-olds was highest in the South East RDTF area, followed by the North Dublin and the Southern RDTF areas.

Opiates (mainly heroin) were the most common problem drugs reported for all years, with the proportion of opiate users remaining stable between 2005 and 2008 but decreasing slightly in the following two years. The number of cases reporting cannabis as their main problem substance increased significantly over the reporting period, from 1,039 in 2005 to 1,893 in 2010. The number of cases reporting cocaine as their main problem substance peaked in 2007 and decreased slightly in the following years. Head shop compounds were reported as a main problem substance for the first time in 2009 (17 cases), with the number increasing significantly to 213 cases in 2010, when it exceeded the numbers reporting amphetamines, ecstasy and volatile inhalants.

The use of more than one problem substance continues to present a challenge to the treatment services. The vast majority (68%) of cases treated between 2005 and 2010 reported problem use of more than one substance. Cannabis, alcohol, cocaine and benzodiazepines were the most common additional problem drugs reported by all cases entering treatment. Information about the combinations of drugs used is important in terms of individual clients' care plans, and in terms of policy initiatives.

Data show that half of the new cases entering treatment between 2005 and 2010 had started drug use at or before the age of 15 years. This finding highlights the need for prevention measures and service initiatives specially targeted at young teenagers in an attempt to delay initiation to drug use.

The proportion of previously treated cases who reported ever injecting decreased steadily over the reporting period, falling from 66% in 2005 to 48% in 2010; the proportion who were currently injecting, and the proportion who had ever shared injecting equipment also decreased. Although the proportion of new cases who reported ever injecting increased from 19% in 2005 to 22% in 2008, the overall downward trend in the proportions of injector cases is reflected among new cases in 2009 and 2010. The growth in harm reduction services over the reporting period is likely to have influenced this progress.

The profile of cases entering drug treatment remained stable over the reporting period; in general, problem drug users were male and in their twenties. The proportion of new cases aged under 18 years has increased since 2007 and reached 16% in 2010. The median age of all cases entering treatment increased from 26 years in 2005 to 28 years in 2010. Another change was the drop in the proportion of cases who were in employment, from 22% in 2005 to 9% in 2010. This is most likely a reflection of the current economic climate, and highlights the continued importance of social and occupational reintegration interventions as part of the drug treatment process.

The significant increase in the total number of people requiring drug treatment services is a strong indication that problem drug use remains a pressing issue throughout the country, and presents complex and multiple challenges to those providing treatment.

An online appendix to this Trends Series paper, containing additional tables and figures with supplementary data, is available on the website of the National Documentation Centre on Drug Use at www.drugsandalcohol.ie/16381

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Glossary and acronyms can be accessed online at www.drugsandalcohol.ie/glossary

Introduction

National drug prevalence studies^{1,2} show that the proportion of adults (aged 15–64 years) in Ireland who reported using an illegal drug in their lifetime increased by 5%, from 19% in 2002/3 to 24% in 2006/7. The proportion of young adults (aged 15–34 years) who reported ever using an illegal drug was higher, increasing from 26% in 2002/3 to 31% in 2006/7. The surveys show that cannabis was the most commonly used illicit drug and that more men than women reported having ever used an illicit drug.

The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated drug and alcohol misuse in Ireland. It is co-ordinated by the National Health Information Systems staff of the Health Research Board (HRB) on behalf of the Department of Health.

Drug treatment data are viewed as an indirect indicator of drug and alcohol misuse, as well as a direct indicator of demand for treatment services. NDTRS data are used at national level (alcohol and drug data) and at European level (drug data) to provide information on the characteristics of clients entering treatment and on patterns of substance misuse, such as types of substance used and consumption behaviours. Drug data are 'valuable from a public health perspective to assess needs, ... and to plan and evaluate services'.³

The monitoring role of the NDTRS was recognised by the government in its document *Building on experience: National Drugs Strategy 2001–2008*.⁴ The collection and reporting of data to the NDTRS was one of the actions identified and agreed by the government for implementation. *The National Drugs Strategy (interim) 2009–2016*⁵ recognised the positive impact of the NDTRS on the development of key indicators, stating that 'the information provided through the NDTRS provide[s] significant insights into the patterns

of problem drug use', and that 'drug treatment data has also improved substantially through the NDTRS' (p. 69). The National Drugs Strategy (NDS) also recommends the continuation and further development of data-collection systems, including the NDTRS (Action 49).

The HRB supplies service providers and policy makers with relevant data from the NDTRS to inform local and national substance misuse policy and planning. In recent years this information has been central to drugs strategy and policy decisions:

- In 1996 NDTRS data were used to identify a number of local areas with problematic heroin use.⁶ These areas were later designated as local drugs task force (LDTF) areas, and task force teams have continued to provide strategic responses to drug misuse in their communities.
- In 2004 NDTRS data were used to describe treatment-seeking characteristics and behaviours of those aged under 18 years and to inform the deliberations of the Working Group on Treatment of under 18 Year Olds.⁷
- In 2007 NDTRS data were used to inform some of the recommendations of the Working Group on Drugs Rehabilitation, and to assist the Working Group on Residential Services in estimating the number of residential places required to address severe alcohol and drug problems in Ireland.⁸
- In 2009 the Comptroller and Auditor General used data from the NDTRS in a special report on treatment and rehabilitation services provided for people with drug addiction.⁹
- In 2009 the NDS Steering Group used NDTRS data extensively to assess progress under the previous strategy.⁵

In addition, updated NDTRS data on trends in treated problem drug use over time are published in a regular and consistent manner, thus providing service providers and policy makers with the most recent figures available.

Background and methods

The NDTRS was established in 1990 in the Greater Dublin area and was extended in 1995 to cover all areas of the country. It was developed in line with the Pompidou Group's Definitive Protocol¹⁰ and subsequently refined in accordance with the Treatment Demand Indicator Protocol. Originally designed to record drug misuse, the NDTRS recorded problematic use of alcohol only in cases where it was an additional problem substance, that is, where the client's main reason for entering treatment was drug misuse, but he/she also reported problematic use of alcohol. In 2004, the remit of the NDTRS was extended to include cases where alcohol is recorded as the main or only reason for seeking treatment.

Treatment for problem substance use in Ireland is provided by statutory and non-statutory services, including residential centres, community-based addiction services and general practices.

For the purpose of the NDTRS, treatment is broadly defined as any activity that aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems. Clients who attend needle-exchange services are not included in this reporting system. Treatment options for problem substance use include one or more of the following: medication, psychiatric treatment, brief intervention, counselling (including cognitive behavioural therapy), medication-free therapy, family therapy, complementary therapy and/or life-skills training.

Compliance with the NDTRS requires that one form be completed for each new client coming for first treatment and for each previously treated client returning to treatment for problem substance use. Service providers at treatment centres throughout Ireland collect data on episodes of treatment, rather than on the

individual person treated each year. HRB staff then compile the anonymous, aggregated data, which are analysed and reported at national and European levels.

In order to analyse trends over time and thus provide an updated picture of treated problem drug use in Ireland, the last six years of available data were extracted from the NDTRS. A descriptive analysis of this subset of data was then done through frequencies and cross-tabulations of selected variables, and by calculating proportions and medians (for the age variables). Cases who reported alcohol as their main problem substance were excluded from this analysis (refer Trends paper 11).

The main elements of the reporting system in the context of this paper are defined as follows.

All treated cases – individuals who **enter** treatment for problem substance use at each treatment centre in a calendar year, including:

New cases treated – individuals who have never been treated for problem substance use;

Previously treated cases – individuals who were previously treated for problem substance use at any treatment centre and have returned to treatment for problem drug use in the reporting year;

Status unknown – individuals whose status with respect to previous treatment for problem substance use is not known.

The limitations of this analysis relate to the nature of the reporting system. Each record in the NDTRS database relates to a treatment episode (a case), and not to a person because there is currently no unique health identifier in Ireland. This means that the same person could be counted more than once in the reporting year if he/she had more than one treatment episode in that year.

While the coverage achieved by the NDTRS is very high overall, the number of services participating in the reporting system can vary over time. This makes small fluctuations in the numbers of cases more difficult to interpret.

The Central Treatment List (CTL) is another source of data on treated drug misuse. The CTL was established under Statutory Instrument No. 225, and is administered by the Drug Treatment Centre Board on behalf of the Health Service Executive (HSE). It is a complete register of all clients receiving methadone as a treatment for problem opiate use in Ireland. Each client is allocated a unique number and receives his/her methadone from one source only. Every year, CTL staff provide the HRB with data on the number of individuals who were receiving methadone treatment on 31 December in the preceding year and carried forward to 1 January in the current year (continuous care cases). CTL data in relation to these cases were used in the calculation of prevalence rates presented in the first section of this analysis; continuous care cases are not included in the remaining sections of the analysis, which relate to NDTRS-recorded cases only.

Analysis

The analysis provides an outline of the following:

- incidence and prevalence;
- treatment provision;
- place of residence;
- substances;
- patterns of use;
- socio-economic characteristics.

Incidence and prevalence

The total number of cases in treatment for problem drug use increased over the reporting period, from 12,101 in 2005 to 16,429 in 2010. Over half (55%) of these were continuous care cases, that is, cases continuing in methadone treatment from the preceding calendar year and carried forward on 1 January each year, as reported by the CTL. The number of continuous care cases increased by 23%, from 6,925 in 2005 to 8,551 in 2010 (Table 1).

The number of cases entering drug treatment each year and reported to the NDTRS increased by 52% over the reporting period, from 5,176 in 2005 to 7,878 in 2010. The *number* of new cases entering treatment increased by 59% over the period, rising from 2,054 in 2005 to 3,270 in 2010. New cases entering treatment are an indirect indicator of recent trends in problem drug use and treatment availability. Overall, the *proportion* of new cases increased slightly between 2005 and 2010. In 2010 they represented 42% of cases entering treatment, on a par with the European average of 40% in 2008.¹² The number of previously treated cases entering treatment increased by 49%, rising from 2,970 in 2005 to 4,424 in 2010. The growing number of individuals remaining in treatment or returning to treatment over the years is an indicator of a chronic situation and the need for addiction services into the future.

Table 1 Number of cases in treatment, by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases in treatment	12101		12737		13597		14518		14933		16429	
Cases continuing in methadone treatment from previous year*	6925	(57.2)	7262	(57.0)	7620	(56.0)	7942	(54.7)	8266	(55.4)	8551	(52.0)
Entries into treatment each year	5176		5475		5977		6576		6667		7878	
Of which:												
New cases	2054	(39.7)	2278	(41.6)	2476	(41.4)	2716	(41.3)	2970	(44.5)	3270	(41.5)
Previously treated cases	2970	(57.4)	3000	(54.8)	3309	(55.4)	3700	(56.3)	3565	(53.5)	4424	(56.2)
Treatment status unknown	152	(2.9)	197	(3.6)	192	(3.2)	160	(2.4)	132	(2.0)	184	(2.3)

* Data provided by the Central Treatment List.

Figure 1 presents the rates for the incidence (new cases) and prevalence (all cases) of treated problem drug use for the years 2005–2010, expressed per 100,000 of the population aged 15–64 years, based on census figures for 2005 and 2006 and Central Statistics Office (CSO) estimated figures for 2007 to 2010.^{13,14,15} The incidence increased consistently each year, rising from 70 cases per 100,000 in 2005 to 106 cases in 2010. The number of new cases entering treatment is an indirect indicator of recent trends and points to an increase in drug use over the six-year period.

The prevalence also increased consistently during the reporting period, rising from 423 cases per 100,000 in 2005 to 544 cases in 2010. This indicates that problem drug use is a chronic, recurring health condition that requires repeated episodes of treatment over time.

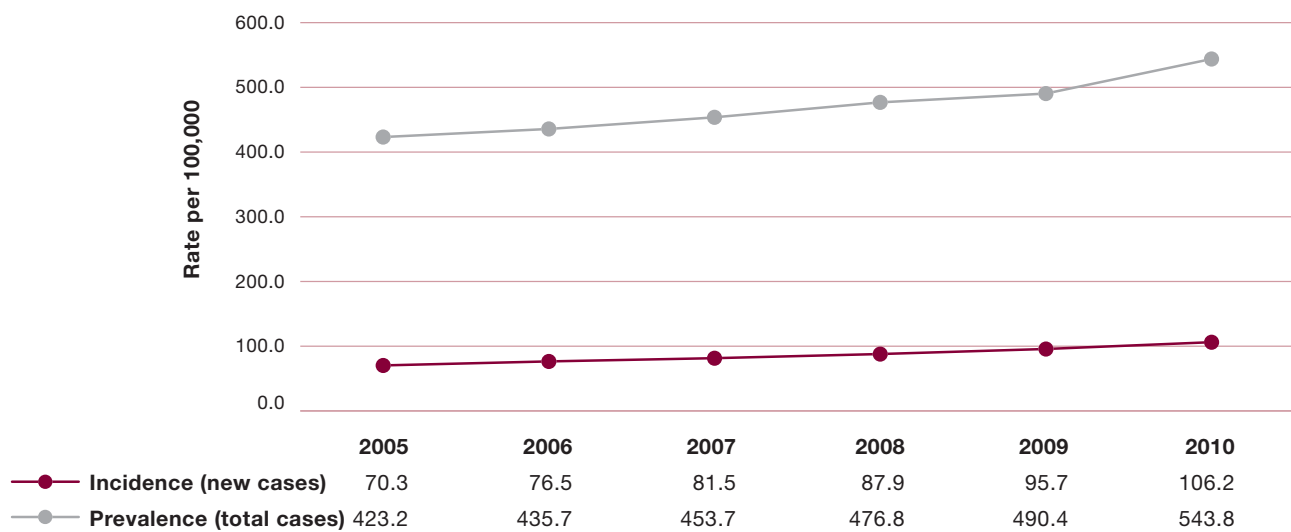


Figure 1 Incidence and prevalence of treated problem drug use per 100,000 15–64-year-olds (NDTRS 2005–2010)

Key points – incidence and prevalence

- Over half (55%) of all cases in treatment for problem drug use between 2005 and 2010 were continuous care cases.
- The number of cases entering drug treatment each year increased by 52% between 2005 and 2010.
- Overall, the proportion of new cases increased slightly between 2005 and 2010. In 2010 they represented 42% of cases entering treatment.
- Incidence increased from 70 cases per 100,000 in 2005 to 106 cases per 100,000 in 2010.
- Prevalence increased from 423 cases per 100,000 in 2005 to 544 cases per 100,000 in 2010.

Treatment provision

There was an increase in the total number of drug treatment services available in Ireland and participating in the NDTRS between 2005 and 2010 (Table 2). In 2010, data were provided by 376 treatment services, an increase of 107 since 2005. The large majority of services were in outpatient settings, while a tenth of services were residential. The recruitment by NDTRS staff of many projects supported by LDTFs resulted in an increase in the number of low-threshold services reporting to the system in 2009 and 2010. The number of general practitioners (GPs) reporting cases entering treatment to the NDTRS fluctuated over the six-year period; however, the overall number of GPs participating in the reporting system increased between 2005 and 2010. This suggests that many GPs were providing methadone maintenance for stable long-term continuing care patients and therefore did not frequently enrol **new** patients. This view is supported by the increasing number of clients **continuing in treatment** from previous years and attending GP practices (Table 3).

Table 2 Number of treatment services, by type of service provider (NDTRS 2005–2010)

	2005	2006	2007	2008	2009	2010
All services	269	238	288	316	349	376
Outpatient	146	146	173	209	212	215
Inpatient	21	23	27	32	34	37
Low threshold	3	3	5	9	27	51
General practitioner	99	66	83	66	76	73

The majority (68%) of cases received treatment in outpatient settings. The number of cases **entering** treatment in outpatient services increased by 45%, from 3,828 cases in 2005 to 5,565 cases in 2010 (Table 3). The number of cases entering residential treatment increased by 51%, from 817 cases in 2005 to 1,232 cases in 2010. The number of cases entering treatment in GP settings and reported to the NDTRS decreased by 15% over the reporting period. This may be due to incomplete returns, but also reflects the cohort of stable clients attending GPs.

Table 3 Cases in treatment, by type of service provider (NDTRS and CTL 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases in treatment	12101		12737		13597		14518		14933		16429	
Outpatient	8154	(67.4)	8621	(67.7)	9262	(68.1)	9987	(68.8)	10146	(67.9)	10869	(66.2)
Inpatient	827	(6.8)	994	(7.8)	1071	(7.9)	1160	(8.0)	1077	(7.2)	1245	(7.6)
Low threshold*	289	(2.4)	233	(1.8)	125	(0.9)	159	(1.1)	368	(2.5)	828	(5.0)
General practitioner	2831	(23.4)	2889	(22.7)	3139	(23.1)	3212	(22.1)	3342	(22.4)	3487	(21.2)
Cases continuing in methadone treatment from previous year†	6925		7262		7620		7942		8266		8551	
Outpatient	4326	(62.5)	4527	(62.3)	4730	(62.1)	4926	(62.0)	5141	(62.2)	5304	(62.0)
Inpatient	10	(0.1)	7	(0.1)	6	(0.1)	4	(0.1)	13	(0.2)	13	(0.2)
Low threshold	98	(1.4)	87	(1.2)	34	(0.4)	22	(0.3)	27	(0.3)	35	(0.4)
General practitioner	2491	(36.0)	2641	(36.4)	2850	(37.4)	2990	(37.6)	3085	(37.3)	3199	(37.4)
Previously treated and new cases entering treatment during year‡	5176		5475		5977		6576		6667		7878	
Outpatient	3828	(74.0)	4094	(74.8)	4532	(75.8)	5061	(77.0)	5005	(75.1)	5565	(70.6)
Inpatient	817	(15.8)	987	(18.0)	1065	(17.8)	1156	(17.6)	1064	(16.0)	1232	(15.6)
Low threshold	191	(3.7)	146	(2.7)	91	(1.5)	137	(2.1)	341	(5.1)	793	(10.1)
General practitioner	340	(6.6)	248	(4.5)	289	(4.8)	222	(3.4)	257	(3.9)	288	(3.7)

* Low-threshold services provide low-dose methadone or drop-in facilities only.

† Data provided by the Central Treatment List.

‡ NDTRS data.

The majority of treated cases received one initial treatment intervention; however, the proportion of cases receiving multiple interventions increased to 49% in 2010 from 36% in 2006.¹⁶ It is important to note that this analysis is based on data provided at the time of entry into treatment and therefore includes only initial treatment interventions. Other interventions that may be provided subsequently are recorded when clients are discharged.

Of the 7,878 cases entering treatment in 2010, 58% received individual or group counselling, 32% received a brief intervention, 25% received methadone substitution and 23% attended individual or group education/awareness programmes (Figure 2). There has been an increase in recent years in non-medical interventions, especially brief interventions and information/educational programmes.

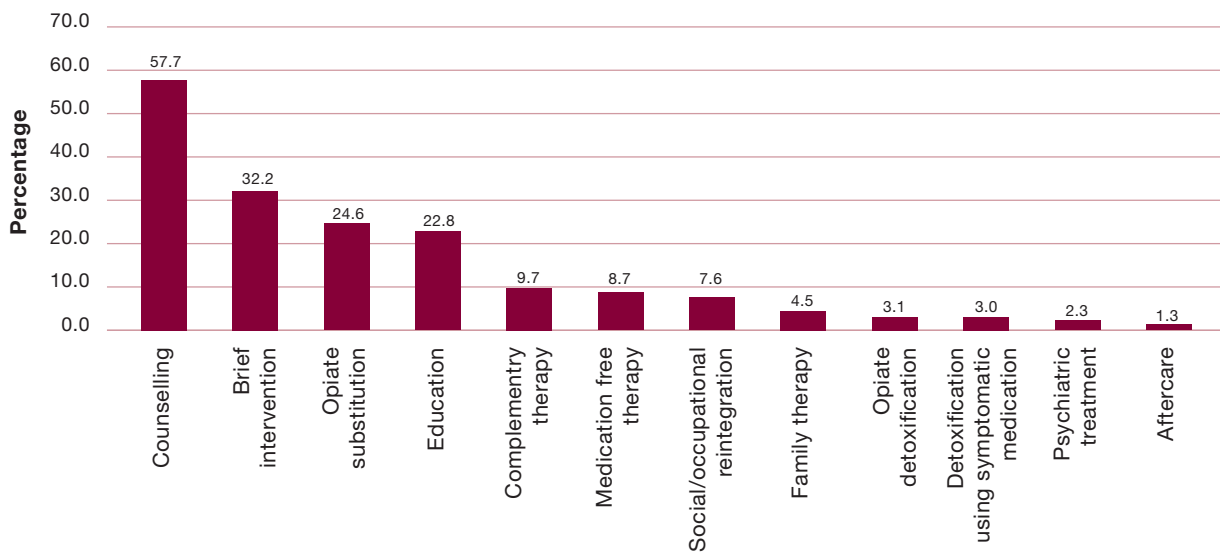


Figure 2 Percentage of treated cases by type of initial treatment intervention availed of (NDTRS 2010)

Key points – treatment provision

- There was an increase in the total number of drug treatment services available in Ireland and participating in the NDTRS between 2005 and 2010.
- The majority (68%) of cases received treatment in outpatient settings.
- The majority (58%) of cases received counselling. There has been an increase in non-medical interventions, especially brief interventions and information/educational programmes.

Place of residence

The annual numbers of treated cases were analysed by place of residence. A total of 37,749 cases entered treatment for problem drug use in the period 2005–2010, of whom 36,276 (96.1%) had a specified Irish address (Table 4). Very few cases each year reported their usual place of residence as outside Ireland, and a small proportion of cases were resident in Ireland but did not specify an address. The large majority of cases with an unknown place of residence were Dublin-based homeless people, who could not be assigned to a HSE region of residence (Dublin North East or Dublin Mid-Leinster).

Table 4 Cases entering treatment, by place of residence (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	5176		5475		5977		6576		6667		7878	
Ireland, specified address	4877	(94.2)	5238	(95.7)	5749	(96.2)	6322	(96.1)	6497	(97.5)	7593	(96.4)
Ireland, address not recorded	290	(5.6)	226	(4.1)	223	(3.7)	245	(3.7)	164	(2.5)	278	(3.6)
Outside Ireland	9	(0.2)	11	(0.2)	5	(0.1)	9	(0.1)	6	(0.1)	7	(0.1)

The following analysis and subsequent tables exclude cases not normally resident in Ireland and cases whose HSE region of residence is not known. When interpreting NDTRS data by geographical area, it is important to note that the numbers reported for each area may be influenced by treatment availability in the area, and by the extent to which services participated in the reporting system.

HSE region of residence

Table 5 presents cases entering treatment by HSE region of residence and by treatment status. In the six-year period, the highest proportion (35%) of cases entering treatment lived in the HSE Dublin Mid-Leinster Region; 27% lived in the Dublin North East Region, 25% in the South and 13% in the West. There was a slight decrease in the proportions of cases in both Dublin regions and a parallel increase in the South and West regions between 2005 and 2010. The actual number of cases decreased in the Dublin North East and Dublin Mid-Leinster regions in 2009 for the first time in five years, but increased again slightly in 2010. In the same year, the highest proportion (34%) of cases entering treatment lived in the HSE South Region.

The highest number of new cases lived in the South Region, with numbers increasing by 86% over the six-year period, from 737 cases in 2005 to 1,369 cases in 2010. The second largest increase in new cases was in the West Region at 84%, followed by the Dublin Mid-Leinster Region (67%). The number of new cases increased in the Dublin North East Region up to 2008, but decreased every year since then.

Table 5 Cases entering treatment, by HSE region of residence and by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases*	4877		5238		5749		6322		6497		7593	
Dublin North East	1484	(30.4)	1522	(29.1)	1530	(26.6)	1742	(27.6)	1668	(25.7)	1781	(23.5)
Dublin Mid-Leinster	1824	(37.4)	1986	(37.9)	2137	(37.2)	2279	(36.0)	2191	(33.7)	2252	(29.7)
South	1099	(22.5)	1149	(21.9)	1264	(22.0)	1363	(21.6)	1812	(27.9)	2541	(33.5)
West	470	(9.6)	581	(11.1)	818	(14.2)	938	(14.8)	826	(12.7)	1019	(13.4)
New cases	1976		2229		2430		2658		2930		3207	
Dublin North East	488	(24.7)	630	(28.3)	636	(26.2)	779	(29.3)	695	(23.7)	534	(16.7)
Dublin Mid-Leinster	452	(22.9)	541	(24.3)	583	(24.0)	622	(23.4)	714	(24.4)	755	(23.5)
South	737	(37.3)	724	(32.5)	752	(30.9)	761	(28.6)	1086	(37.1)	1369	(42.7)
West	299	(15.1)	334	(15.0)	459	(18.9)	496	(18.7)	435	(14.8)	549	(17.1)
Previously treated cases	2760		2825		3144		3510		3439		4217	
Dublin North East	942	(34.1)	820	(29.0)	834	(26.5)	912	(26.0)	935	(27.2)	1202	(28.5)
Dublin Mid-Leinster	1317	(47.7)	1362	(48.2)	1483	(47.2)	1592	(45.4)	1415	(41.1)	1427	(33.8)
South	348	(12.6)	407	(14.4)	488	(15.5)	580	(16.5)	707	(20.6)	1132	(26.8)
West	153	(5.5)	236	(8.4)	339	(10.8)	426	(12.1)	382	(11.1)	456	(10.8)
Treatment status not known	141		184		175		154		128		169	

* Excludes cases whose HSE region of residence is not known and cases not normally resident in Ireland.

A more detailed analysis of treated problem drug use by HSE region of residence is available in the online appendix (www.drugsandalcohol.ie/16381).

Regional drugs task force area of residence

Data were further analysed by regional drugs task force (RDTF) area of residence. In order to adjust for variation in population size by geographical area, the actual incidence of treated drug use in each area was calculated using the average number of new cases over the six-year period living in each of the 10 RDTF areas; this average was divided by the population aged 15–64 years living in the respective RDTF areas, using the census figures for 2005 and 2006 and CSO estimated figures for 2007 to 2010.^{13, 14, 15}

Between 2005 and 2010, the average annual incidence of treated drug use was highest in the South East RDTF area at 152 cases per 100,000, followed by the North Dublin area (101 cases) and the Southern area (93 cases). The incidence was lowest in the North West RDTF area at 52 cases per 100,000, the Western area (50 cases) and the East Coast area (38 cases).

In order to illustrate trends over time, the average annual incidence of treated problem drug use was examined for two distinct time periods, 2005–2007 (Figure 3) and 2008–2010 (Figure 4), by RDTF area of residence.

In the 2005–2007 period, the average annual incidence of treated drug use ranged from 31 cases per 100,000 in the East Coast RDTF area to 131 cases in the South East RDTF area.

In the 2008–2010 period, the average annual incidence of treated drug use ranged from 44 cases per 100,000 in the East Coast RDTF area to 174 cases in the South East area. The incidence increased in all areas compared to the previous three-year period except in the North Eastern RDTF area. No RDTF area had an average annual incidence of less than 40 cases per 100,000 in the 2008–2010 period, while there were two such areas in the earlier period.

The two maps (Figures 3 and 4) clearly show both the spread and the increase in cases of treated drug use throughout the country. This reflects not only the extent of problem drug use but also an increase in treatment availability and in compliance with the NDTRS. The highest proportional increase between the two three-year periods occurred in the Western RDTF area, where the average annual incidence increased by 66%, from 38 cases in 2005–2007 to 62 cases in 2008–2010. The incidence increased by 48% in the Southern RDTF area and by 41% in the East Coast area. The lowest proportional increase was in the Midland RDTF area, at 12%, and the incidence decreased by 16% in the North Eastern area.

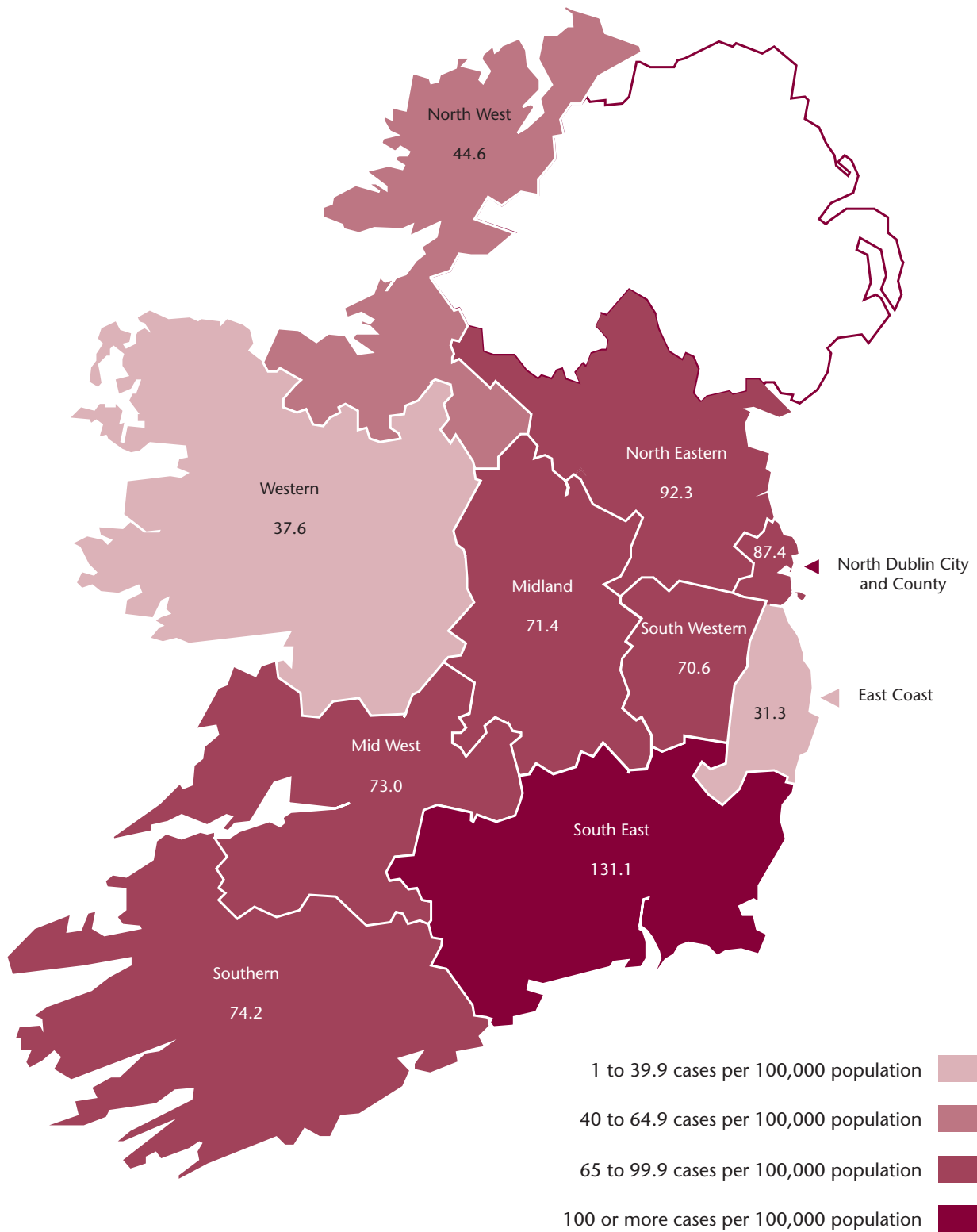


Figure 3 Average annual incidence of treated problem drug use per 100,000 15–64-year-olds, by regional drugs task force area of residence (NDTRS 2005–2007)

NB: Incidence rates are affected by level of participation in the NDTRS.

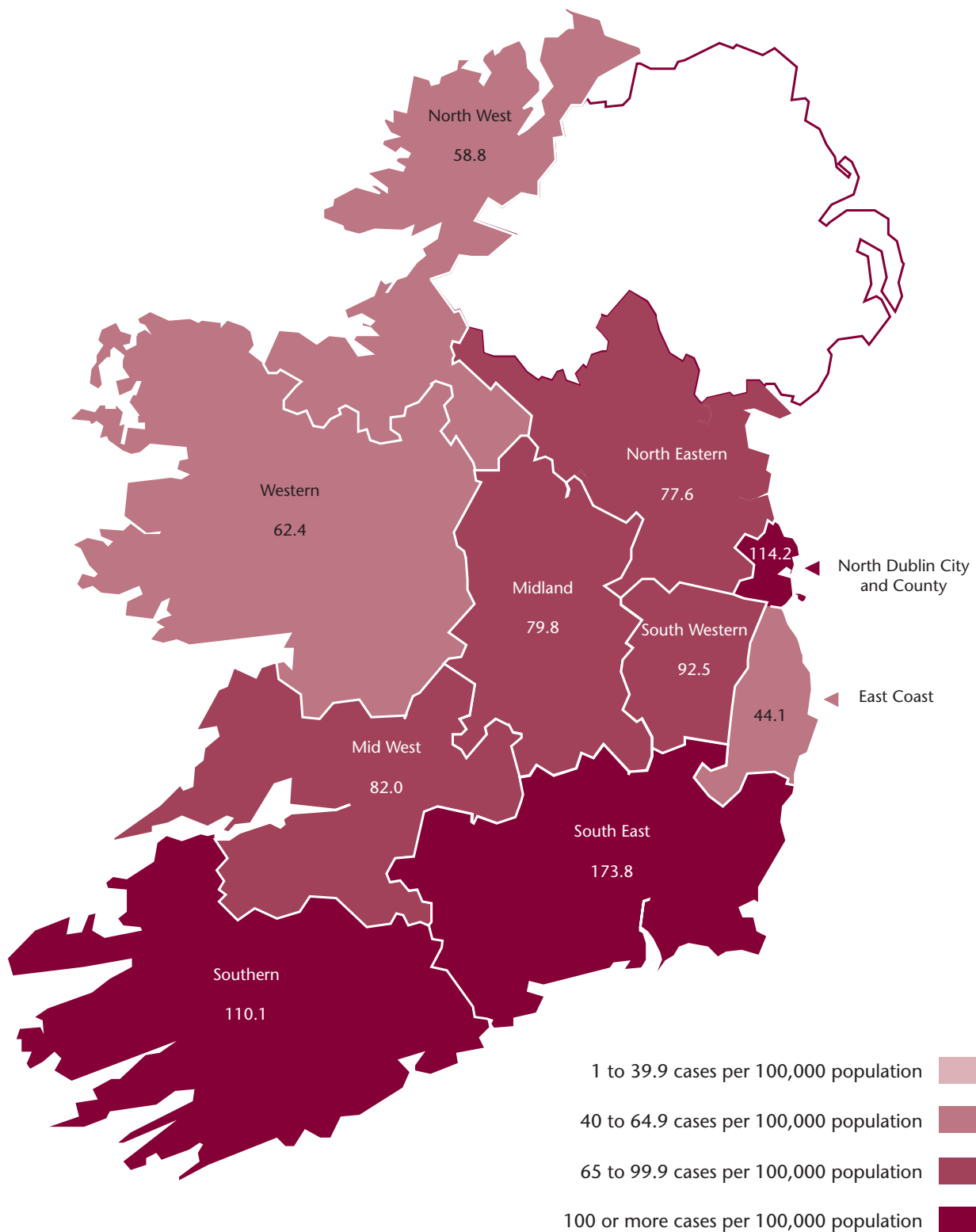


Figure 4 Average annual incidence of treated problem drug use per 100,000 15–64-year-olds, by regional drugs task force area of residence (NDTRS 2008–2010)

NB: Incidence rates are affected by level of participation in the NDTRS.

Key points – place of residence

- Between 2005 and 2010, the highest proportion of cases lived in the HSE Dublin Mid-Leinster Region (35%); 27% lived in the Dublin North East, 24% in the South and 13% in the West regions.
- There was a slight decrease in the proportion of cases in both HSE Dublin regions and a parallel increase in the South and West HSE regions.
- The average annual incidence was highest in the South East RDTF area, followed by the North Dublin and North Eastern areas. It was lowest in the North West, Western and East Coast areas.
- The clear spread and increase in treated drug use throughout the country reflect not only the extent of problem drug use but also an increase in treatment availability and in compliance with the NDTRS.

Problem substances

Main problem substance

In the six-year period, opiates, mainly heroin, were the most common main problem drugs (61%), followed by cannabis (21%) and cocaine (11%). The proportion of opiate users remained stable between 2005 and 2008, but decreased slightly in 2009 and 2010. The proportion of cases reporting cannabis as their main problem substance decreased between 2005 and 2007 but increased steadily thereafter, reaching its highest level in 2010 at 25% (1,893 cases) (Table 6). Following a steady increase to a peak in 2007 (777 cases), the number of cases reporting cocaine as their main problem substance decreased in the subsequent two years and remained stable in 2010 (Figure 5).

While the number of opiate cases increased overall, the proportion of opiate users among previously treated cases decreased over the reporting period, from 83% in 2005 to 72% in 2010. A growing proportion of cases returning to treatment reported problem use of drugs other than opiates, such as cannabis or benzodiazepines.

Substances categorised as 'other' comprised: substances bought in head shops (58%); sedatives other than benzodiazepines (15%); hallucinogenic substances such as lysergic acid (7%); and other unspecified medication (6%). The significant increase in the number of new cases reporting an 'other' drug as their main problem substance is mainly due to the appearance of head shop substances in treatment data. In 2010, 213 cases reported a head shop substance as their main problem drug (accounting for 77% of the 'other' category), while there were only 17 cases in 2009.

Table 6 Main problem drug used by cases entering treatment, by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	4877		5238		5749		6322		6497		7593	
Opiates	3094	(63.4)	3326	(63.5)	3627	(63.1)	4004	(63.3)	3862	(59.4)	4300	(56.6)
Ecstasy	124	(2.5)	95	(1.8)	129	(2.2)	103	(1.6)	64	(1.0)	48	(0.6)
Cocaine	467	(9.6)	552	(10.5)	777	(13.5)	762	(12.1)	696	(10.7)	698	(9.2)
Amphetamines	36	(0.7)	30	(0.6)	39	(0.7)	36	(0.6)	33	(0.5)	56	(0.7)
Benzodiazepines	75	(1.5)	96	(1.8)	163	(2.8)	167	(2.6)	260	(4.0)	292	(3.8)
Volatile inhalants	27	(0.6)	23	(0.4)	32	(0.6)	28	(0.4)	21	(0.3)	31	(0.4)
Cannabis	1039	(21.3)	1097	(20.9)	963	(16.8)	1192	(18.9)	1519	(23.4)	1893	(24.9)
Other	15	(0.3)	19	(0.4)	19	(0.3)	30	(0.5)	42	(0.6)	275	(3.6)
New cases	1976		2229		2430		2658		2930		3207	
Opiates	722	(36.5)	913	(41.0)	1037	(42.7)	1169	(44.0)	1221	(41.7)	1172	(36.5)
Ecstasy	92	(4.7)	65	(2.9)	86	(3.5)	66	(2.5)	47	(1.6)	21	(0.7)
Cocaine	275	(13.9)	342	(15.3)	466	(19.2)	447	(16.8)	417	(14.2)	382	(11.9)
Amphetamines	22	(1.1)	21	(0.9)	25	(1.0)	26	(1.0)	22	(0.8)	33	(1.0)
Benzodiazepines	42	(2.1)	50	(2.2)	85	(3.5)	74	(2.8)	137	(4.7)	140	(4.4)
Volatile inhalants	21	(1.1)	19	(0.9)	24	(1.0)	16	(0.6)	14	(0.5)	25	(0.8)
Cannabis	794	(40.2)	809	(36.3)	695	(28.6)	845	(31.8)	1047	(35.7)	1253	(39.1)
Other	8	(0.4)	10	(0.4)	12	(0.5)	15	(0.6)	25	(0.9)	181	(5.6)
Previously treated cases	2760		2825		3144		3510		3439		4217	
Opiates	2281	(82.6)	2281	(80.7)	2450	(77.9)	2723	(77.6)	2566	(74.6)	3034	(71.9)
Ecstasy	30	(1.1)	29	(1.0)	42	(1.3)	36	(1.0)	17	(0.5)	23	(0.5)
Cocaine	175	(6.3)	194	(6.9)	293	(9.3)	300	(8.5)	261	(7.6)	304	(7.2)
Amphetamines	14	(0.5)	9	(0.3)	14	(0.4)	10	(0.3)	11	(0.3)	20	(0.5)
Benzodiazepines	30	(1.1)	40	(1.4)	72	(2.3)	87	(2.5)	118	(3.4)	143	(3.4)
Volatile inhalants	5	(0.2)	3	(0.1)	7	(0.2)	12	(0.3)	7	(0.2)	5	(0.1)
Cannabis	219	(7.9)	260	(9.2)	259	(8.2)	330	(9.4)	443	(12.9)	597	(14.2)
Other	6	(0.2)	9	(0.3)	7	(0.2)	12	(0.3)	16	(0.5)	91	(2.2)
Treatment status unknown	141		184		175		154		128		169	

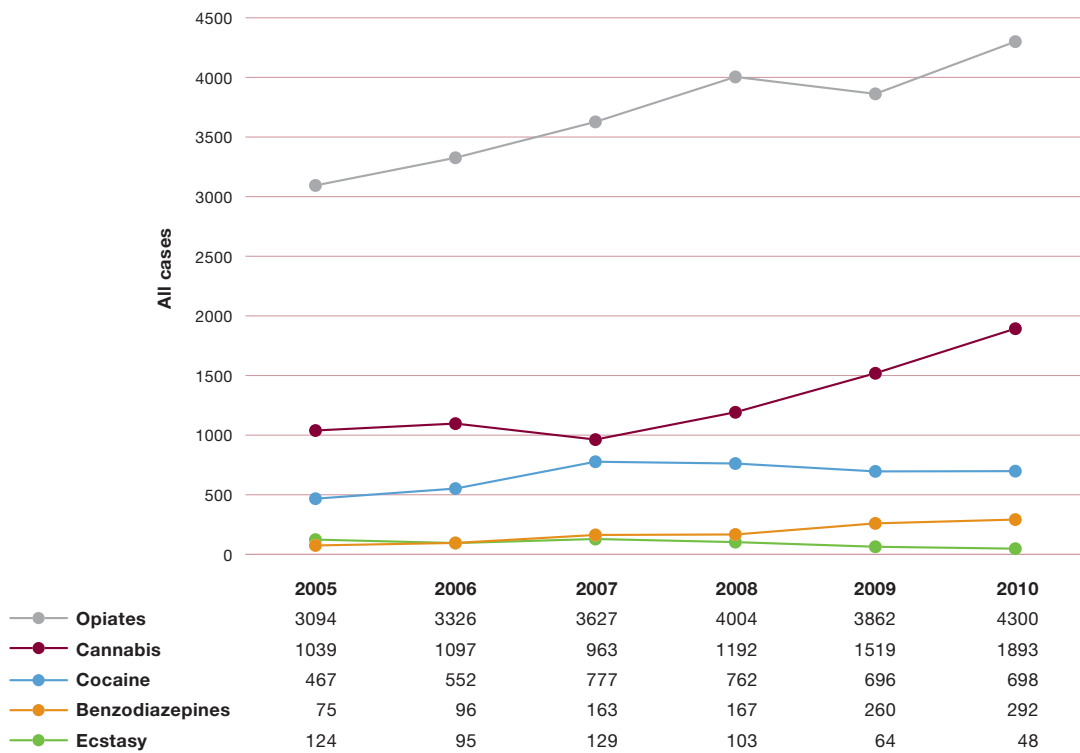


Figure 5 All cases: main problem drug (NDTRS 2005–2010)

Among new cases, the numbers reporting an opiate as their main problem drug increased by 62%, from 722 in 2005 to 1,172 in 2010 (Figure 6). Cannabis was increasingly reported as a main problem drug between 2005 and 2010, with the numbers increasing by 48% in the last two years. In 2010, cannabis became the most common main problem drug reported by new cases, ahead of opiates for the first time since 2005. The number of new cases reporting ecstasy as their main problem drug dropped by over 77% between 2005 and 2010. The highest proportional increase (233%) over the six-year period was among new cases reporting a benzodiazepine as their main problem drug.

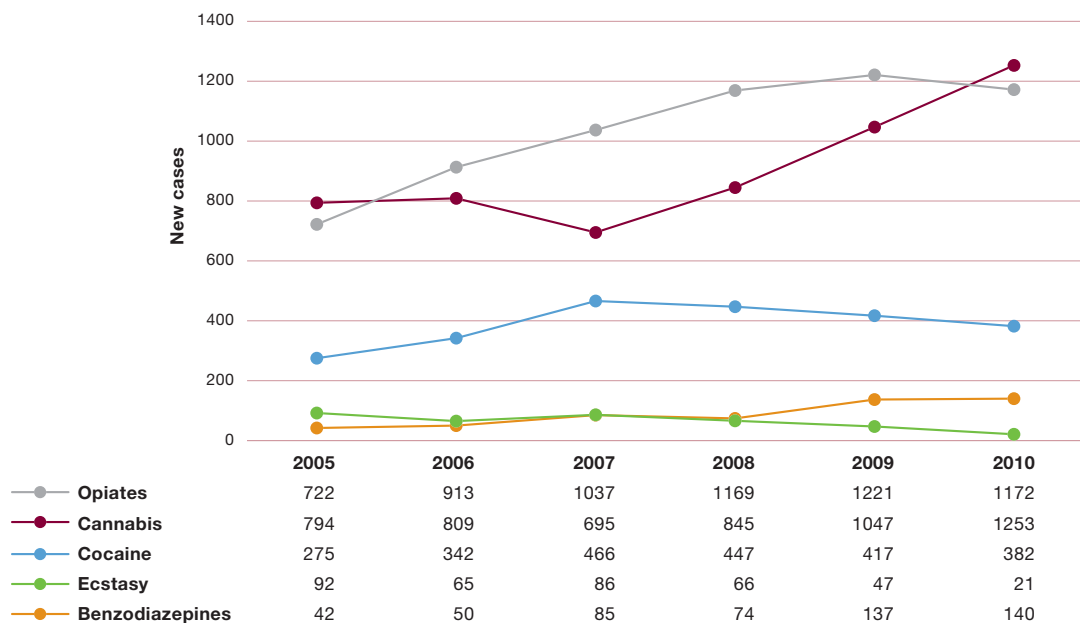


Figure 6 New cases: main problem drug (NDTRS 2005–2010)

Trends in the main problem drugs reported are in line with those at European level, where the three most common main problem drugs reported by new cases in 2009 were the same as in Ireland. However, the proportion of new opiate cases was higher in Ireland (42%, compared to 31% in the EU). The proportion of new cocaine cases was lower (14%, compared to 23% in the EU). The proportion of new cannabis cases was 36% in Ireland and 33% in the EU.¹⁷

The proportions of new cases reporting each substance as their main problem drug differed according to gender (Figure 7). Over the six-year period, cannabis was the main problem drug most commonly reported by new male cases (39%), just ahead of opiates (37%) and followed by cocaine (17%). The majority (52%) of new female cases reported an opiate as their main problem drug, followed by cannabis (24%) and cocaine (10%). The proportion of new cases reporting ecstasy was just about the same for both genders; 3% of males and 6% of females reported a benzodiazepine as their main problem drug.

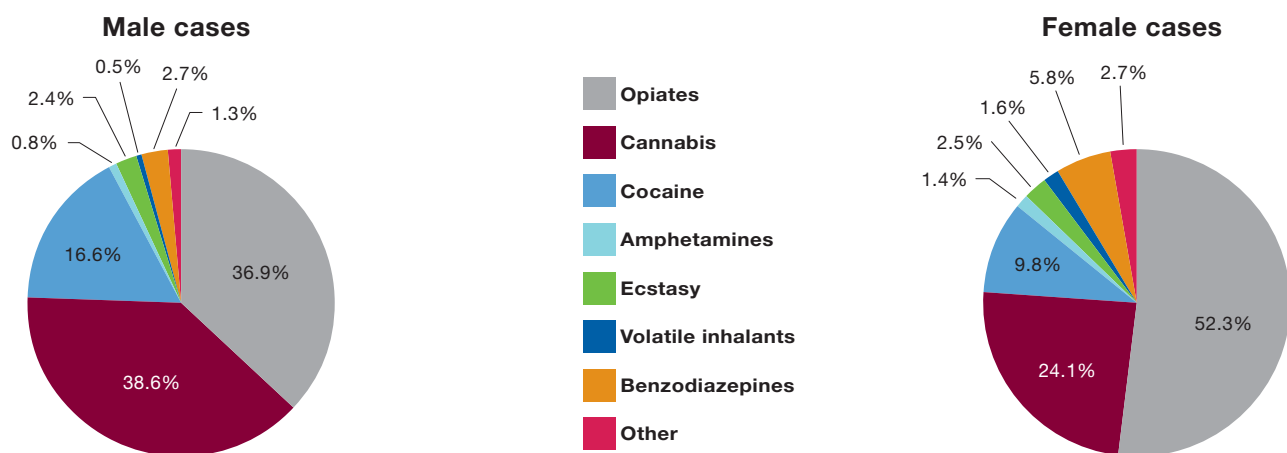


Figure 7 New cases: main problem drug by gender (NDTRS 2005–2010)

Key points – main problem substance

- In the period 2005–2010, opiates were the most common problem drug (61%), followed by cannabis (21%) and cocaine (11%).
- The proportion of opiate users remained stable between 2005 and 2008, but decreased in 2009 and 2010.
- The number of cases reporting cannabis as their main problem substance increased significantly, with cannabis becoming the most common problem drug reported by new cases in 2010.
- Since 2007, the number of cases reporting cocaine as a main problem drug has decreased. There was also a drop in the number of ecstasy cases.
- In 2010, nearly 5% of new cases reported a head shop substance as their main problem drug.
- Among new cases, benzodiazepines accounted for the highest proportional increase over the reporting period.
- Cannabis was the main problem drug most commonly reported by new male cases, while the majority of new female cases reported an opiate as their main problem drug.

Additional problem substances

The majority (68%) of treated cases between 2005 and 2010 reported problem use of more than one substance. The proportion of cases reporting multiple problem substances fluctuated over the reporting period, with the highest proportion (71%) recorded in 2006 and the lowest proportion (65%) recorded in 2010 (Table 7). The use of several substances increases the complexity of cases, and is generally associated with poorer treatment outcomes.

Table 7 Use of more than one drug, by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	4877		5238		5749		6322		6497		7593	
Using more than one drug	3401	(69.7)	3732	(71.2)	3850	(67.0)	4430	(70.1)	4324	(66.6)	4913	(64.7)
New cases	1976		2229		2430		2658		2930		3207	
Using more than one drug	1374	(69.5)	1556	(69.8)	1612	(66.3)	1820	(68.5)	1926	(65.7)	2018	(62.9)
Previously treated cases	2760		2825		3144		3510		3439		4217	
Using more than one drug	1934	(70.1)	2044	(72.4)	2144	(68.2)	2532	(72.1)	2336	(67.9)	2809	(66.6)
Treatment status unknown	141		184		175		154		128		169	

Of the cases who entered treatment during the period under review, 28% reported problem use of two substances, 22% reported problem use of three, and 18% reported problem use of four. Previously treated and new cases showed similar trends.

Table 8 presents the additional problem substances used by cases reporting more than one problem substance. Cannabis, alcohol, cocaine and benzodiazepines were the most common additional problem drugs reported by cases entering treatment in the period 2005–2010. Cannabis was top of this list between 2005 and 2007, replaced by alcohol in the subsequent years. In 2010, alcohol was reported as an additional substance by 2,026 cases, a 78% increase on the 2005 figure of 1,136. Benzodiazepines became the third most common additional drug in 2010, ranking ahead of cocaine. Figure 8 provides a visual outline of these trends. A growing number of cases reported the use of drugs in the category 'Other', overtaking the amphetamine category from 2008 onwards. Ten per cent of all additional drugs reported in 2010 were in the category 'Other', and comprised substances purchased in head shops (59%), sedatives other than benzodiazepines (19%, most of which are those colloquially known as 'Z-drugs'), hallucinogenic substances such as lysergic acid (9%) and other medication (6%).

The additional substances most frequently reported by previously treated cases were cannabis (40%), cocaine (38%) and benzodiazepines (37%). Alcohol was fourth in the ranking, at 32%, with the number increasing by a substantial 125% over the six-year period, from 439 cases in 2005 to 988 cases in 2010. The proportion of previously treated cases reporting ecstasy as an additional problem substance fluctuated between 10% and 12% during the period.

Table 8 Additional problem substances, by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases*	3401		3732		3850		4430		4324		4913	
Opiates	686	(20.2)	707	(18.9)	661	(17.2)	777	(17.5)	684	(15.8)	816	(16.6)
Ecstasy	645	(19.0)	597	(16.0)	640	(16.6)	638	(14.4)	626	(14.5)	560	(11.4)
Cocaine	1144	(33.6)	1384	(37.1)	1386	(36.0)	1631	(36.8)	1448	(33.5)	1393	(28.4)
Amphetamines	195	(5.7)	205	(5.5)	181	(4.7)	131	(3.0)	143	(3.3)	156	(3.2)
Benzodiazepines	963	(28.3)	1067	(28.6)	947	(24.6)	1424	(32.1)	1289	(29.8)	1608	(32.7)
Volatile inhalants	31	(0.9)	23	(0.6)	24	(0.6)	23	(0.5)	30	(0.7)	18	(0.4)
Cannabis	1417	(41.7)	1596	(42.8)	1637	(42.5)	1809	(40.8)	1545	(35.7)	1694	(34.5)
Alcohol	1136	(33.4)	1466	(39.3)	1529	(39.7)	1826	(41.2)	1931	(44.7)	2026	(41.2)
Other	113	(3.3)	98	(2.6)	142	(3.7)	172	(3.9)	213	(4.9)	476	(9.7)
New cases	1374		1556		1612		1820		1926		2018	
Opiates	150	(10.9)	194	(12.5)	172	(10.7)	237	(13.0)	214	(11.1)	187	(9.3)
Ecstasy	407	(29.6)	394	(25.3)	394	(24.4)	370	(20.3)	367	(19.1)	285	(14.1)
Cocaine	401	(29.2)	478	(30.7)	505	(31.3)	582	(32.0)	547	(28.4)	492	(24.4)
Amphetamines	123	(9.0)	113	(7.3)	103	(6.4)	69	(3.8)	91	(4.7)	80	(4.0)
Benzodiazepines	198	(14.4)	257	(16.5)	255	(15.8)	423	(23.2)	417	(21.7)	498	(24.7)
Volatile inhalants	20	(1.5)	14	(0.9)	14	(0.9)	9	(0.5)	14	(0.7)	8	(0.4)
Cannabis	527	(38.4)	583	(37.5)	682	(42.3)	703	(38.6)	671	(34.8)	718	(35.6)
Alcohol	663	(48.3)	846	(54.4)	821	(50.9)	921	(50.6)	1047	(54.4)	1004	(49.8)
Other	57	(4.1)	58	(3.7)	63	(3.9)	90	(4.9)	97	(5.0)	257	(12.7)
Previously treated cases	1934		2044		2144		2532		2336		2809	
Opiates	515	(26.6)	469	(22.9)	471	(22.0)	525	(20.7)	464	(19.9)	617	(22.0)
Ecstasy	223	(11.5)	197	(9.6)	237	(11.1)	260	(10.3)	253	(10.8)	270	(9.6)
Cocaine	717	(37.1)	848	(41.5)	851	(39.7)	1026	(40.5)	884	(37.8)	880	(31.3)
Amphetamines	69	(3.6)	88	(4.3)	77	(3.6)	59	(2.3)	50	(2.1)	74	(2.6)
Benzodiazepines	739	(38.2)	787	(38.5)	677	(31.6)	980	(38.7)	855	(36.6)	1086	(38.7)
Volatile inhalants	9	(0.5)	9	(0.4)	9	(0.4)	14	(0.6)	12	(0.5)	10	(0.4)
Cannabis	844	(43.6)	942	(46.1)	910	(42.4)	1071	(42.3)	858	(36.7)	946	(33.7)
Alcohol	439	(22.7)	582	(28.5)	670	(31.3)	872	(34.4)	852	(36.5)	988	(35.2)
Other	53	(2.7)	38	(1.9)	78	(3.6)	77	(3.0)	111	(4.8)	214	(7.6)
Treatment status unknown	93		132		94		78		62		86	

* All cases who reported use of one, two or three additional drugs.

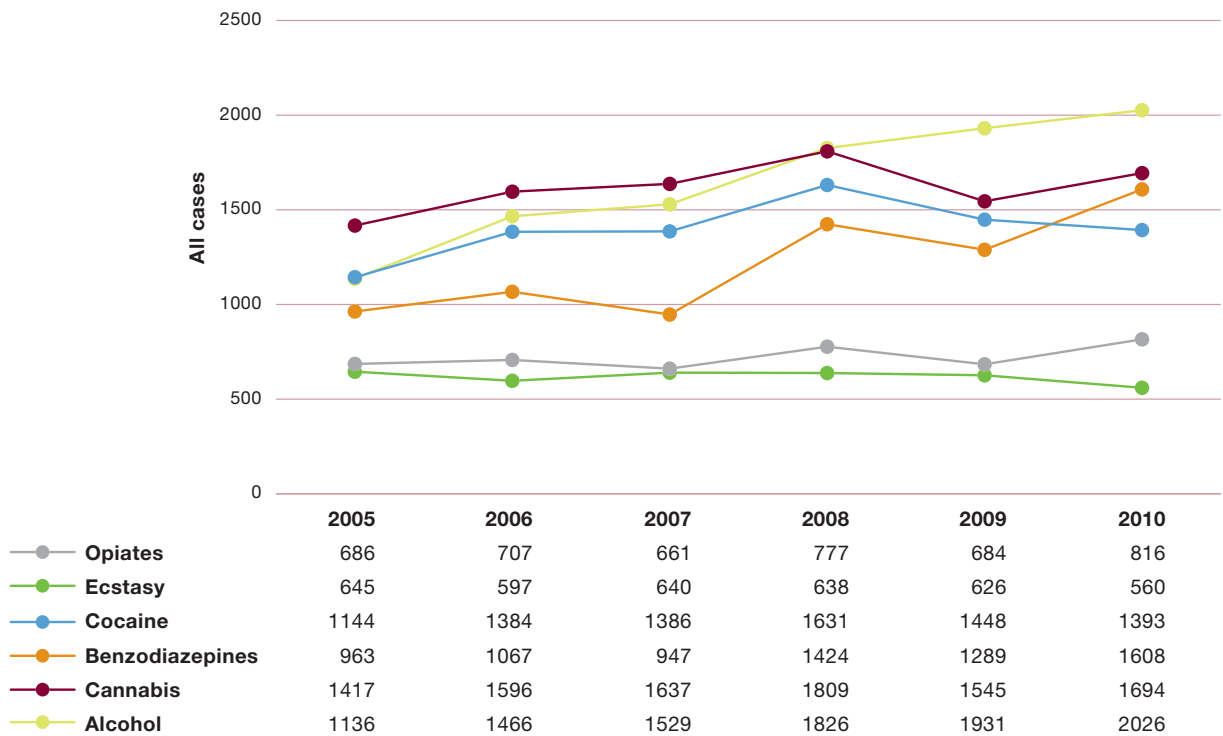


Figure 8 All cases: additional problem substances (NDTRS 2005–2010)

Alcohol (51%), cannabis (38%) and cocaine (29%) were the additional substances most frequently reported by new cases. Alcohol ranked first in each year and increased its lead significantly after 2007, widening the gap between it and cannabis, the second most common additional drug (Figure 9). There was an increase of 152% in the number reporting a benzodiazepine as an additional substance, causing it to move up the ranking from fifth place in 2007 to third place in 2010. The number of cases reporting ecstasy decreased over the years.

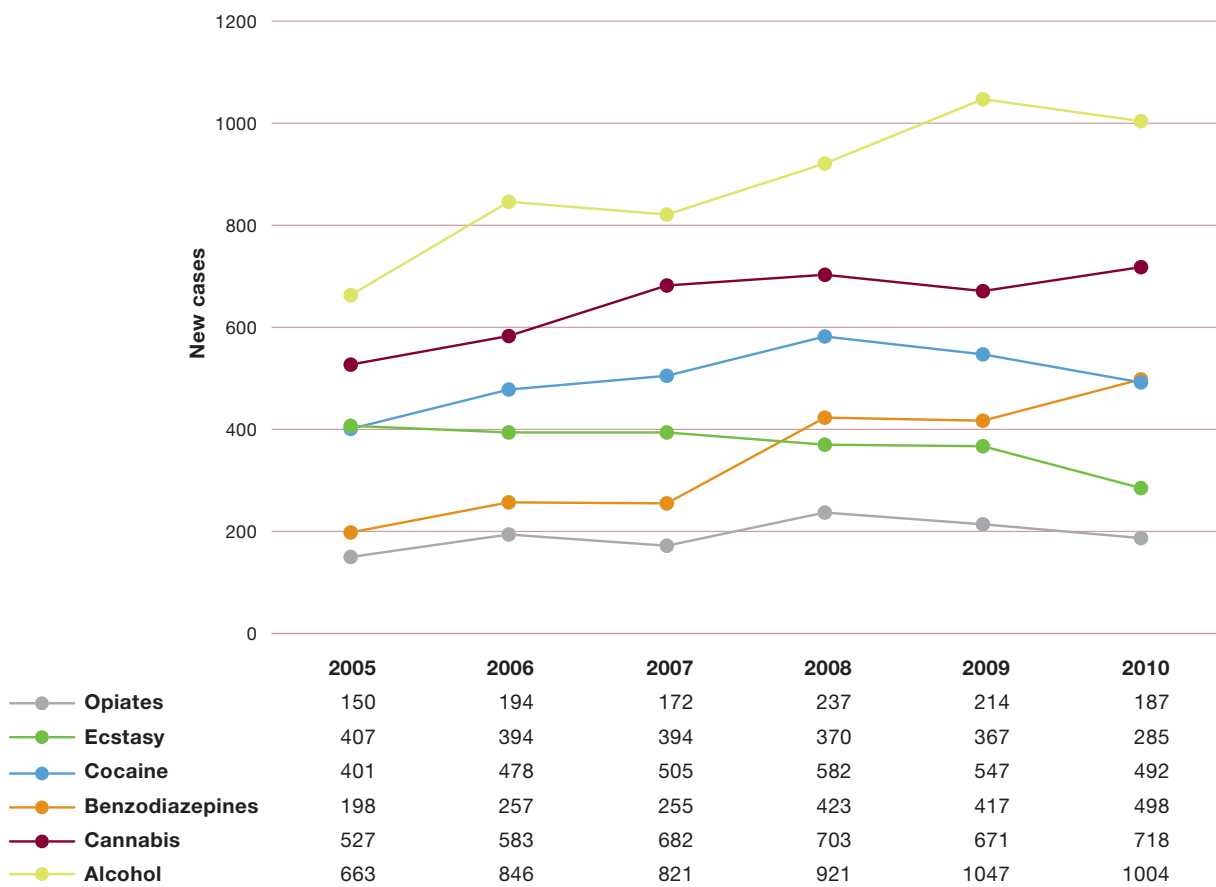


Figure 9 New cases: additional problem substances (NDTRS 2005–2010)

The association between main problem drug and additional problem drugs among new cases entering treatment was examined for the period 2005–2010 (Table 9). The pattern of additional drugs used was linked to the main problem drug. For example, where an opiate was the main problem drug (first number column), the most common additional problem drugs were cannabis (54%), followed by benzodiazepines (35%) and cocaine (34%); whereas where cannabis was the main problem drug (second last column), the most common additional drugs were alcohol (74%), followed by cocaine (38%) and ecstasy (32%). In fact, the proportion of new cases reporting alcohol as an additional problem substance was over 50% for all substances except opiates and 'other' substances. These data emphasise the link between alcohol and illicit drug use.

Table 9 New cases: main problem substance and associated additional problem substances (NDTRS 2005–2010)

	Main problem drug															
	Opiates		Ecstasy		Cocaine		Amphetamines		Benzo-diazepines		Volatile inhalants		Cannabis		Other	
New cases	3912		308		1848		120		385		56		3505		172	
Additional problem drug(s) used*	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Opiates	728	(18.6)†	11	(3.6)	122	(6.6)	4	(3.3)	81	(21.0)	3	(5.4)	195	(5.6)	10	(5.8)
Ecstasy	325	(8.3)	0	(0.0)	625	(33.8)	52	(43.3)	54	(14.0)	4	(7.1)	1136	(32.4)	21	(12.2)
Cocaine	1321	(33.8)	143	(46.4)	31	(1.7)†	44	(36.7)	107	(27.8)	3	(5.4)	1321	(37.7)	35	(20.3)
Amphetamines	76	(1.9)	64	(20.8)	124	(6.7)	0	(0.0)	7	(1.8)	0	(0.0)	299	(8.5)	9	(5.2)
Benzodiazepines	1350	(34.5)	17	(5.5)	223	(12.1)	4	(3.3)	15	(3.9)†	2	(3.6)	413	(11.8)	24	(14.0)
Volatile inhalants	9	(0.2)	1	(0.3)	9	(0.5)	0	(0.0)	4	(1.0)	3	(5.4)†	53	(1.5)	0	(0.0)
Cannabis	2116	(54.1)	182	(59.1)	1160	(62.8)	59	(49.2)	211	(54.8)	36	(64.3)	26	(0.7)†	94	(54.7)
Alcohol	1072	(27.4)	158	(51.3)	1074	(58.1)	63	(52.5)	235	(61.0)	40	(71.4)	2575	(73.5)	85	(49.4)
Other	193	(4.9)	14	(4.5)	81	(4.4)	7	(5.8)	28	(7.3)	1	(1.8)	276	(7.9)	22	(12.8)

* By cases reporting use of one, two or three additional drugs.

† Additional problem drug(s) used may be a form of drug in the same family as the main problem drug.

Key points – additional problem substances

- The majority (68%) of cases entering treatment between 2005 and 2010 reported problem use of more than one substance.
- Cannabis, alcohol, cocaine and benzodiazepines were the most common additional problem substances reported by all cases entering treatment.
- Alcohol, cannabis and cocaine were the additional substances most frequently reported by new cases, although benzodiazepines became the third most common additional substance in 2010.
- The proportion of new cases reporting alcohol as an additional problem substance was over 50% for all substances except opiates and 'other' substances, which highlights the link between alcohol and illicit drug use.

Patterns of use

Table 10 presents the median age of new cases at significant milestone indicators, by the most common main problem substances. Half of new cases started their drug use at or before the age of 15. The median age at which new cases first used any drug was younger for cannabis cases, at 14 years, and older for ecstasy cases, at 16 years. The median age was 15 years for opiate, cocaine and benzodiazepine cases. This means that 50% of those cases first used drugs at or before the age of 15.

While the median age at first use of **any** drug was similar for all substances, there were differences in the median age at first use of the **main** problem drug reported. The median age at which opiate users first used **any** drug was 15 years, but the median age at which they first used opiates was 20 years. This indicates that many of those reporting opiates as a main problem substance started using other drugs before moving to opiates. For cannabis cases the median age at first use of **any** drug (14 years) and at first use of cannabis (14 years) was the same, indicating that cannabis probably was the first drug ever used by many cases.

Half of the cases reporting a benzodiazepine as their main problem substance started to use benzodiazepines before the age of 18, but these cases show the widest range for age at first use, at between 13 and 40 years.

The median age at which new cases first sought treatment for their problem drug use varied between 20 and 28 years.

The number of years between first use of the main problem substance and first entry into treatment was calculated by deducting the age at first use from the age of new cases entering treatment. Half of the new opiate, cannabis and benzodiazepine cases first entered treatment five years after they first used their main problem substance. The time lag is slightly shorter for new ecstasy and cocaine cases, with three and four years respectively between first use and first treatment.

Table 10 New cases: median age at significant points, and time in years between first use of main problem substance and entry into treatment (NDTRS 2005–2010)

	Age first used any drug		Age first used main problem substance		Age first sought treatment		Years between first use of main problem substance and first entry to treatment	
	Median	(range*)	Median	(range*)	Median	(range*)	Median	(range*)
New cases	15	(11–24)	17	(12–31)	24	(15–41)	5	(0–19)
Most common main problem substance								
Opiates	15	(11–27)	20	(14–35)	28	(19–44)	5	(1–20)
Ecstasy	16	(12–22)	17	(13–24)	21	(16–33)	3	(0–14)
Cocaine	15	(11–23)	18	(14–30)	24	(18–38)	4	(1–15)
Cannabis	14	(11–20)	14	(11–20)	20	(15–37)	5	(1–21)
Benzodiazepines	15	(11–39)	18	(13–40)	25	(16–54)	5	(0–23)

* Age/time range presented is 5th percentile to 95th percentile (90% of cases are included within this range).

Risk behaviours

Table 11 presents the number and proportion of cases who reported having ever injected (injector cases) as well as their characteristics. While the actual number of injector cases increased in all years except 2006 and 2009, the proportion decreased each year during the period under review, from 46% in 2005 to 34% in 2010. This finding is in line with trends in other European countries.^{12,17} The proportion of previously treated cases who reported ever injecting decreased steadily over the reporting period, from 66% in 2005 to 48% in 2010.

The median age at which injector cases first started their drug use remained stable, at 14 years, over the reporting period, and was the same for new and previously treated cases. This means that half of the injector cases started their drug use at or before the age of 14.

The median age at which previously treated cases first injected was 19 years in the period 2005–2007, and 20 years in the period 2008–2010. The median age at which new injector cases first injected was slightly higher; in 2010, half of new injector cases started injecting at or before the age of 22 years. These data suggest a trend towards an increasing interval between the start of illicit drug use and first injecting.

Table 11 Risk behaviours by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases*	4707		5037		5522		6107		6270		7236	
Ever injected	2164	(46.0)	2149	(42.7)	2331	(42.2)	2471	(40.5)	2341	(37.3)	2428	(33.6)
Injector cases	2164		2149		2331		2471		2341		2428	
Of which:												
Ever shared	1305	(60.3)	1268	(59.0)	1333	(57.2)	1339	(54.2)	1195	(51.0)	1246	(51.3)
Currently injecting	918	(42.4)	976	(45.4)	986	(42.3)	1017	(41.2)	877	(37.5)	855	(35.2)
Median age (range†) started drug use, in years	14	(11–20)	14	(10–20)	14	(10–19)	14	(10–20)	14	(10–19)	14	(10–20)
Median age (range) started injecting, in years	19	(14–30)	19	(15–30)	20	(15–30)	20	(15–32)	20	(15–32)	20	(15–32)
New cases	1940		2174		2371		2605		2856		3075	
Ever injected	358	(18.5)	424	(19.5)	477	(20.1)	561	(21.5)	576	(20.2)	445	(14.5)
Injector cases	358		424		477		561		576		445	
Of which:												
Ever shared	160	(44.7)	189	(44.6)	228	(47.8)	229	(40.8)	242	(42.0)	177	(39.8)
Currently injecting	189	(52.8)	216	(50.9)	234	(49.1)	241	(43.0)	255	(44.3)	213	(47.9)
Median age (range) started drug use, in years	14	(11–22)	14	(11–22)	14	(10–20)	14	(10–20)	14	(10–20)	14	(11–24)
Median age (range) started injecting, in years	20	(15–31)	20	(15–32)	21	(15–33)	21	(15–33)	21	(15–33)	22	(15–35)
Previously treated cases	2639		2703		3023		3405		3315		4023	
Ever injected	1745	(66.1)	1638	(60.6)	1798	(59.5)	1875	(55.1)	1737	(52.4)	1946	(48.4)
Injector cases	1745		1638		1798		1875		1737		1946	
Of which:												
Ever shared	1112	(63.7)	1040	(63.5)	1082	(60.2)	1100	(58.7)	947	(54.5)	1056	(54.3)
Currently injecting	704	(40.3)	727	(44.4)	717	(39.9)	764	(40.7)	614	(35.3)	628	(32.3)
Median age (range) started drug use, in years	14	(11–20)	14	(11–20)	14	(10–19)	14	(10–20)	14	(10–19)	14	(10–19)
Median age (range) started injecting, in years	19	(14–30)	19	(15–29)	19	(15–30)	20	(15–31)	20	(15–31)	20	(15–31)
Treatment status unknown	128		160		128		97		99		138	

* Excludes cases whose injecting status is not known.

† Age range presented is the 5th to 95th percentile (90% of cases are included within this range).

Although the proportion of new cases who reported ever injecting increased slightly, from 19% in 2005 to 22% in 2008, the overall downward trend in the proportions of injector cases is reflected among new cases in the later years of the review period, with a slight decrease in 2009 (to 20%) followed by a sharper drop in 2010 (to 15%) (Figure 10). The proportion of new cases reporting injecting in the four weeks prior to entering treatment decreased from 10% in 2005 to 7% in 2010. The proportion of new cases reporting having shared injecting equipment peaked in 2007 (at 10%) and decreased in subsequent years.

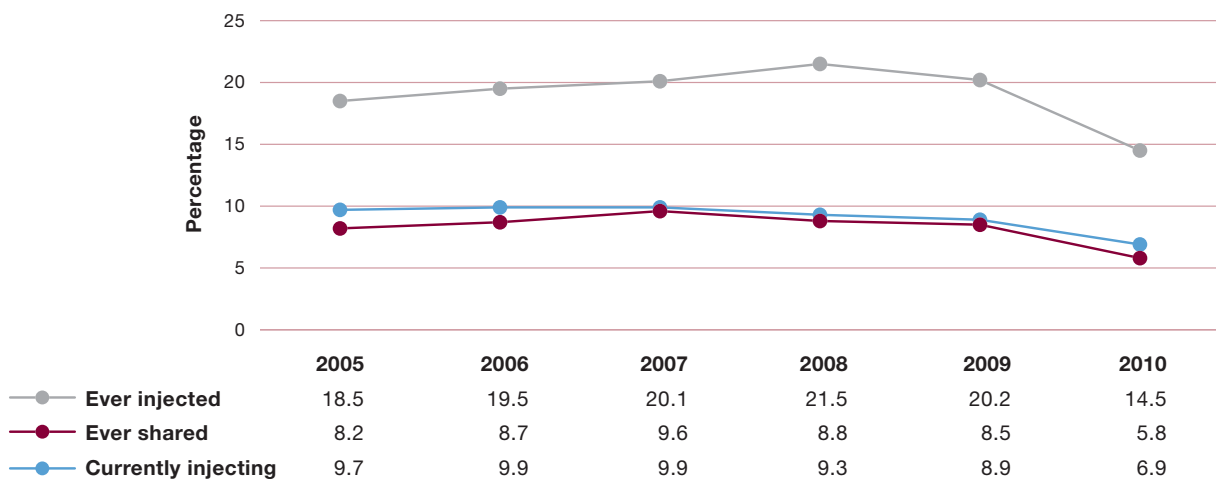


Figure 10 New cases: reported risk behaviours (NDTRS 2005–2010)

Figure 11 shows the decrease in the **proportion** of injectors and in the sharing of injecting equipment as reported by previously treated cases between 2005 and 2010. This decrease is likely to be the result of the more widespread adoption of harm reduction policies and practices in recent years.

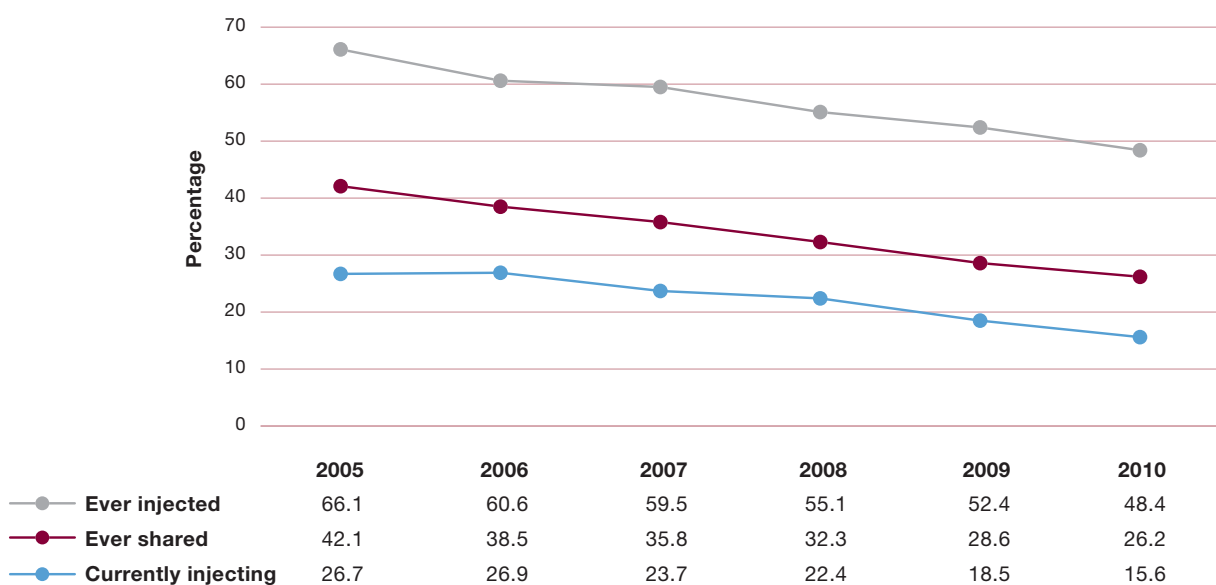


Figure 11 Previously treated cases: reported risk behaviours (NDTRS 2005–2010)

Key points – patterns of use

- Half of new cases entering treatment between 2005 and 2010 started their drug use at or before the age of 15.
- Five years was the average time lag between first use of main problem drug and first entry into treatment.
- Among previously treated cases there was a decrease in injecting behaviours, including the sharing of injecting equipment, between 2005 and 2010. A similar trend was noted among new cases from 2008 onwards.

Socio-economic characteristics

Table 12 presents socio-economic characteristics of treated cases. In the six-year period, the median age of cases increased from 26 years in 2005 to 28 years in 2010. The trend was similar for previously treated cases (from 28 years in 2005 to 30 years in 2010) and for new cases (from 23 years in 2005 to 24 years in 2010). Just over 8% of cases were under 18 years of age. The proportion of new cases under 18 years of age decreased between 2005 and 2006 but increased again in the subsequent four years, to reach 16% in 2010. Cases in that age group represented just over 3% of previously treated cases, with a slight increase throughout the period under review.

Though small, the proportion of cases who reported being homeless increased between 2005 and 2008, when it peaked at 6%, and then decreased to its lowest level, at 4%, in 2010. Overall, the incidence of homelessness was higher among previously treated cases (6%) than among new cases (4%).

The number of non-Irish nationals entering treatment increased during the period under review. In 2010, 5% of new cases reported a nationality other than Irish. This increase may have implications for service provision as the majority of treatment interventions rely heavily on verbal communication, and there may be a language barrier if clients are not fluent in English.

Overall, the proportion of cases who had left mainstream education before the age of 14 remained relatively stable at 20%, with a slight decrease to 19% in 2010. Five per cent of cases were still attending school, with a higher proportion among new cases (10%) than among previously treated cases (1%).

The proportion of all cases who reported being employed dropped from 22% in 2005 to 9% in 2010.

Table 12 Socio-economic characteristics of cases, by treatment status (NDTRS 2005–2010)

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	4877		5238		5749		6322		6497		7593	
Median age (range*)	26 (16–41)		27 (17–42)		27 (17–42)		28 (16–43)		28 (16–44)		28 (16–44)	
Under 18 years	404 (8.3)		363 (6.9)		423 (7.4)		493 (7.8)		592 (9.1)		707 (9.3)	
Male	3613 (74.1)		4018 (76.7)		4386 (76.3)		4641 (73.4)		4805 (74.0)		5508 (72.5)	
Living with parents and/or family	2536 (52.0)		2664 (50.9)		2853 (49.6)		3175 (50.2)		3192 (49.1)		3681 (48.5)	
Homeless	217 (4.4)		303 (5.8)		300 (5.2)		382 (6.0)		315 (4.8)		297 (3.9)	
Non-Irish national	162 (3.3)		195 (3.7)		240 (4.2)		251 (4.0)		276 (4.2)		317 (4.2)	
Early school leaver	986 (20.2)		1059 (20.2)		1149 (20.0)		1324 (20.9)		1315 (20.2)		1413 (18.6)	
Still at school	275 (5.6)		222 (4.2)		252 (4.4)		303 (4.8)		340 (5.2)		449 (5.9)	
Employed (aged 16–64)	1025 (21.8)		1071 (21.0)		1059 (18.9)		921 (15.0)		689 (10.9)		670 (9.1)	
New cases	1976		2229		2430		2658		2930		3207	
Median age (range)	23 (15–39)		24 (15–40)		24 (16–41)		25 (15–43)		25 (15–43)		24 (16–42)	
Under 18 years	326 (16.5)		285 (12.8)		328 (13.5)		374 (14.1)		466 (15.9)		516 (16.1)	
Male	1542 (78.0)		1759 (78.9)		1877 (77.2)		2011 (75.7)		2261 (77.2)		2414 (75.3)	
Living with parents and/or family	1175 (59.5)		1227 (55.0)		1359 (55.9)		1519 (57.1)		1629 (55.6)		1752 (54.6)	
Homeless	54 (2.7)		104 (4.7)		90 (3.7)		100 (3.8)		101 (3.4)		84 (2.6)	
Non-Irish national	84 (4.3)		93 (4.2)		98 (4.0)		133 (5.0)		141 (4.8)		145 (4.5)	
Early school leaver	274 (13.9)		340 (15.3)		369 (15.2)		412 (15.5)		477 (16.3)		448 (14.0)	
Still at school	240 (12.1)		196 (8.8)		208 (8.6)		242 (9.1)		281 (9.6)		358 (11.2)	
Employed (aged 16–64)	542 (29.7)		590 (28.0)		592 (25.6)		524 (20.8)		386 (13.9)		357 (11.7)	
Previously treated cases	2760		2825		3144		3510		3439		4217	
Median age (range)	28 (19–42)		28 (19–43)		29 (19–43)		29 (19–44)		30 (18–45)		30 (18–44)	
Under 18 years	72 (2.6)		72 (2.5)		88 (2.8)		108 (3.1)		110 (3.2)		174 (4.1)	
Male	1972 (71.4)		2126 (75.3)		2363 (75.2)		2517 (71.7)		2446 (71.1)		2965 (70.3)	
Living with parents and/or family	1291 (46.8)		1343 (47.5)		1408 (44.8)		1587 (45.2)		1500 (43.6)		1846 (43.8)	
Homeless	155 (5.6)		193 (6.8)		197 (6.3)		273 (7.8)		203 (5.9)		207 (4.9)	
Non-Irish national	74 (2.7)		95 (3.4)		134 (4.3)		116 (3.3)		127 (3.7)		165 (3.9)	
Early school leaver	685 (24.8)		678 (24.0)		749 (23.8)		889 (25.3)		821 (23.9)		945 (22.4)	
Still at school	29 (1.1)		22 (0.8)		42 (1.3)		56 (1.6)		52 (1.5)		82 (1.9)	
Employed (aged 16–64)	460 (16.8)		448 (16.0)		433 (13.9)		380 (11.0)		293 (8.6)		294 (7.0)	
Treatment status unknown	141		184		175		154		128		169	

* Age range presented is the 5th to 95th percentile (90% of cases are included within this range).

In order to illustrate trends over the reporting period, data were further examined for selected socio-economic characteristics for two distinct time periods, comparing the period 2005–2007 with the period 2008–2010.

Figure 12 shows the variation among new cases in the proportion of male cases and in the proportion of cases in employment. Overall, there was a very small decrease in the **proportion** of males between the two three-year periods, from 78% to 76%.

Some changes were observed between males and females and the type of substances used. There was a decrease in the proportion of male cases reporting substances typically reported predominantly by males, such as opiates and cannabis. There was, however, a slight increase in the proportion of male cases reporting substances that were previously commonly reported by females, such as cocaine and benzodiazepines.

The employment rate among cases aged 16–64 years dropped from 28% in 2005–2007 to 15% in 2008–2010, which is considerably lower than that in the general population (53% of the national population aged 15–64 were employed in 2010).¹⁸ This sharp decline in the number of cases in employment is most likely a direct consequence of the current economic climate and reflects the rise in unemployment in the general population. This has important implications for the social and occupational reintegration of drug users.

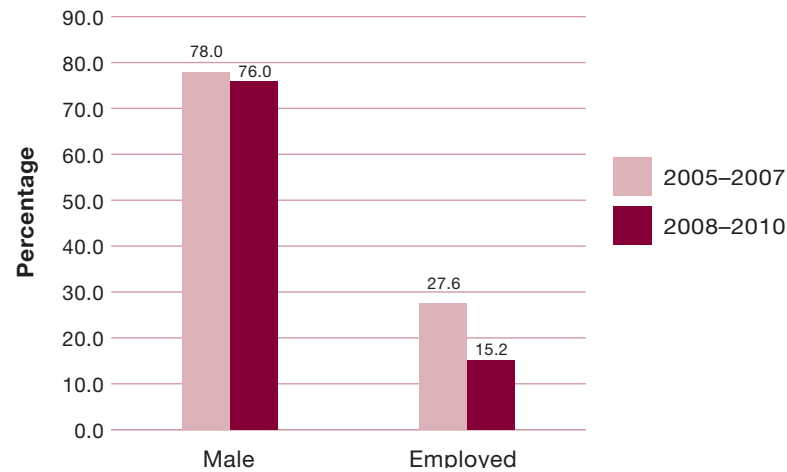


Figure 12 New cases: proportion of male cases and employed cases (NDTRS 2005–2010)

Figure 13 presents a breakdown of new cases by age group for the two time periods. The proportion of new cases decreased in the age groups 18 to 34 years, while it increased for the age groups 35 years and older. This suggests that there is a growing number of older drug users entering treatment for the first time. A slight increase in the proportion of cases aged under 18 was also noted.

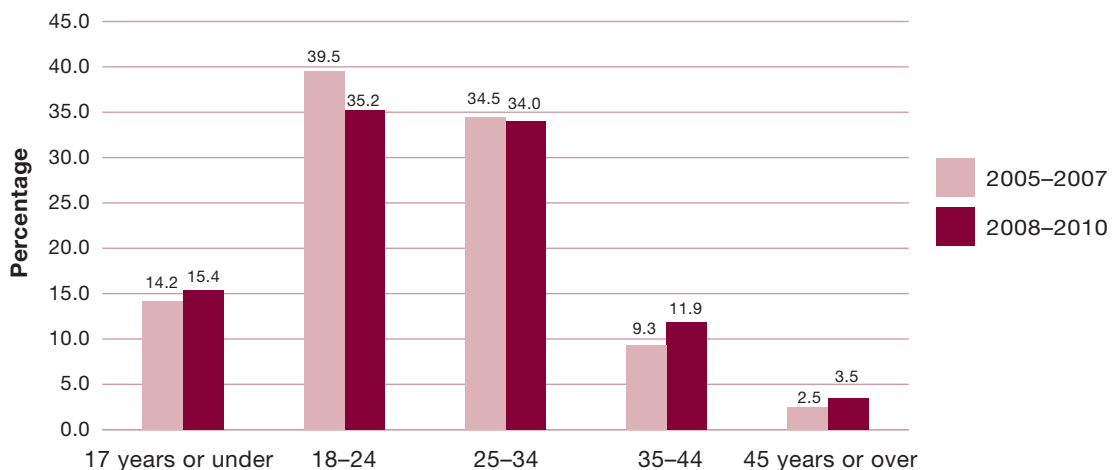


Figure 13 New cases: age groups (NDTRS 2005–2010)

The trends related to age group differed according to the main problem substance used (Figure 14). There was a 79% increase in new opiate cases aged 35 or over, from 448 in 2005–2007 to 802 in 2008–2010. In contrast, however, and although the number of cases was smaller, the age distribution of new benzodiazepine cases has evolved differently over the same period. An increase was noted in the younger age groups, with the proportion of cases under 18 years rising from 15% (27 cases) in the first period to

19% (67 cases) in the second period. There was a 165% increase in new benzodiazepine cases aged under 25, from 72 in 2005–2007 to 191 in 2008–2010, with a parallel proportional decrease in the older age groups, especially among cases aged 45 or over.

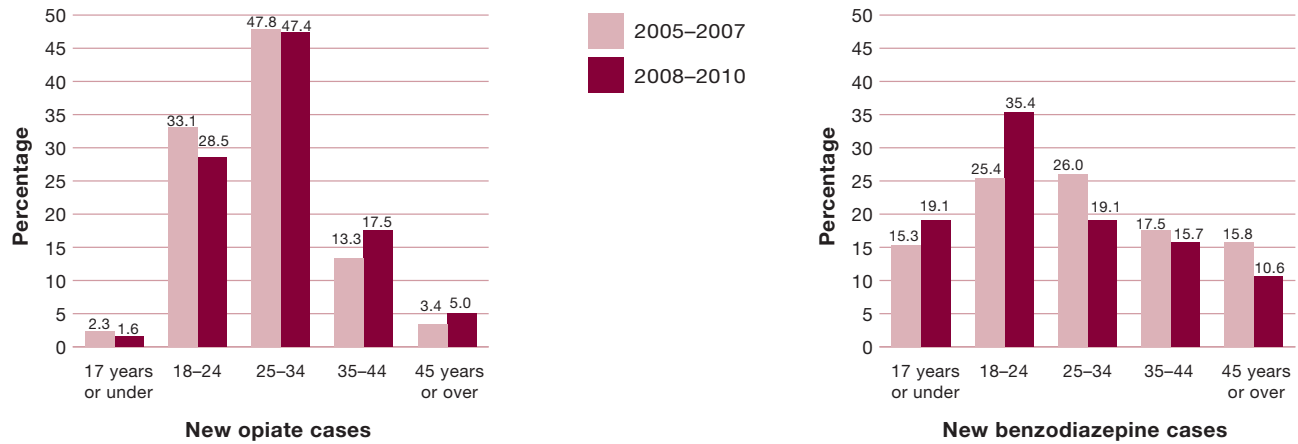


Figure 14 New cases: opiate cases and benzodiazepine cases by age group (NDTRS 2005–2010)

Key points – socio-economic characteristics

- The median age of cases entering treatment increased from 26 in 2005 to 28 in 2010.
- The proportion of cases who had left mainstream education before the age of 14 remained relatively stable at 20%, with a slight decrease to 19% in 2010.
- The proportion of all cases who reported being employed dropped from 22% in 2005 to 9% in 2010.
- Increasing proportions of older drug users sought treatment for the first time; however, trends in this respect varied according to the main problem substance.
- Trends indicate an increase in older opiate users seeking treatment for the first time, while there was an increase in younger new benzodiazepine cases.

Conclusions

Data on treated problem drug use provide an indication of the extent of problem drug use, the utilisation and the demand for treatment services, patterns of drug use and characteristics of those seeking treatment. The analysis presented in this paper provides service planners and policy makers with valuable information in order to highlight and address problem drug use. New data collected by the NDTRS at the time of exit from treatment will provide additional important information on the outcome of treatment, and will be published in future Trends Series papers, which will further assist service planners and policy makers.

The increase in the total number of people requiring drug treatment services, including previously treated cases returning to treatment, is a strong indication that problematic drug use remains a pressing issue throughout the country, often requiring long and repeated episodes of treatment over time.

Between 2005 and 2010, the total number of cases entering treatment for problem drug use increased by 52%. New cases (those who had never been treated before) accounted for 45% of this increase. In 2010, opiates were the most common problem drug (57%), followed by cannabis (25%) and cocaine (9%). The proportion of opiate users remained stable between 2005 and 2008 but decreased slightly in the following two years, whereas the number of cases reporting cannabis as their main problem substance increased significantly. Following a steady increase to a peak in 2007, the number of cases reporting cocaine as their main problem substance decreased in the subsequent two years and remained stable in 2010. Among new cases, benzodiazepines accounted for the highest proportional increase.

The very large number of cases reporting alcohol as an additional problem substance highlights the strong links between alcohol and illicit substance use. As recommended in the National Drugs Strategy 2010–2016, there is a need ‘to bring greater coherence and co-ordination to alcohol and drug issues at a policy, planning and operational level’ (p. 42).⁵

Cases appeared to start using licit and illicit substances as young teenagers, and the age at first use was stable over the period reviewed. However, data showed a decline in injecting behaviour and, for new injectors, an increasing interval between starting drug use and starting injecting. The increase in harm reduction services and practices over the reporting period is likely to have influenced this progress.

The figures show that there was a significant decline in employment rates among drug users, a direct indication of the effect of the current economic climate. These findings outline the continued importance of social and occupational reintegration interventions as part of the drug treatment process.

It is important to reiterate that the data recorded by the NDTRS relate to episodes of treatment, rather than to individual people treated each year, which is a limitation. This means that individuals may appear in the figures more than once if they attend more than one treatment service in a year, and may reappear in subsequent years. This limits the types of analysis that can be done on the data. Proposals for a unique health identifier as an essential element of a national health information strategy are being considered in the context of the forthcoming Health Information Bill. The introduction of such an identifier would be invaluable to the NDTRS in determining the precise numbers of people treated for problem drug and/or alcohol use and the types of service they attend, as well as in identifying patterns in treatment pathways.

The growing demand for treatment for problem use of substances other than heroin, combined with the high proportion of cases using multiple problem substances, remains a constant challenge for service providers, as drug users often require multiple treatment interventions, which in turn require a high

degree of co-operation between services. This inter-agency approach to treatment and rehabilitation was highlighted as one of the priorities in the current drugs strategy.⁵ Supported by the drugs task force structure, many services are increasingly participating in local inter-agency initiatives in order to provide a wide range of interventions and a continuum of care for clients; for example, through the development of case management and key working strategies.^{19, 20}

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Acknowledgements

We thank our reviewers, Dr Eamon Keenan and Ms Linda Montanari, for their helpful comments on earlier drafts of this paper. In addition, we would like to give special thanks to Joan Moore for editing this paper.

The authors would like to express sincere thanks to all those who contribute to the work of the NDTRS, in particular Lorraine Caprani, Ita Condron and Vivion McGuire.

Without the ongoing support of the staff in the alcohol and drug treatment services throughout the country it would not be possible to maintain the NDTRS. Their co-operation is very much appreciated and valued.

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