The need for more comprehensive data on addicts

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The importance of database was recognised within the field of addiction as far back as 1967 when the Home Office Addicts Index was first set up. Over the years, the Addicts Index has developed considerably, serving not only epidemiological but also clinical purposes. However, the information contained in the Addicts Index relates only to users of opiates and cocaine who are attended by doctors. This seriously limits its use as an epidemiological tool, particularly in the light of the current widespread use of a number of drugs unrelated to opiates or cocaine, along with an acceptance of the validity of a non-medical response to drug use.

In recognition of this, the Department of Health started work in the 1980s on developing a nationwide database of drug misuse. The Regional Drug Misuse Databases were developed in response to Department of Health circular HC(89)30 in 1989.

More recently, a Mental Health Information Systems (MHIS) Working Group was set up by the Research Committee of the Royal College of Psychiatrists. Its primary function was to advise the College of the information needs of psychiatrists and the information systems which would support these. In its report to the Research Committee in September 1992, the working group clearly recommended the increased participation of clinicians in the development and implementation of information systems to the benefit of clinical care.

The Regional Drug Misuse Databases (DMDs) represent just such an information system. The DMDs aim to monitor trends in drug misuse and the use of drug misuse services so that the development of services may be targeted to meet changing needs. A further aim of the DMDs is to monitor the success of services in reaching more drug misusers, both in order to offer help and advice in reducing the risk of HIV infection, and to offer treatment for drug misuse.

Monitoring the nature and extent of problem drug use is important for several reasons: it assists government departments in the allocation of budgets; purchasers in their assessment of a population's health and social care needs at a local level; and service providers in planning the development of services; and can be used to assess the impact of preventive programmes as well as social or legal changes.

More importantly, from the clinician's point of view, a body of research data such as is contained in the DMDs provides an invaluable baseline for evaluating the impact of treatment programmes. However, as the MHIS Working Group points out, the value of such a system lies chiefly in its nationwide compatibility:

> "Potential benefits for clinical practice, audit, research, and service evaluation can only be realised if information systems collect data in a standardised form and are compatible;"

Although more than one system exists for the collection, storage and analysis of data, the DMDs collect an identical minimum data set. This does not record the outcome of a full clinical assessment as, for example, the Substance Abuse Assessment Questionnaires does (1989), which can provide an extensive clinical research database. The DMDs contain data items which can be gleaned from a brief clinical assessment, allowing ease of completion at the same time as providing useful epidemiological information.

Nevertheless, the minimum data set does include items which act as criteria for measuring the achievement of relevant health targets. *The Health of the Nation* White Paper pledges to reduce the percentages of injecting drug misusers who report sharing injecting equipment in the previous four weeks from 20% in 1990 to no more than 10% in 1997 and no more than 5% by the year 2000. All DMDs collect data concerning the sharing of injecting equipment within the last month, allowing the achievement of these targets in that part of the drug misusing population that is in contact with services to be measured.

Certain data items within the minimum data set are summarised for each health authority within a region, and submitted by the regional health authority to the Department of Health on a six-monthly basis. These are aggregated to produce a national picture. So far these figures have not been published since the different rates of implementation between regions did not afford

a sound basis for the aggregation or comparison of regional data. However, the Department of Health in conjunction with the National Forum on Drug Data has decided that implementation of the DMDs throughout the various regions is now consistent enough to warrant publication of the figures submitted for the six months ending 31 March 1993.

Data are currently collected from the majority of specialist drug units, both statutory and non-statutory, throughout the country. However, many drug users are seen within general psychiatric settings, and it is therefore vitally important to the validity of the DMDs that data are collected from general psychiatrists.

Within the general psychiatric unit, the volume of data to be collected will be less than within the specialist unit and therefore less time consuming. However, the fact that data need to be gathered only from those patients who misuse drugs means that the task is easily forgotten.

The form itself consists of one side of A4, with tick-boxes for most items: the majority of doctors who have had experience in completing the form agree that it takes around five minutes. A few regions provide software for data-entry and report-generation on site, while in the majority of regions these functions are performed centrally and specific reports generated on request to the database manager. The notification form also provides the means of meeting the doctors' obligation to notify the Home Office of those patients they consider to be dependent on a range of controlled drugs.

Data from the DMDs are already widely used. Most regional health authorities provide regular reports based on DMD statistics, as well as responding to requests for more specific information. An excerpt is available on request from a recent publication by the four Thames regional health authorities in which problem drug use in Greater London, as reported to the DMDs, was examined (Daniel *et al*, 1993). The report has been widely welcomed by service providers, purchasers and policy makers.

For further information about your regional drug misuse database, contact your regional drug misuse database manager who will normally be located within the regional health authority offices.

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A visit to Byelorus

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Byelorussia or Byelorus (ye pronounced as in B'yellow) means White Russia, metaphorically named as the only part of Russia never to have been conquered by the Tartars. One of the former Soviet republics, it lies sandwiched between Russia to the east and Poland to the west with the Baltic states to the north. To the south lies Ukraine with Chernobyl only a stone's throw from the border. This fact of geography allied to the prevailing wind resulted in more than 70% of the damage from the nuclear disaster falling to Byelorussia rather than Ukraine.

The population of Byelorussia is about 11 million, some two million of whom live in the capital, Minsk. Byelorussians were relatively more isolated from western contact and influence than their counterparts in Moscow, Leningrad and Kiev. With the collapse of the Soviet state they have been keen to make up for lost time and to establish links with other countries which will not only help them to recover from a disastrous economic situation but also to learn from ideas, medicine, social systems and legislation. It was in this spirit that Professor Vladimir Ivanov,

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