

COUNCIL  
OF EUROPE



CONSEIL  
DE L'EUROPE

Co-operation Group to Combat Drug Abuse  
and Illicit Trafficking in Drugs  
(Pompidou Group)

## Multi-city study of drug misuse

in Amsterdam, Dublin, Hamburg, London, Paris, Rome, Stockholm

### Final report

Section 1

Drug misuse in the seven cities:  
overview and city reports

Strasbourg 1987

COUNCIL  
OF EUROPE



COUNCIL  
DE'EUROPE

Co-operation Group to Combat Drug Abuse  
and Illicit Trafficking in Drugs  
(Pompidou Group)

**Multi-city study of drug misuse**

in Amsterdam, Dublin, Hamburg, London, Paris, Rome, Stockholm

**Final report**

Section 1

**Drug misuse in the seven cities:  
overview and city reports**

Strasbourg 1987

TABLE OF CONTENTS

	<u>Page</u>
Overview and synthesis of city reports (containing a Foreword on Principles of epidemiology as related to the objectives of the study) <prepared on the basis of drafts submitted respectively by Mr L Lenke and Dr. FR Ingold>	5
Amsterdam city report, by Ms A de Roij-Motshagen	27
Dublin city report, by Ms A O'Hare	71
Hamburg city report, by Mr K J Lange	105
London city report, by Mr R Hartnoll (and Mr D Grey)	135
Paris city report, by Dr. PR Ingold	189
Rome city report, by Mr U Avico	219
Stockholm city report, by MM B Olsson and L Lenke	265

The authors of the final report:

Mr U Avico, Chemist/Pharmatotoxicologist, Istituto Superiore  
di Sanita, Drug Abuse Section, Rome

Mr R Hartnoll, Psychologist/Criminologist,  
Senior Research Fellow, Drug Indicators Project,  
Birkbeck College, University of London

Dr F R Ingold, Psychiatrist/Anthropologist,  
Institut de Recherche en  
Epidemiologie de la Pharmacodependance,  
Paris

Mr K J Lange, Psychologist,  
Section of Drug Abuse Issues, Public Health  
Department in Hamburg

Mr L Lenke, BL, Senior Lecturer,  
Dep. of Criminology, University of Stockholm

Ms A O'Hare, Medical Sociologist,  
Medico-Social Research Board, Dublin

Mr B Olsson, Sociologist, Council for Information  
on Alcohol and Other Drugs (CAN), Stockholm

Ms A J de Roij-Motshagen, Psychologist,  
Public Mental Health Department (GG & GD), Amsterdam

Note

Preliminary work on the study commenced in December 1982.  
The study was completed in autumn 1986.

[The views expressed are those of the authors.]

13.732

03.6

Blank page

OVERVIEW AND SYNTHESIS OF CITY REPORTS  
CONTAINING A FOREWORD ON PRINCIPLES OF EPIDEMIOLOGY AS RELATED TO  
THE OBJECTIVES OF THE STUDY \*

---

\* prepared on the basis of drafts submitted respectively  
by Mr L Lenke and Dr. F R Ingold

Blank page

## FOREWORD

### Principles of epidemiology as related to the objectives of the study

---

In the field of the use of illicit drugs and misuse of medicines, the epidemiological approach cannot satisfactorily be based on a single universal model derived from a study of the distribution and frequency of a pathological phenomenon in a given population. Even the definition of the object of the study and the field of investigation a moot point, and it is quite possible for this definition to vary from one society to another, and from one age to another.

Consequently, when they met for the first time, the experts found themselves confronted with serious epistemological difficulties. Is it scientifically permissible to compare one and the same phenomenon in different societies when the phenomenon is not defined according to the same criteria in each of the societies in question?

Depending on the country in which he is working, his training, his convictions, his preconception of the phenomenon, the researcher in fact inevitably tends to pursue his investigations in a certain direction and to adopt the definitions, field and methods which work best for him. There are various conceptions of drug addiction. It is regarded by some as a disease; some regard it as a symptom; others as a particular mode of behaviour whose meaning or purpose is as yet undiscovered. The fact that not all these substances are equally dangerous, that some are more toxic than others, that consumption or possession of some is legal, and of others illegal, are points which he may or may not take into consideration in his approach; of course, he may limit his investigations to those aspects of the use of such substances that are most harmful to the individual and to society, starting from a medical and legal conception of the problems; but he has to realise that his point of view is not the only one, and that there is inevitably an element of the arbitrary in his choice.

These epistemological questions prompted the researchers to begin by proffering a definition of epidemiology and this definition has proved to be the basic tool for their work.

“PRINCIPLES AND OBJECTIVES (Text adopted by the meeting of research experts in the field of drug use) (Strasbourg, 15-17 June 1983)”

The term ‘epidemiological research’, as commonly used in the drug use field, refers to a broadly defined area of inquiry, reporting and analysis. The phenomena being quantified and studied here are not seen in terms of diseases or symptoms in the biological sense, but patterns of behaviours, as well as the social and psychological conditions associated with or contributory to, those behaviours. The etiology of those behaviour patterns and the study of their consequences are sometimes encompassed under the epidemiological rubric, as well.

There is a wide range of methodologies available in this general field of inquiry: surveys of general populations, surveys of special subpopulations (such as students or conscripts), longitudinal surveys of panels of subjects, surveys of populations of known users, information systems based on data from treatment agencies, ethnographic studies, systems which report related medical consequences (such as medical emergencies and deaths), law enforcement reporting systems (such as seizures, arrests, price and purity) and so on.

### General principles

The following general principles were agreed upon by the participants in relation to any collaborative activities which might be undertaken.

1. Before beginning to count, or describe the phenomena, it is critical to deal with the definitions of the data we collect or intend to collect; and it is important as well to move towards the use of common definitions.
2. It is also critical to be clear and explicit about the populations to which the findings can be generalised.
3. Data collecting or counting numbers is the first step: the second one must be the interpretation of the findings. Numerical techniques should be supplemented by qualitative approaches.
4. The impact of national, regional or local interventions can ultimately be determined only on the basis of solid statistical findings.
5. The same may be said at the international level. The question of what policies have what consequences is most convincingly answered with the help of empirical data.
6. It must be recognised that differences exist among the European countries in laws, culture, social structure and other objective conditions related to drug use. Thus, the common available indicators have quite different meanings from country to country. Nevertheless, it should prove valuable to try to move in the direction of better and more comparable systems for assessing drug use in our various populations.
7. Social problems such as criminality, alcohol use and drug use are most meaningfully understood in the context of the system created to control them. It is, therefore, desirable that studies of drug problems should include the study of such control systems and should bear in mind the underlying ethical judgments regarding the character of the problem.
8. All countries stand to benefit from good evaluation of the 'natural experiments' in policy which take place from time to time in different countries.



### General objectives

The participants adopted the following as the general objectives which would, and should, be served by their collaborative activities.

1. To continue an active exchange of information and experiences in research on drug use.
2. To work towards common definitions and some common techniques for assessing drug use.
3. To improve data gathering concerning the kinds and patterns of the use of psychoactive drugs – both licit and illicit – with particular emphasis on those drugs judged to be associated with the most serious risk of harm.
4. To improve understanding of how and why those patterns (as well as related individual, cultural, social and historical factors) are changing.
5. To provide insight into the role of drug use for the drug users themselves, and into the needs that arise from drug using.
6. To improve understanding of the impact of medical, social and legal policy and of specific interventions.
7. To communicate the information to policy-makers and individual facilities in a form that relates the information to prevention, treatment, and other policy issues.”

This definition suggests that it would not have been appropriate to begin by making a country-by-country comparison of drug misuse. The fact is, there are wide variations within each country, from one region to another, and from one town or city to another, in the scale of the phenomenon and the way in which it is perceived and controlled. This is why it was finally decided to carry out a multi-city study, which had the twofold advantage of bringing together a wealth of information and observations, and of providing, by means of “the framework of communication” set up by the experts, perspectives for a European epidemiological approach. The experts agreed that agency data can make some contribution to answering basic epidemiological questions, but they are aware that there are strong limitations and that this kind of data must be interpreted with great caution. The participants concluded that agency statistics are influenced by several factors and are at best used as part of a set of indicators. In this context the most convincing result occurs when there is a convergence of findings from several reliable and valid indicators. The first step of the study was to collect data of selected and theoretically relevant indicators in the participating cities.

## INTRODUCTION

The task of the working group has been to examine to what extent existing sources of information can be used for describing and measuring drug misuse in European countries. To achieve this aim different approaches have been used.

A natural approach to give information about a problem of this kind is to collect findings from indicators of drug misuse and analyse the results. Already a preliminary inspection of the information made it however evident that this would be a very complicated operation. The reason is that the indicators, even when they seem to show comparable entities, are created in social systems based on substantial differences in perspectives and control philosophies as regards drug misuse.

Drug misuse in Europe as elsewhere has taken on different forms and been introduced at different times. Also the ways in which different societies have tried to cope with this problem vary according to tradition, ideology, control policies and earlier experience. Such experience can vary a great deal. Contacts with cultures where use of narcotic drugs has a long tradition can influence the perspective as well as special traditions concerning control of alcohol and psychoactive substances.

An illustration of the difficulties at present encountered in the epidemiology of drug misuse, and especially of the dangers inherent in attempting to make a "straightforward comparison" can be found in a report on an international seminar on the care of "hard-core addicts" (1). In preparation for the seminar, Pompidou Group member States were requested to give their views on the meaning of the concept of "hard-core addicts". The answers varied a great deal, covering such criteria as "injections", physical harm, dependence, criminality etc. Two countries illuminated the definition problem in a very drastic way. Country A included only drug users who had asked for treatment. Country B, on the other hand, included only drug users who were unwilling to seek help. They thus totally excluded each other's populations from the discussion to come. To an outsider such a result must seem somewhat odd, but knowledge about the different perspectives, for example as regards priority attached to control and care questions, helps to explain.

Efforts have been made in the multi-city study to overcome such problems in finding a system for providing information on the development of drug misuse in Europe: it has been felt that comparison of indicators should be combined with a "case study" approach, the individual cities being the "cases" in question. The term used in the project has been "framework of communication".

Behind the "case study" concept lies the mutual experience that the best way to obtain information on the drug situation in a country is for experts to provide a genuine picture themselves according to their own frames of references and using their own systems of information. This method has the advantage of taking all information from each country into consideration and benefiting from each country's knowledge of the relevance and validity of the information. The method used in this crude form has, however, some obvious shortcomings. One very basic one is the difficulty for an outsider to understand and compare. Therefore a second stage has been introduced.

Taking the individual description of the local situation as a starting point, experts from other countries have posed questions about the more specific meaning of elements of the preliminary descriptions. These questions have had a double function. First, the descriptions have been rendered more accurate as the respondent has understood that there are other possible, and sometimes also more relevant, ways of looking at the description. The questions also demonstrate substantial differences in perspectives and basic institutional goals for drug policy.

In a process allowing for description to be followed by questions and redescription in several steps, it has been possible to reach a situation where the cities can be compared as regards their drug problem and its development. The comparison is however not made in tables where data from the cities' indicators are placed together. Rather, the cities are compared as "cases" or entities with certain profiles of drug use and, to some extent, drug-related problems.

The choice of large cities as units for the study is partly determined by the need to take social anthropology into consideration. To describe the drug misuse problem in a certain area, care and control systems give more information than national averages. In the case of the functioning of the criminal justice system it should be borne in mind that this can in practice vary somewhat according to the local area.

#### 1. THE LEGAL FRAMEWORK – perspectives of control

To be able to understand the meaning of information concerning drug misuse, it is necessary to have some knowledge about the laws regulating the activities of individuals and authorities in a given country. The legislation can be divided into two main sub-groups, the penal laws describing the criminalised area on the one hand and the laws regulating health services and social welfare measures on the other.

The penal laws define when the control apparatus will take action. The strength of the penalties also determines however which measures the authorities are permitted to use and to some extent also the resources that should be destined to "drug problems" for example. The other category of laws regulates the possibilities and responsibilities of the authorities to provide care.

Of special interest in this connection, is the balance between the two approaches to drug problems. Large differences exist between the countries in this respect. These differences have their roots in cultural, organisational and institutional disparities and traditions. Depending on where this point of balance is situated, information will predominantly be provided from the legal or the health sector.

Statistics are also influenced by tradition in the sense that criminal statistics have existed in developed form since the beginning of the 19th century. Health statistics on the other hand, are in some countries a modern form of statistics without the same consistency and stability.

For the countries involved in the multi-city study, there are many similarities in the legal regulations of drug-associated activities. International Conventions influence the national penal codes which cover in general the same drugs and the same acts in relation to drugs. Some countries have categorised drugs differently according to their perceived danger. This often means a priority for substance type rather than quantity and this in turn affects the statistical outcome rather drastically.

Clear differences also exist in health legislation. Some countries stress the duty of the authorities to provide care, others the duty of the individual to accept care or supervision. In practice, however, other differences are more important such as the existence of large-scale maintenance programmes with methadone etc. Many countries also have a rather open communication between the criminal justice system and the care system. Thus, possible ways of using referral for treatment as an alternative to prosecution or penal sanctions seem to be examined in one way or another by all countries in the study.

SWEDEN can be described as a country with a strong control policy approach to drug problems. A large number of persons are sentenced to imprisonment for offences against the drug legislation. (The rate is about 13 per 100,000 inhabitants). The narcotic legislation is extensive and includes besides opiates, cocaine, cannabis, LSD and amphetamines, also for example benzodiazepines.

There is no differentiation in the law between more or less harmful drugs. In court practice cannabis, however, is treated more leniently, but even dealing in small quantities yields prison sentences. Further, special rules regulate the prison conditions for drug offenders.

Large-scale trafficking in cannabis can, however, give rise to maximum penalties (10 years plus 2) and a sentence of 11 years' of imprisonment was passed in Stockholm for such a crime (the Criminal Court in Stockholm, May 1986).

The treatment system acts basically – as regards adults – on the principle of free will. Sweden, with a long history of compulsory treatment for alcoholics, in 1982 extended the legislation in this field to include also abuse of narcotics. So far, however, the law has only been applied in a small number of cases. Maintenance programmes only exist on an experimental basis including about 100 persons. Swedish doctors cannot prescribe opiates and methadone for drug addiction treatment and they cannot prescribe stimulants at all.

The Swedish control profile involves large police resources and extended powers for police surveillance. Telephone tapping (after court decision) is a standard method in Swedish anti-drug campaigns and affects several hundred persons every year. Each county has its own drug squad, and in Stockholm it comprises 80-100 police officers. The criminal justice system is thus a natural source of information.

Somewhat atypical to the Swedish profile is the fact that drug use per se is not a criminal offence. All forms of possession are however criminalised and acted upon.

In contrast with the Swedish profile, the UNITED KINGDOM has a long tradition of maintenance programmes also including heroin. Methadone programmes are common and any doctor still has the right to prescribe drugs with the exception of heroin and cocaine. (Earlier any general practitioner could prescribe heroin, as well.) In fact, any drug addict seen by a doctor should be reported to the Home Office.

The legislation differentiates between three classes of narcotic drugs and the sanctions vary according to the class. Cannabis and amphetamines are classified in a category with more lenient sanctions.

A gradual shift from a strict medical perspective towards a control orientation is taking place. In the 1980s police and customs resources have increased substantially, life imprisonment for trafficking in class A drugs was introduced, and sentences have become more severe.

The FEDERAL REPUBLIC OF GERMANY is rather close to the Swedish profile. The country rejects the use of maintenance programmes. Drug use per se is not an offence, but possession of drugs in small quantities is prosecuted, although proceedings can be dropped\*- The law does not differentiate between more or less harmful drugs. The drug squad in the Hamburg police department is composed of about 50 persons.

In FRANCE the drug legislation is part of the public health code and any person making use of substances or plants classified as narcotics is placed under the supervision of the Health Authority. The use of illicit drugs is criminalised but the prosecuting authority may require the drug user to undergo treatment. Drug users may also be referred to the Health Authority by medical or social services or they may apply spontaneously to prevention and treatment programmes. The maximum penalty is ten years of imprisonment for trafficking, and is doubled in the case of a further offence.

ITALY gives low priority to cannabis drugs. Since 1975 it punishes neither use, nor possession of narcotic drugs for "own use", by addicts. It provides methadone programmes, with rather strict limits. In Rome, about half of the treatment units use methadone, and for the period 1980-1985 also morphine was used in the programmes. The maximum prison sentence for drug crimes is 15 years.

In IRELAND drugs are controlled with varying degrees of stringency under four schedules of Misuse of Drugs legislation. In response to evidence of growing opiate misuse in the early 1980s, legislation was enacted which provides for longer prison sentences and higher fines for drug-related offences. The Dublin police force now has a drug squad of approximately 40 persons. Maintenance programmes exist on a small scale and with very low doses.

The NETHERLANDS has a rather non-repressive approach to drug problems and only the gravest forms are acted upon. (The imprisonment rate for crimes against the drug legislation is, however, ca 10 per 100,000 inhabitants. This rate has increased dramatically during the last years and the country is in fact rather close to Sweden in this respect.) (2)

A large-scale maintenance programme with methadone exists in Amsterdam. The motive for this policy has been to decrease the risk of social marginalisation and criminalisation of the drug users.

## 2. THE TREATMENT SYSTEMS

### 2.1 Overview

The best way to reach an understanding of the functioning of the treatment systems in the different cities is probably to look at their aims. Naturally, every system has as the main goal the total rehabilitation of drug users. In practice it is however not always possible to obtain this goal. Many subordinate goals have therefore been established to fill urgent needs.

In order to give an accurate description of the different treatment systems, a main factor for consideration is to what extent they are aimed at obtaining total abstention from drug use or at least maintaining some form of controlled drug use. Motives behind the choice of model of treatment are again determined by socio-cultural and organisational questions and are probably strongly affected by the size and structure of the drug problem.

As a general feature all cities have emergency rooms for critical incidents connected with drug misuse and also units for detoxification as a part of primary treatment. As a secondary treatment line the use of therapeutic communities exists in some form and sometimes also maintenance programmes with primarily the use of methadone. Finally, as a tertiary line almost all cities use maintenance programmes when the hope of drug abstention seems unrealistic.

AMSTERDAM. The treatment system in Amsterdam is the most diversified and includes almost all varieties available in the other cities. A well-known feature of the Amsterdam treatment system is the different and manifold forms of methadone programmes in effect. These programmes aim at "blocking" the use of illegal drugs and to obtain this goal also buses provide methadone on a so-called "low threshold basis". This means that methadone is given without controlling for a parallel use of illegal drugs with for example urine tests. One motive for this programme is to decrease the risk of criminalisation and social marginalisation seen as consequences if drug users are referred to the illegal market. Other motives for this project are that all drug users are not motivated for treatment and that the supply of treatment facilities is not in balance with the demand.

Methadone is also used by general practitioners to make socially adjusted drug users able to lead a non-criminal life. Finally methadone is used in detoxification treatment and in Amsterdam there is also a special unit for the treatment of drug users while under police arrest.

When drug users are motivated to go into treatment in the form of social training, therapy etc and such treatment is available, methadone can still be used but under special circumstances. In these settings controls are made to guarantee that illegal or other legal drugs are not used simultaneously. In order to control the provision of methadone in the different settings, a central register has been established and includes in 1986 about 13,000 names.

The treatment available is of many kinds and often in the form of therapeutic communities, with or without the use of professional staff. The programmes are specially designed to meet the demands of particular sub-populations of the drug users such as the criminally involved, chronic users but also persons with ties to a "normal" lifestyle.

Amsterdam drug policy is aimed at treatment of drug addicts in their own social environment. Contacts with parents and other relatives are therefore considered of great importance. Finally, interest, promotion among drug users is taken care of by the Medical Social Service of heroin addicts (MDHG), often referred to as the "junkie union".

DUBLIN. The treatment of drug users in Dublin takes place in a system built up around one medical treatment centre, the Jervis Street Drug Centre opened in 1970. The majority of attenders are self-referred but also come from the probation service, general practitioners and the drug squad. They can be further referred to two therapeutic communities or can receive counselling from social workers.

The standard treatment at the Jervis Street Drug Centre for opiate misuse is maintenance programmes with methadone in liquid form taken orally and with doses of approximately 10-25% of those provided in for example Britain or the United States. Additionally, treatment is provided in the psychiatric hospitals. The role of general practitioners varies. The majority refer drug users to the Jervis Street Drug Centre while a few have been known to provide long-term methadone maintenance treatment.

Various treatment programmes operate within the prison services, notably a methadone one, available to drug users who enter prison while still addicted. The professional services of psychiatrists, psychologists, social workers and probation officers are available to individuals seeking counselling. Voluntary groups, like Narcotics Anonymous, come into the prisons, usually on a weekly basis, to assess the suitability of persons interested in participation in their various programmes. However, little objective information is available on the number and characteristics of persons who use these services.

HAMBURG. In Hamburg methadone is not used for treatment, but only for detoxification and then only if the drug user has declared himself/herself willing to go into treatment. Therapeutic communities constitute the dominating form of treatment with professional staff and with long-term treatment of about 18 months as the recommended time.

Four therapeutic communities provide places for 115 residents and "there are no admission problems since the drop-out rate is quite high" (Hamburg report, page 112). The treatment is based on the principle of voluntary decision. In practice the court system puts pressure on the drug users to go into treatment and "most clients seek treatment in order to avoid imprisonment" (page 114).

LONDON. The treatment system in London has an old tradition of serving a small number of opiate addicts with the prescription of opiates or methadone. Some general practitioners have continued this tradition and still provide methadone on a non-reducing basis. The modern pattern is however that drug users are treated in special treatment centres and the dominating model is out-patient treatment on a dose-reducing basis with methadone. The recommended time for this treatment is one to six months.

From the treatment centres drug users may be referred to a number of treatment units around London, often organised as therapeutic communities. Referrals to “non-acute” treatment are generally made by the treatment centres with one exception. This is the so-called “City Roads” centre, functioning as a crisis centre with short-term (three weeks) interventions and providing detoxification and possible referral to more long-term treatment.

In the prisons there are no specific facilities established for drug users and they are treated by the ordinary Prison Medical Officers, who can only provide detoxification. The probation service plays a substantial though often unrecognised role in supervising offenders with drug problems.

A significant role in the British treatment system is played by a range of non-statutory organisations which offer confidential and easily accessible advice, counselling and referral. Recently, client organisations such as the NA (Narcotics Anonymous) and FA (Families Anonymous) and other voluntary groups have also become important in rehabilitation and in encouraging drug users to seek and get help.

PARIS. Before 1971 treatment of drug users was taken care of in psychiatric hospitals or in some private clinics. The treatment system specially designed for drug users in Paris was established in 1971 with the medical treatment centre of Marmottan as the starting-point.

The development of treatment in Paris since this period can be described as a wish to avoid that one treatment ideology dominate. Private associations funded by the State, along with special units in general and psychiatric hospitals, provide a broad treatment system, which includes methadone treatment on an experimental basis, therapeutic communities, family therapy and social guidance.

In the second half of the 1970s the accent was shifted from basic treatment to the process of after-care and follow-up. The latest trend in the process is to de-specialise the medical and social care and to engage ordinary practitioners in treatment.

Diversification is a keyword in Paris treatment and neither maintenance programmes nor therapeutic communities are dominating. Total anonymity is guaranteed and the treatment is free of charge.

ROME. The Rome treatment system is decentralised and consists of 28 treatment services (emergency units not included). From these services referrals can be made to therapeutic communities run by private or public organisations.

Treatment in Rome follows two main streams, maintenance programmes and therapy (even if the term “therapy” is not accepted by many therapeutic communities, as they do not perceive drug misuse as an illness). The treatment programmes use methadone (for a period morphine was also used) and it is estimated that about 50% of the persons in treatment are pharmacologically treated.

In Rome detection techniques are elaborated (with different criteria according to the services concerned) and used to assess the degree of tolerance the drug user has developed and thus the kind of treatment he/she needs. (Reference is made in the Rome city report to the possible use of the naloxone test in the criminal justice system to find out to what extent a certain quantity of possessed drugs can be said to be “for personal use”.)



Drug treatment in Rome is provided free of charge and with a guarantee of anonymity.

STOCKHOLM. The Stockholm treatment system differs in many respects from the systems of the other cities. Principally, total abstinence is the only accepted goal for treatment. In practice this implies that maintenance programmes are only used on an experimental basis at a treatment facility on the tertiary line, i.e., for about 100 opiate users for whom abstinence is believed to be unrealistic.

Psychiatric hospitals play an important role in the system. One reason for this can be that the dominating – and before 1970 almost exclusive – drug misuse has been the intravenous taking of stimulants like amphetamines often with psychosis as a consequence of heavy use.

In Sweden there is also a tradition of compulsory treatment of alcoholics introduced in 1916. Even if this law is not applicable to drug users, the concept of compulsive treatment has always been on the agenda also for drug users. In practice only a limited number of drug users has been treated compulsorily and then according to the legislation for the mentally ill. The new law of 1981 makes it possible to carry out compulsory treatment under special “ xxx r r circumstances, with a time limit of two (plus two) months. In spite of an intensive debate, the measure has so far only been used in a small number of cases. For drug users below the age of 18 however it is not rare to use compulsory treatment; this takes place in reformatory schools or at collectivities using for example the “Hassela-model” of treatment. This means long-term residence in a small family-based collectivity and with a three-year social training and educational programme.

In Stockholm medical care is administered by the county and social care by the local community (the city). Thus, hospital admissions and detoxification are governed at county level while social programmes such as therapeutic communities are governed and paid for by the city council. In practice most treatment facilities like therapeutic communities are run by private organisations like the client organisation for drug users (RFHL) or the therapeutic communities working on a Daytop model. As a rule these units are financed by the city council and to some extent with federal support.

Within the criminal justice system it is possible for part of the prison sentence of a drug user to be converted into a treatment programme (or education etc). In one prison – Osteraker – there is also a special treatment unit with the condition that urine tests are carried out.

A special feature of social care in Sweden is the placing of persons in ordinary families. This has also been a growing facility for drug users and the families are specially supported by the social services at community level. This facility is designed for young persons but has more and more been used also for adult drug users.

## 2.2 Comments on the treatment systems

The following comments can be made concerning the treatment systems and their relevance in the context of the information systems.

First, there are signs of a growing scepticism as regards professionalisation and a pharmacological categorisation of drug problems. Legal drugs such as alcohol and tranquillizers are pointed out as being far more damaging to society than illegal drugs. Drug misuse is also perceived as only one of many serious problems facing the categories of population focused on in this study. It has even been questioned whether a strict categorising as “drug addicts” favours in any way the interests of these persons.

Another notion is that “treatment ideology” – strongly criticised in the field of criminal policy – seems to carry much weight as regards drug misuse. The implications are that models of drug addiction are “illnesses” and the addicts necessarily in need of treatment. This concerns not only opiate and cocaine addicts but also in some cases cannabis users.

An implication of a “treatment ideology” is arbitrariness in contacts with the criminal justice system. Earlier experiences in the case of alcoholics showed that short prison sentences could be replaced by months and sometimes years of treatment, more or less compulsory.

Of special relevance to this study is how decisions in courts or in pre-trial settings affect the interest of “seeking” treatment.

### 3. THE INFORMATION SYSTEMS

#### 3.1 Overview

AMSTERDAM – Information is mainly received from the Central Registration System (CMR). This system aims at controlling the distribution of methadone to different programmes in the city. The register for this programme includes some 13,000 names and functions as the main source of information for drug problems in the city.

DUBLIN – The main source of information about serious drug misuse is the “Jervis Street Drug Centre”. Five indicators of drug misuse in the city have been selected as most reliable: first treatment demand, hepatitis B, police seizures and arrests, surveys.

HAMBURG – A register is kept with information mainly from the police. Opiate users have been the main target for registration; in recent years cocaine users have also been notified.

LONDON – A central register has been kept by the Home Office since the “1930s. Since 1968 it has been a statutory requirement for doctors to notify any addict they see to the Home Office. “Addicts” denotes in this case opiate users.

PARIS – No central register exists (a working party has been given the task of putting forward proposals for a monitoring system). The main source of information is the treatment centres, using statistics on “first contact” as an indicator. Also the military services produce statistics on “drug-related behaviour”. Surveys have so far only been used to a very limited degree.

ROME – Anonymous urine tests among draftees in 1980 and 1982 made it possible to estimate drug misuse among the younger age groups of the male population. A central monitoring system is run by the Ministry of the Interior, based on treatment demand at public services and residential communities.

STOCKHOLM – No register of drug users exists in Sweden. Case-finding studies have been performed in 1967, 1979 and 1984. Besides, a continued study of vein punctures among arrestees provides information. Information from the Maria Drug Centre is used to describe contacts with young drug users. Surveys among pupils in primary schools and among draftees have been conducted since 1970.

### 3.2 Comments on the information systems

A very wide range of channels exists in the different cities for collecting information about the drug situation. The ways in which information systems have been set up or developed reflect policy priorities. As a general conclusion it can be stated that at local level certain authorities seem to have a good overview of the drug situation and its development. A striking feature is however that many potential methods and sources of information are not being used in the different cities.

The question of integrity of the information systems is highlighted in the reports. Only Paris and Rome so far can guarantee total anonymity for people seeking care. Confidentiality is the general rule and information is seldom sent from the health sector to the criminal justice system, but often in the opposite direction. The Home Office notification system in London cannot be used by the criminal justice system.

As concerns the validity of information from different sources, the problem of misclassification should be discussed. Traditionally police statistics have been viewed with scepticism as an indicator of “real” criminality. Policy and organisational incentives can obviously affect the picture of crime. Seldom is it noted that similar incentives exist within the treatment system and that these systems also “create” their own reality. Over-estimation thus strengthens the position of the treatment organisations and helps to obtain funding.

That over-reporting exists is illustrated by Italian findings that many “self-reported” addicts received in prisons have not shown signs of tolerance when tested. In certain cities treatment centres’ use of “outreach activities” among addicts can have the same effect on statistics as police activities.

Also in case-finding studies of drug users the problem of over-reporting is one obstacle. In a Swedish study it was found that the risk of “occasional users” being classified as “regular users” was significant. As the former group is many times larger, the risk of over-estimation of “regular users”, can distort the picture to a very great extent.

One final comment on information available: “drug-related deaths” has been judged to be a poor indicator for variation in drug misuse in the seven cities. There are many reasons for this; arguments are presented in the Technical report on indicators (Section 2).

Against this background of policy and information systems, the drug situation and its development can be described as follows:

#### 4. DRUG MISUSE – development and current situation

##### 4.1 Overview

AMSTERDAM – From experimental use of many different drugs in the 1960s a heroin market was established in 1972. Since then the problem has increased considerably and in the 1980s cocaine misuse has also become of significance.

The monitoring system includes in 1986 approximately 13,000 persons, of whom 6657 have been provided with methadone this year. An estimation of the rate of regular users of opiates would be 20-30 (per 1,000 inhabitants aged 15-39 years). However the drug user population in Amsterdam is known for the large number of foreigners or persons non-resident in Amsterdam but in other parts of the country.

DUBLIN – The first wave of drug misuse occurred in 1969-1970: mainly amphetamines, barbiturates and cannabis. Heroin was introduced in the second half of the 1970s and approximately a fivefold increase was observed between 1979 and 1983. In that year the problem peaked and has now stabilised at a lower level.

Surveys of secondary school children (aged 12 to 18 years) in 1971 and 1981 showed an increase in the group which had “ever experimented” with drugs from 2.3% to 11%. Heroin use was very rare in this age group, but had also increased.

All available evidence supports the view that Dublin is so far the only city in Ireland which has experienced a severe opiate problem.

Using treatment data as a basis for estimation, a rate of 3 per 1,000 (15-39 years of age) can be calculated. Since only this form of data is used, the estimate is probably too low.

HAMBURG – Around the year of 1970 a drug culture using cannabis and LSD emerged, with a middle-class social background. Out of this group a segment went on using opiates. In 1974 a heroin market was established, probably supplied from Amsterdam. This market functioned with some interruption until today. There is a significant number of injecting opiate users in Hamburg, but there has been a certain stability in the situation since the early 1980s.

Survey data suggest a decline in the number of persons who have “ever used illegal drugs” (mainly cannabis): from 27% to 14% at the beginning of the present decade.

The estimated number of regular users of opiates is about 1,800 (the number of “active” cases counted in December 1985 was 1,764). The rate is 3 per 1,000 inhabitants (15 to 39 years). This rate takes into account an established significant proportion of out-flow (“maturing out”) cases. However, if one looks at the cumulative figure of 3,232 persons notified as opiate misusers since 1969, then of course the prevalence rate is 5.5 per 1,000. As the estimation is mainly based on police contacts, it might be too low.

LONDON – The first increase in opiate addiction took place in the 1960s. The most commonly used drugs were cannabis among students and middle-class groups and amphetamines among working class groups. At the end of the 1970s a second opiate epidemic developed, although now the situation seems to have stabilised. Opiate misuse has spread from socially marginalised groups to a wider range of the population, including both working-class and middle-class communities. It often starts in the form of heroin sniffing or smoking. Sometimes this develops into use by injection. Use of amphetamines and, to a lesser extent, cocaine, has increased in recent years; however, although relatively widespread, they are less visible from agency data.

The estimated number of regular opiate users is between 25,000 and 30,000 giving a rate of 8 to 10 per 1,000 inhabitants (15-39 years). This estimate is based on several sources and should cover also undetected cases.

PARIS – Illicit use of drugs started at the end of the 60s. It increased considerably during the second half of the 70s, when a market was established, which continued in the beginning of the 80s. Heroin use has stabilised but the use of cocaine has become rather widespread. Cocaine use is also found in the heroin-using population.

Taking 5,800 persons who have made a contact with a treatment centre as a basis for estimation, the rate would be about 7 per 1,000 inhabitants (15-39 years). As in the case of Dublin, the estimate is based on treatment contacts and is probably too low.

ROME – A great increase occurred in heroin use in 1974-75, when less harmful drugs disappeared from the market and were substituted with heroin. Also a cocaine problem has emerged during the last years.

The estimated number of regular opiate users in Rome is about 10,000. This gives a rate of about 9 per 1,000 inhabitants (15-39 years). The estimate is based on studies using tests of body fluids and should cover all cases.

STOCKHOLM – Widespread use of injections of amphetamines since the middle of the 1960s complemented cannabis use in other groups. The problem culminated at the beginning of the 1970s. Heroin injection use was introduced in the middle of the 1970s, but was concentrated in Stockholm (and Malmo, close to Copenhagen).

The injection users in Stockholm were estimated to be about 3,000 to 4,000 and heroin use never exceeded one third of this population. The drug situation seems to have stabilised at a lower level. The rate of regular users of injections for Stockholm is about 7 per 1,000 inhabitants (15-39 years). As the estimate is based on case-finding and the use of capture-recapture techniques, it should include all cases.

It might seem that some cities like Hamburg, London, Rome and Stockholm have more confidence in their estimates than do Amsterdam, Dublin and Paris. This might be due to the varying potential of their sources of information when it comes to creating valid point-prevalence rates (which is a separate aspect from the use of data from indicators to illustrate changes in drug misuse over time).

## 4.2 Comments on the drug situation

### 4.2.1 Forms of drug misuse and administration

As a commentary on the drug situation in the different cities', many similarities can be noted. All cities experienced illicit drug use for the first time as a more widely spread social phenomenon in the 1960s. At that time drug misuse was however almost exclusively centred on cannabis products and, to a more limited extent, stimulants (amphetamines etc). The mode of administration was primarily the smoking of cannabis and the oral consumption of stimulants. Exceptions to this rule are Stockholm, with an early epidemic of injection of stimulants and London with a limited epidemic of opiate injections.

These exceptions had nevertheless little in common. While the British problem was socially primarily located among middle-class groups using leakage supply from general practitioners, the Swedish epidemic was already in 1966 primarily found among marginalised groups such as ex-convicts, institutionalised youth, prostitutes etc.

Even some of the other cities report early experience of the more harmful drugs, under various circumstances. Paris has for a long time had a prominent "subculture" of artists etc, using "hard" drugs." Certain minority groups in Amsterdam had brought drug habits with them during the decolonisation period.

### 4.2.2 Development

Looking at the situation today, only Stockholm can be said to have kept its drug pattern intact since the 1960s, while often dramatic changes have taken place in the other cities. Thus, the dominating drug problem in Stockholm is still stimulant injection, even if there also exists a minority of heroin users. The injection population seems to be of about the same size and found in the same segments of the population as before.

All other cities in the study report marked and sometimes dramatic changes in injection use during the 70s and 80s. Specific mention should also be made of observations of cocaine use at "street level" in Amsterdam, Paris and Rome.

The introduction of drug problems started at about the same period of time, but the development has varied substantially. Cities like Hamburg and Stockholm can look back at a rather long period with a stable, and in the case of Stockholm probably even declining, drug problem. For Dublin, London, Paris and Rome, the picture is not as clear, even if there are indications of stabilisation. For Amsterdam most information indicates a still growing trend.

### 4.2.3 Populations

Varying patterns can also be noted as regards recruitment to the drug using population. As mentioned before, the "main" characteristic of the Swedish injection users was – and still is – their origin in segments of the population already notified by the police and social service agents (Sarnecki 1985).

Belonging to a “criminalised” sub-culture already before the onset of drug misuse is hardly representative for all heavy users in the multi-city study. A statement to the effect that injection use of drugs (during the last decade) is a phenomenon concentrated in the lower and even lowest strata of the populations, stands on safe ground. London could however be one exception to this generalisation.

Another factor to take into consideration is “nationality” and belonging to minority groups. Not surprisingly there is often an over-representation of “foreign nationality” in populations convicted of serious drug trafficking. The reason for this – among others – is the advantage of foreigners in relation to national criminals as regards the necessary contacts with producers and “wholesale” dealers. These close contacts are a necessary condition to be able to control the quality of the drugs and to settle a deal. It should also be kept in mind that “foreign nationals” in the study often denotes persons from the other cities of the study.

Another aspect is the nationality of the users. Primarily Amsterdam is known for the presence of a high number of foreign users. Another peculiarity of the drug pattern in Amsterdam is the large proportion of users (with Dutch nationality) originating from Surinam (a former colony of the Netherlands). In this minority an early habit of smoking opiates shifted during the 1970s over to injection use.

A different pattern is observed in London. There is a tradition of cannabis-smoking amongst some of the Vest Indian minority, but widespread use of other drugs has not been reported, although in the last two years there has been some evidence of heroin and cocaine use.

#### 4.2.4 Age

It is not possible to describe the age structure of drug-using populations without methodological difficulties. The first problem appears in the selection process. Surveys will probably be directed at specific groups such as students, conscripts etc and populations in a sense already defined as regards age. Besides the selection problem, one has to make a separation between incidence and prevalence and be aware of the fact that a phenomenon which starts in young age groups will logically produce an increase in average age, as the involved persons grow older.

A new phenomenon with a stable recruitment will thus automatically produce an increase in the average age of the population. Of special interest is (a) to try to find the rate of onset at a certain age and (b) to calculate the average age of active drug users. Further, with a rather “young” phenomenon, the total active population (and their activities) can continue to increase even if there is a decrease in inflow of new users.

With this in mind, there are certain observations to be made concerning the multi-city reports. In the Swedish report, there are strong indications of a stabilisation or even decrease in inflow (the conclusion based on surveys and case-finding studies). A similar pattern is reported from Paris, Rome and Hamburg, while it is not possible to draw such a conclusion for Dublin and London, although there are indications in those two cities that the situation may now be stabilising.

For Paris and London there has been a broadening in the age range for onset of drug misuse; younger as well as older persons have started to use drugs. In Hamburg a study based on police records produced results supporting the “maturing out” hypothesis.

Illegal drug use seems to show rather strong signs of “cohort-effect” (3), in the sense that those who have been in certain age groups at a certain period of time have adopted specific habits and lifestyles and carried them with them for a very long time. Again London, with its second generation of drug misuse, can be an exception and probably also Paris.

To assess the age distribution and changes in in- and outflow as to the drug-using population, must be seen as a major topic for future epidemiological research.

#### 4.2.5 Sex

In contrast with most other forms of deviant behaviour females constitute a significant proportion of drug users. The general sex-ratio varies according to the source. The proportion of females –although generally smaller than the proportion of males – is larger among “users” and in-treatment populations as well as deaths’ figures in comparison with control system populations. The ratio varies from 1:1.5 to 1:4.

#### 4.2.6 The market

Comments should also be made on the market situation and availability of drugs. The city reports include information pointing at the important role of the “supply-side” alongside the above-mentioned “demand (user) side” of the drug problem.

A striking example of the role of the “market” is the Italian “substitution case” in 1973-74. Cannabis suddenly disappeared from the market and was immediately substituted with more harmful drugs, such as heroin. In only a couple of years (1980-1982) a drug-using population of more than 100,000 was estimated for Italy.

A comparable situation emerged in Stockholm in 1973 and 1974. At the time, the supply of stimulants ceased for a long period, due to the police capture of a monopoly dealer (Lenke 1979). In this period of “vacuum”, heroin was introduced for the first time in the city. (It had already three years earlier been introduced in the city of Malmo).

An aspect to take seriously is also the connections between the different markets and cities. Although most heroin coming to Paris in the late 1960s and early 1970s passed through Marseilles, both Paris and Hamburg report Amsterdam to have become the transition centre for their heroin in 1973-74. This is also about the time Amsterdam itself experienced a large increase in heroin use.



Amsterdam was also the main source of heroin and amphetamines for Stockholm at the beginning of the 1970s. However, it was mainly a question of stimulants produced in the Netherlands. Nowadays part of the heroin in Stockholm also comes from Amsterdam, but the bulk is brought in from Turkey and the Middle East.

In London, the effect of supply on patterns of use was seen in the late 1970s when increased importation of South-West Asian heroin was followed by a sharp fall in price and a rise in heroin use.

A number of studies have been directed at the international drugs market. Little has however been done at national and local level and on the link between these levels. Some efforts to analyse the national and local market situations have been made, primarily in the United States, and to some extent also in Europe.

#### 4.2.7 Unemployment

As one major parallel problem to drug misuse, unemployment is reported. As with other forms of deviant behaviour, it should of course not be assumed that there is a direct cause link between unemployment and the drug situation. The connection should however be subject to further attention. It is to be noted that in Hamburg there was no unemployment at the beginning of the 1970s when illicit drug misuse was widespread and a group of "mainliners" gradually emerged. There is a high unemployment rate (almost 13%) today but drug misuse presently appears to be levelling off.

Empirical research in other cities has supported the hypothesis of unemployment as one generating factor behind drug problems (Plant 1986). Thus even for Stockholm, with the lowest rate of unemployment of all the cities, there exists a covariation between the two phenomena, in the sense that, when Stockholm experienced its peak in unemployment at the beginning of the 1970s, drug problems also peaked. (The connection can also be found within regions in Sweden, Lenke 1979). Further, the fact that Stockholm seems to be the only city with a declining drug problem, could also point at unemployment as an important generating factor in relation to drug misuse.

That youth unemployment has an outstanding potentiality as a risk factor in this connection is also illustrated by the rates. Both Amsterdam and Dublin report high levels of unemployment, approximately 18% of the labour force of which one third are estimated to be aged under 25 years. In Dublin most of the drug problem is in the inner city area, which is associated with high levels of unemployment and deprivation. The 1986 youth unemployment rate is 18% (of the labour force) for "outer" London, and for "inner" London – comprising 2 million inhabitants – the rate exceeds 35% for young males.

Notes:

1. Symposium on the care of hard-core addicts. Council of Europe. Strasbourg 1984.
2. Statistical Yearbook of the Netherlands 1985. P. 374. The Hague 1986
3. The classical example of a potential “cohort effect” originates from political sociology. It regards the “faithfulness” of persons voting continuously for the Democrats in the United States, who voted for the first time in the crisis-struck period of the 1930s.

REFERENCES

City reports, Multi-city study, Pompidou Group

Technical report on indicators of drug misuse in seven cities and recommendations for future monitoring, Multi-city study, Pompidou Group.

Avico, U, Mariani, F. (1983). Spread of use of opiates and other psychotropic drugs, and profiles of users among 1982 draftees.

Istituto superiore di sanita. Rome.

Council of Europe. (1974). Penal aspects of drug abuse. European Committee on Crime Problems. Strasbourg.

Council of Europe. (1984). Symposium on the care of hard-core addicts. Strasbourg.

Enroth, H., Lenke, L. (1980). Narkotika och ekonomisk kriminalitet – en studie av den ekonomiska omsättningen på Stockholms narkotikamarknad. (Drugs and economic crimes. An analysis of the economic turnover at the Stockholm drug market). Report to the City Council of Stockholm. Committee on Economic Crimes and Social Marginalisation. (Mimeo).

Hulsman, L. (1984). Drug policy as a source of drug problems and a vehicle of colonisation and repression. Institute Preventieve en Sociale Psychiatrie. Erasmus University. Rotterdam.

Ingold, R. (1984). La dependance economique chez les heroinomanes. Revue Internationale de criminologie et de police technique. No. 3. Geneve.

Lange, K-J. (1986). Neuere kriminalstatistische Beobachtungen zum Verlauf von Opiatabhangigkeit. Monatsschrift für Kriminologie und Strafrechtsreform 69:2.

Lenke, L. (1979). Narkotikamarknad och formogenhetsbrott. (Drug market and the development of crimes against property).

See reference at Enroth, above.

Mott, J. (1981). Criminal involvement and penal response. In Edwards, G., Busch, C. Drug problems in Britain. Academic Press. London.

Peck, D F and Plant, M A (1986). Unemployment and illegal drug use; concordant evidence from a prospective study and from national trends. British Medical Journal, 293, pp. 929-932.

Sarnecki, J. (1985). Sprutnarkomani bland “vuxna stockholmsojkar. (Injection abuse among Stockholm youth – a retrospective study).

Crime Prevention Council. Stockholm

## REPORT ON DRUG MISUSE IN AMSTERDAM

by

Ms A J de Roij-Motshagen

	<u>Page</u>
INTRODUCTION.....	28
<b>A. <u>DESCRIPTION OF THE CITY</u></b>	
1. History of drug misuse.....	29
2. General policy; legislation .....	30
3. Demographic information .....	32
4. Surveys on drug misuse .....	32
5. Treatment and social care systems/facilities .....	34
6. Control systems and resources (law enforcement).....	41
7. Monitoring systems.....	42
<b>B. <u>INDICATORS</u></b>	
1. First treatment demand.....	45
2. Hospital admissions .....	45
3. Viral hepatitis .....	46
4. Drug-related deaths .....	46
5. Police arrests .....	46
6. Imprisonment .....	48
7. Seizures of illicit drugs .....	48
8. Price/purity of illicit drugs .....	48
9. Survey data.....	49
10. Other indicators; comments on AIDS .....	49
<b>C. <u>ASSESSMENT OF THE USE AND VALUE OF INDICATORS</u></b>	
1. Use of indicators in the city .....	50
2. Relationship between indicators .....	51
<b>D. <u>CONCLUSIONS</u>.....</b>	<b>53</b>
Appendix I: Data .....	54
Appendix II: Glossary of terms and definitions .....	68
Appendix III: References .....	69

## INTRODUCTION

The drug epidemic in the Netherlands began in Amsterdam in the late sixties, a period in which many individuals involved had society-changing aspirations. They sought a better world with new values, abolishing old politics and corruption. However, in the seventies both the climate and the epidemic changed. Heroin was introduced on a large scale and drug abuse drifted down from high and middle social classes to the lower layers of society. In this phase society became aware of the criminal side-effects of the heroin epidemic and of the epidemic itself. As a consequence many drug addicts were arrested by the Metropolitan Police; this caused serious disturbances at the local police stations. General hospitals were also confronted with a growing proportion of drug users; this caused major disturbances in wards.

It became apparent that a large proportion of the drug-using population did not or could not make use of the existing treatment facilities. These institutions had their own functional criteria within which they gave or refused entrance to their programmes. This finally resulted in an emergency situation, both from the medical and political points of view.

The main objective of this report is to describe the development and changes in Amsterdam. As was agreed within the epidemiology working group, emphasis has been put on a concise description of systems and data available from those systems.

The report should be considered as a working document to be used in the search for the feasibility of an international multi-city research project on drugs and drug abuse.

## A. DESCRIPTION OF THE CITY

### A.1 History of drug misuse

The late sixties were characterised by rapid changes in social values and standards. This was a period for the spreading of youth subculture: expressing changes in pop music, long hair, massive use of cannabis and other hallucinogens. In these years the Netherlands, particularly Amsterdam, was confronted with a rapid spread of (soft) drug use.

Up until 1960 only a few persons (aged 12-18 years) were known to have got into serious trouble because of the use of cannabis. As from 1960 the number of young people experimenting with the use of drugs (such as marijuana, LSD, opium) increased and some of these youngsters became addicted to the drugs mentioned. This latter group of people differed from the first group both with respect to its lower age (14-16 years) and by a lack of bond with either profession or education. In 1968 the use of drugs was still restricted to a few larger cities such as Amsterdam, The Hague, Rotterdam and Dordrecht. In 1970, however, only two years later, the situation seems to have changed.

The necessity to cope with life within the framework of society as such became apparent. Most of the people earlier involved in the subculture picked up their original occupations. A relatively small group did not. This group continued to use drugs. Most of them switched from cannabis to opium and amphetamines. They started injecting and many had severe psychiatric problems. They were repeatedly admitted to psychiatric hospitals because of psychiatric "episodes", often brought on by amphetamines. These drug users originated mostly from middle and high social classes.

In 1972 heroin was introduced on a large scale in Amsterdam by American Vietnam veterans. In this year, the previously existing group of opium-amphetamine users switched over to heroin because opium disappeared from the market. In this phase of the epidemic, the number of people involved was relatively small. However the use of drugs was no longer located in a few specific cities and had spread into the country. A new phenomenon was the relatively extended use and addiction among the so-called minority groups, mainly people from Surinam. The drug takers were characterised by a higher age at the start of using heroin, smoking, rather than injecting, and demanding treatment at an earlier stage of their addiction.

In the mid-seventies the epidemic changed. The drug abuse drifted down to the lower layers of society. Whereas those people involved in the beginning of the seventies had a rather rich background, the mid-seventies showed a sharp increase in drug abuse among young working class people. Where there was excessive abuse of alcohol and accompanying aggressive behaviour, heroin use became fashionable in community youth centres and bars in the 19th century areas of the city. In this phase society became aware of the criminal side effects of the heroin epidemic and of the epidemic itself. Criminal acts consisted mainly of car thefts, shoplifting, drug dealing on the streets, prostitution, etc. The realisation that heroin abuse was not something innocent passing by in the same way as the hippy age caused it to be viewed as some sinister threat to society itself. This collective fear gave political weight to the problem.

Although it is still assumed that heroin is the primary drug of abuse, a strong swing to the use of cocaine is being perceived. Besides, the simultaneous use of all kinds of other psychotropic drugs, in principle legally obtained by medical prescription, has increased. The “illegal” use of these legally obtained drugs cannot be seen separately from the enormous increase in the legal use of medicines with a psychotropic effect. However, the circumstances under which these medicines are taken by the licit and illicit user do differ. Therefore, the present use of these drugs among young people ‘should be considered threatening. Large groups of drug abusers have developed a deviating life-style which not only has proved to be harmful for themselves but also for their direct environment and for society. Only a well-balanced and coherent drug policy might contribute to an easing of (not a solution to!) the problem.

## A.2 General drug policy; legislation

### Policy

The understanding of the conditions under which drug use arises has gradually increased. The use of drugs is often accompanied by a lack of perspectives and prospects which causes certain young people to feel that they are misunderstood or that their lives are meaningless. This lack of a genuine social perspective in terms of work, education, training and accommodation, which is the fate of many addicts, emphasises the limits of support. The mere provision of assistance does not give the addict a genuinely different view of his problem or, in other words, a new perspective for the future. This means that matters such as housing, vocational training and appropriate work not only are important in the after-care stage, but do also constitute an inseparable part of treatment. Assistance with these matters should be provided right from the beginning. The very fact that addicts are hard to reach and approach and in general show little willingness to accept help has meant that it was necessary to put the main emphasis on services that do not immediately confront them with stringent criteria for admission to treatment. This does not imply however that easy accessibility to aid facilities is equal to indulgence. Treatment only of the so-called “motivated” addicts will result in social isolation and pauperisation of the large majority of addicts. The Dutch Government has accepted the fact that alongside treatment there are forms of aid which are not primarily aimed at the termination of addiction itself, but rather at the improvement of social and physical functioning of the addicts. The use of heroin is often preceded by the development of a deviating (sometimes criminal) lifestyle and obtains, from the user’s point of view and within certain deviating sub-cultures, a meaningful function. In other words, users of drugs have their own reasons for starting and, especially, for continuing the use. As a consequence not every person who accidentally comes into touch with heroin will be a potential addict. Both at national and city level drug policy is therefore aimed at discouragement and obstruction of the use of drugs by inexperienced users and the abatement of risks for experienced users.

In the seventies the treatment of opiate addicts in Amsterdam was aimed at a drug-free life. The disappointing results of this approach led to a major shift in the policies regarding aid for the drug

addicts. Since it seemed impossible, at least in the short term, to cure addicts, the idea evolved of setting less ambitious goals. Instead of aiming at total abstinence, the principle goal of the aid for addicts in Amsterdam is merely to minimise the risks for the drug addict and the environment.

In 1984 the burgomaster and Alderman of Amsterdam introduced a comprehensive drug policy. It is planned that the lines of this policy will be followed during the coming years.

According to this drug policy, it is intended to implement not only a policy that discourages the use of drugs by taking more severe measures against the illegal drug trade and drug-related crime, but also to alleviate at the same time the day-to-day needs of the city's drug addicts by reorganising and expanding the available facilities. Since an all-encompassing solution to the drug-related problems still has to be found, it is not only advisable but imperative as well to try to keep their development under control.

The comprehensive policy is based on the following:

- provision of conditions that enable drug takers to regulate their use of “hard” drugs and adopt a more socially acceptable lifestyle, and give users who want to stop using drugs the opportunity to do so;
- improvement in the “liveable” nature of the areas where there is a concentration of drug use and dealing;
- more focus on combating drug-related crime and on decreasing
- the city's attraction for drug users from abroad; the combating of the illegal trade in “hard” drugs.

Inasmuch as the measures to be taken are to a great extent interrelated and cannot be regarded as separate entities, good progress should be made with each of them in order to control the various related problems. For such a policy at city level the support of the national government is indispensable.

### Legislation

In 1976 the Opium Act was changed mainly to:

- increase the penalties for the possession of and trade in amphetamines (amphetamines were not included in the old Opium Act);
- recognise the difference between cannabis and other drugs;
- reduce the possession of small quantities of cannabis (30 gr) from a crime to an offence.

It has never been the intention to intensify the action taken against users and addicts, but to consider whether the amount of help available for addicts can be further geared to needs, taking into account the limited funds available. On the other hand detection and prosecution of persons trafficking in drugs which involve unacceptable risks are intensified.

A new bill by which the Opium Act will be amended has now been approved by the Netherlands Parliament. This legislation will make it possible to prosecute for activities carried out with the intention of preparing or furthering trafficking in drugs which involve unacceptable risks, making it somewhat easier for the police and the public prosecutors to take action against "bigger" dealers in particular. The bill also extends the powers of the judiciary in the Netherlands, in that it will be possible to prosecute in the Netherlands anyone, regardless of nationality, who attempts in another country to import such drugs into the Netherlands or who supports such activities abroad.

Discussions on the legal and public order aspects of the drug problem are now taking place between the central government, the four largest cities in the Netherlands (Amsterdam, Rotterdam, The Hague and Utrecht) and the association of Netherlands Municipalities. The central government and the municipalities should jointly, but each on the basis of its own involvement and responsibility, work towards developing and implementing a body of legislation designed effectively to combat crime and maintain public order.

### A.3 Demographic information

Table 1 (Appendix I) presents the population figures of Amsterdam for 1975 and 1983. The data show a decrease of the total city population from 751,054 in 1975 to 676,524 in 1983, a decrease of 9.9%. A comparison of the population numbers in age percentages reveals a decrease of numbers in the age category under 15 and an increase of numbers in the age category 30-39 years. The size of area in km<sup>2</sup> shows a slight increase.

The unemployment figures for 1983 are:

Netherlands:	18.3%	
		(of the working population)
Amsterdam:	22.0%	

Unemployment figures for persons under 25 are not available. For this group of people the unemployment rate is estimated at one-third of the total unemployed population.

### A.4 Surveys on drug misuse

In 1970 22% of a sample of 1,600 persons stated that they had at some time experimented with the use of drugs like marijuana, hashish, LSD and amphetamines. In 1972 heroin was introduced on a large scale. Since then the number of young people in trouble because of addiction to the use of heroin has increased.

Table 14 shows the increase of the use of heroin expressed as a percentage of the total number of drug takers known at the Mental Health Department of the Community Medical Health Service of Amsterdam (GG&GD).



At this moment it is known from regular consultations with treatment centres, local authorities, judicial services and “junkies” that some changes have occurred in the drug abuse patterns during the last couple of years. It is known that:

- almost all users are addicted to heroin;
- the scope of the problem seems to have stabilised although within the drug field different groups of users still come and go;
- the use of heroin seems to have increased specifically in groups with a relatively low socio-economic status;
- polydrug abuse and the use of cocaine are still on the increase;
- the availability of heroin and cocaine has become rather scattered; as a result youth sub-cultures seem to have become less important as a starting point in a drug use “career”;
- it has been indicated that the average age of drug users has increased; it is thought that drug use starts at a higher age today;
- as far as the tracing of and prosecution for opium offences are concerned, the increase in cocaine supplies gives cause for concern.

However, despite this knowledge not much effort has been put into research on drug abuse patterns in the Netherlands. It is only recently that there has been a growing demand for data from this kind of research. In 1983 the national government had a study carried out on the extent of the use of cannabis, alcohol and tobacco among young people aged 15-24 (N of sample is 1306). A summary of the most significant results is presented in Table 15 of Appendix I.

In 1984 a large school survey on the use of drugs, alcohol and tobacco was carried out, at the initiative of the Public Health Inspectorate. 25,000 school pupils, aged 10-18, took part in this survey. Although the results have not yet been published, some data have been released by personal communication. In general the results support the results of the national survey mentioned above. However the prevalence of the “ever” use of hashish and marijuana in the school survey seemed to be twice as high as that in the national survey, 4% versus 2%. Less than half of this group still used “soft” drugs. Regular use (once a week, once a month) was only stated by a very small part of the group of users.

A disadvantage of the school survey seems to be the fact that students and working people in this age group are not involved. It is supposed that the use of “soft” drugs is greater among these groups of persons. As in the national survey it was shown that general knowledge as regards drugs was rather poor.

The results of the school survey did not, however, provide any information on the use and knowledge of drugs in Amsterdam: schools in Amsterdam did not take part in this survey.

It is intended that national surveys will be performed on a more regular basis in the future. In 1985 a survey on drugs, alcohol and tobacco was performed concerning youngsters aged 10-18 out of school and/or in special educational establishments. As far as Amsterdam is concerned, proposals have been prepared to perform a school survey on drug abuse in Amsterdam. The survey proposals have been made as a result of participation in the Pompidou Group activity on epidemiology of drug abuse.

#### A.5 Treatment and social care systems/facilities

Care services have been organised in accordance with the comprehensive drug policy mentioned above. The treatment system in Amsterdam can be divided into four main levels:

- i. first-line treatment facilities
- ii. second-line treatment facilities
- iii. special groups
- iv. support services.

Figure 1 gives a schematic outline of the organisational structure.

##### i. First-line treatment facilities

The facilities on this level have been organised mainly to combat the risks resulting from drug abuse and to prevent pauperisation and social expulsion. Therefore the aid provided must be easily accessible and far-reaching.

Within this level three kinds of assistance are to be distinguished;

- primary care
- field work
- crisis/reception/detoxification

Both the primary care and the field work have been incorporated into a so-called bus/district/centre system.

#### Bus/district centre system

##### a. Primary care

The treatment facilities in this system aim to transform unregulated use of illegal drugs into a use that is adjusted in such a way that drug addicts will be enabled either to maintain or develop a more socially accepted lifestyle. As a consequence treatment provided in this system may be continued by treatment facilities on a different level (such as general practitioners and facilities in the second line), so that continuous stigmatisation of a drug addict can be avoided.

The treatment is operated according to a so-called “flow-model”, (various treatment facilities corresponding to a range from low to high control):

- daily methadone supply in liquid form provided by a bus with several stops in different parts of Amsterdam, with no control of heroin use by urine analysis (low control);
- daily methadone supply in liquid form provided by a district centre with regular control of heroin use by urine analysis (medium control);
- methadone supply in tablets provided by a district centre on a regular basis (once a day, once every two days, once a week, etc) with regular control of heroin use by urine analysis (high control);
- reference to a general practitioner or treatment centre in the second line.

Apart from methadone supply the assistance in this system is of a rather general nature in order to guarantee a wide scope for the population of drug users. The aid consists mainly of medical treatment, social guidance and public assistance.

Within this system specific reference should be made to two supporting projects:

- a medical treatment programme for drug addicts under arrest at police stations. Medical care is given twice a day at the request of the police. Treatment is aimed at improving the general physical condition and at treating withdrawal symptoms.
- social guidance of drug addicts admitted to general hospitals. Guidance is given at the request of the various hospitals.

Furthermore general support and consultation are offered in the framework of other social welfare assistance schemes.

b. Fieldwork

The fieldwork has been reorganised in line with the organisation of the bus/district centre system. Fieldwork should be considered a vital component of this system, its main task being the development of assistance offered to drug users during all phases of drug abuse. The assistance is directed among others towards persons dependent on drugs who:

- are beginning or experimenting with the use of drugs while still
- having attachments to society;
- do not make use of the existing treatment facilities;
- are receiving methadone prescriptions from general practitioners;
- are arrested and held by the police.

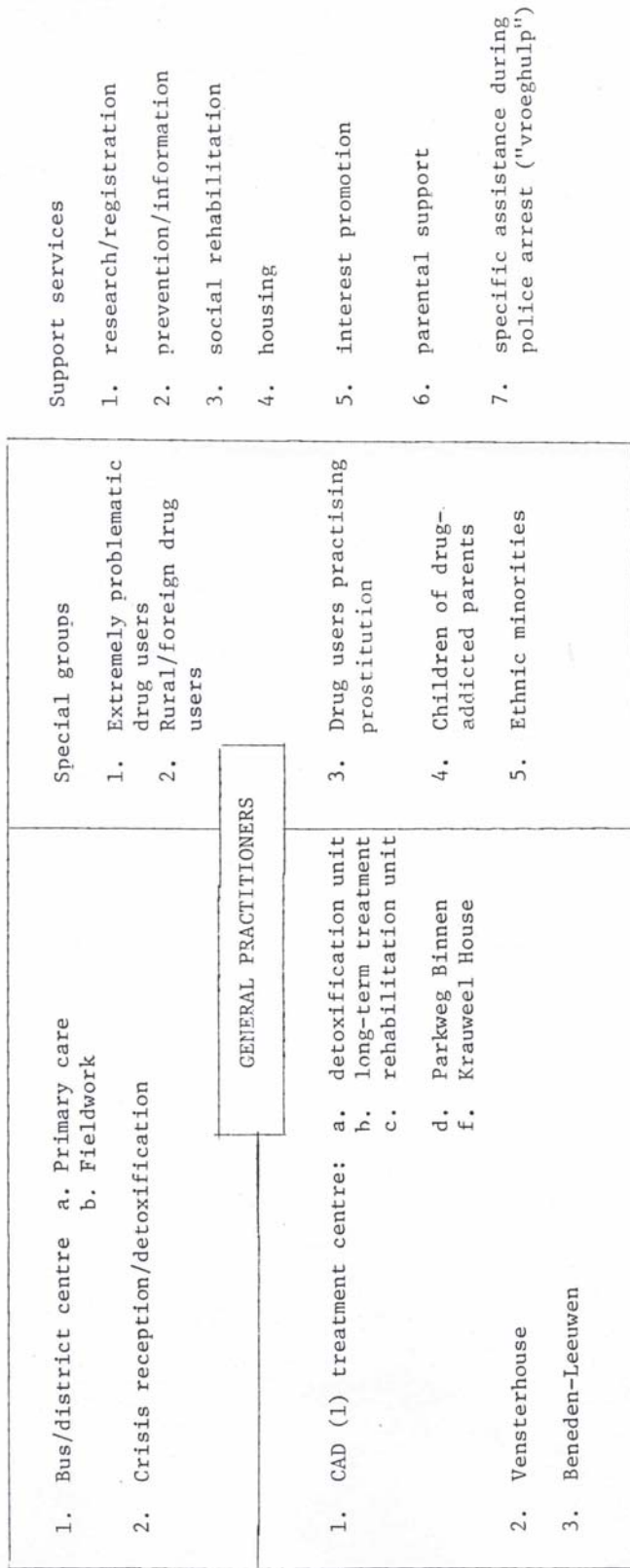


Figure 1: Organisation outline for assistance in the field of drug abuse in Amsterdam

(1) Consultation Bureau for Alcohol and Drugs

### Crisis reception/detoxification

Crisis reception should be a major factor in a system aimed at decreasing the risks involved in the use of illegal drugs. The reception care should be of rather short duration and mainly concerned with the introduction of patients to various types of treatment facilities.

A detoxification centre of sufficient size should therefore be part of the first-line drug treatment system. A short stay of at most two weeks should contribute to the stabilisation of drug use (at least), the reduction of drug use and eventually the end of the drug use. In general it should be possible for a detoxification programme to demonstrate to patients the possibility of their becoming drug-free.

Even though both crisis reception and detoxification have been described as vital parts of the system they do not function yet. The first-line treatment system does have at its disposal an improvised detoxification unit of the CAD (Consultation Bureau for Alcohol and Drugs). However because of the restricted capacity of this unit <<there is a long waiting list.

#### ii. The second-line treatment system

The treatment systems in the second-line are primarily concerned with the treatment of drug addicts motivated to terminate the use of drugs, to whatever extent. Two kinds of treatment are to be distinguished: in-patient and out-patient.

### The Consultation Bureau for Alcohol and Drugs (CAD)

The institutional out-patient treatment is taken care of by the CAD, a subdivision of the Jellinek Centre in Amsterdam. Within this institute treatment programmes have been organised in three different categories:

- a. detoxification unit
  - b. long-term treatment programme
  - c. rehabilitation unit.
- 
- a. Detoxification unit

Treatment within this unit is concerned with persons who, although dependent upon drugs, want to stop using (hem. Detoxification is accomplished by ways of methadone provision and intensive medical and social guidance on an individual basis according to two different methods:

- short detoxification (2-3 months) for persons dependent upon drugs but with a relatively short drug career;
- detoxification of medium length (4-5 months) for persons dependent upon drugs with a long career of addiction (4-6 years).

b. Long-term treatment programme

This programme is for addicted persons with a prolonged career of addiction. The aim of the programme is to help to model the lifestyle of the addicted person in the long term. The programme involves the use of methadone accompanied by intensive individual guidance and forms part of the treatment system for extremely problematic drug users (see below).

c. Rehabilitation unit

Within this unit assistance is offered to drug addicts who have problems related to the criminal justice system (police arrest, detention pending trial, imprisonment). Drug addicts are given guidance in this respect, notwithstanding their history and career of addiction.

d. "Parkweg Binnen"

This centre also forms a part of the Jellinek Centre and provides in-treatment (5 months) for addicts who, despite their psycho-social problems, do have a reasonably short addiction career and still have rather favourable social prospects. Treatment is aimed at a return to a normal lifestyle.

e. "Parkweg But ten"

This centre, part of the Jellinek, is oriented towards therapy. In comparison with the "Parkweg Binnen" treatment has a longer duration (9 months) and is mainly intended for addicts with a long addiction career (3-4 years) and a lifestyle which is mostly centred on the drug scene.

f. "Krauweel House"

Although the treatment programme is specifically oriented towards alcoholics, assistance is offered to drug addicts on certain conditions (eg "double addictions"),

"Vensterhouse"

The "Vensterhouse" is a treatment facility with a social-educational programme situated outside Amsterdam, in Bussum. In general addicts are taught how to spend a drug-free day. The "Regenboog", a fieldwork organisation, is responsible for the guidance of addicts during their stay in this centre.

"Beneden Leeuwen"

"Beneden Leeuwen" is a therapeutic community in the country. This centre contains inter alia a workshop in which metal and woodcrafts can be made. Crafts from this shop are sold in Amsterdam.

iii. Special groups

Extremely problematic drug users

Assistance for this group of addicts is provided by the "Foundation for drug assistance in Amsterdam" (SDA). This assistance consists of:

- social guidance;
- provision of food and a place to sleep;
- control of social benefits.

On behalf of the SDA the GG&GD (1) takes care of a specific programme of supply of substitute drugs and (by way of experiment) the supply of morphine to a small number of addicts from this group. The Foundation for social rehabilitation (MHV) organises a social activity programme for this group.

The foundation "Princenhof" runs a 24-hour service, aimed at recovery in emergency situations after which efforts are made to get to grips with the chaotic background or situation of the drug addict.

As such the "Princenhof" provides assistance of an intermediate nature.

#### Rural/foreign drug users

Policy is aimed at decrease in the attraction of Amsterdam for these drug addicts. Assistance is only given when necessary for humanitarian reasons and consists inter alia of medical treatment and methadone provision by the GG&GD on the basis of a short-term reduction schedule.

#### Prostitutes

Within the first-line treatment special attention is paid to prostitutes. The treatment project is aimed at providing a special kind of intensive care for this group of addicts, who as a result of their lifestyle are often to be found in an extremely bad condition, physically, psychologically and socially. The assistance consists of methadone provision, medical treatment and intensive social care.

#### Children of addicted parents

First-line treatment should not be concerned with children of drug-addicted parents. The treatment system aims to enable drug-addicted parents to take care of their children. However, experience has shown that often specific assistance on behalf of the children is needed. Inasmuch as these children are in general to a certain extent at risk, co-ordination with systems of assistance to families "at risk" has been organised.

#### Ethnic minorities

Up until now the term "ethnic minorities" has mostly been assumed to refer to people originating from Surinam and the West Indies. At present however there is an obvious increase in the use of drugs within other minority groups such as Moroccans and Turkish people. Even though people from the minority groups do use the present provision, this only applies to assistance where contacts between the person assisting and the clients are rather restricted (methadone provision by bus). Just as is shown in other assistance situations, problems arise whenever the nature of the assistance becomes therapeutic. Specific provision of treatment of drug addicts in the minority groups should therefore be organised.

---

(1) Mental Health Department of the Community Medical Health Service of Amsterdam.

v. Support services

Research/registration

So far research has not been integrated into the Amsterdam drug treatment policy. Research has mostly been concerned with short-term projects directed at concrete and sometimes acutely problematic situations. As a consequence of a systematically organised set of treatment facilities the need for support and associated research has become obvious and will therefore now have high priority. Research will have to be directed towards both epidemiology and assurance of the quality of the treatment systems, in accordance with the drug policy.

Prevention/information

The aim of Amsterdam policy on prevention and information is, in a realistic way, to combat potential drug use.

Social rehabilitation

Provisions of this kind are directed towards drug users in all' phases of drug use. These services are intended to be complementary to the supply of substitution drugs and methods of detoxification.

Housing

By way of the bus/district centre system (page 34) independent housing for drug users is provided in co-operation with the Municipal Service for Rehousing.

Interest promotion

Interest promotion among drug users is taken care of by the Medical Social Service of heroin addicts (MDHG): "junky union".

Parental support

Amsterdam drug policy is aimed at treatment of drug addicts in their own social environment. Contacts with parents and other relatives is therefore considered of great importance.

Specific assistance during police arrest and detention pending trial

Specific assistance for drug addicts during police arrest is in general aimed at immediate support at the moment of arrest by the police. The assistance includes both medical treatment provided by the bus/district centre treatment facility and social assistance provided by the CAD (page 37) (Consultation Bureau for Alcohol and Drugs) as far as police arrest is concerned. During detention pending trial both medical and social assistance are provided by the CAD.



### General practitioners

Even though general practitioners are specifically concerned with second-line assistance to drug addicts (by way of methadone supply on a reduction schedule), they do play a vital role in the first-line assistance (provision of methadone on a maintenance basis). As can be seen in Figure 1 (page 36) they might also be involved in treatment of addicts belonging to the specific groups.

### Hospital treatment

Patients are admitted to hospitals either specifically because of a drug dependence diagnosis (ICD -292,304 or 305 2-9) or because of other problems, with drug dependence as a secondary diagnosis. Drug users also attend accident and emergency departments of hospitals, either on a voluntary or involuntary basis.

### Criminal care

Both medical and social care of drug addicts during police arrest and detention pending trial have been described above (pages 35 and 38).

#### A.6 Control systems and resources (law enforcement)

It is primarily the narcotics squad of the Metropolitan Police that has the responsibility for the control of narcotics in Amsterdam. The efforts of the police are mainly aimed at confiscation of narcotics and arrests of persons suspected of narcotics-related crimes.

In 1980 national guidelines were published for tracing and prosecution and a criminal procedures policy. However some of the punishable actions described in the Opium Law are of a very specific nature and may be so varied that it is almost impossible to formulate general guidelines. In these cases policy will vary from case to case and arise from consultations between the Police and the Public Prosecutor.

In general the guidelines may be summarised as follows:

Quantities not for personal use

	<u>“Hard” drugs</u>	<u>“Soft” drugs</u>
Trafficking	Maximum 12 years’ imprisonment and/or Fl.250,000.- fine  Minimum  Dealers: 3 years Couriers: 2 years	Maximum 4 years’ imprisonment and/or Fl.50,000.-fine  Minimum:  1 year
Production	Maximum 8 years’ imprisonment and/or Fl.50,000.- fine  Minimum  Dealers: 2 years Small dealers/users: conditional sentence with non-voluntary treatment	Maximum 2 years’ imprisonment and/or Fl.10,000.- fine  Minimum:  Suspended sentence and/or fine
Possession	Maximum 4 years’ imprisonment and/or Fl.50,000.- fine  Minimum  Dealers: 1 year Small dealers/users: conditional sentence with non-voluntary treatment	Maximum 2 years’ imprisonment and/or Fl.10,000.- fine  Minimum:  Suspended sentence and/or fine

Quantities for personal use

Maximum 1 year imprisonment or Fl.500.- fine	Maximum 1 month imprisonment or F.500.- fine
---	---

No information has been available on the total number of persons convicted and the reasons for their conviction.

A.7 Monitoring systems

In 1979 the “Foundation for Substitute Drugs in Amsterdam (SVMA)” was founded. The aim of this foundation is to check on the supply of substitute drugs to drug addicts living in Amsterdam. The Central Registration System (CMR) on methadone supplies was set up to help to achieve this aim. Thus the CMR:

1. prevents double supplies being provided for one person;
2. provides support to the medical treatment facilities for drug addicts;
3. initiates and improves epidemiological research on drug abuse.

The CMR is a local monitoring and data collection system based on identification and only contains the following information:

1. Family name (for women the maiden name)
2. First name
3. Initials
4. Family name of present or late husband
5. First name
6. Initials Sex
8. Date of birth
9. Country of birth
10. Nationality
11. Address
12. District number
13. City
14. Country
15. Date of supply
16. Dose of supply
17. Provider of supply
18. Pharmacist

Personal data on drug addicts, from methadone treatment programmes as registered by the CMR:

A drug addict is registered whenever he/she comes into contact with either a medical institution (GG&GD, hospital, drug treatment centres etc) or with the criminal justice system (police station, prison etc) and has been provided with methadone as a substitute drug. The CMR monitoring system is run by the GG&GD under the control of the SVMA (see above). Even though data gathering is based on identification, confidentiality is guaranteed by means of regulations concerning privacy. These regulations have specifically been drawn up for the CMR according to the Municipal Privacy Regulation Law of 1982.

According to these regulations, it has been formally stated that;

- Identifiable data on drug addicts may only be available for medical purposes and not for other purposes such as those of policing and inspection of the judicial or health authorities.
- Registration of data is performed under medical professional secrecy.
- Data for epidemiological research may only be available if made anonymous in nature in accordance with certain criteria.

Registration sources of the system are (Figure 2):

1. Methadone supply programmes of the GG&GD (1. 1a; 3.1; 3.2; 3.3)
2. Methadone supply programmes of drug treatment institutes (2.1a, 2.1b, 2.1c and 3.5)
3. Methadone supply programmes of general practitioners.

1st line	1 a (1)	3.1 (1)	
	1 b	3.2 (1)	
	2	3.3 (1)	special
	general practitioners (1)		groups
2nd line	1 a (1)	3.4	
	1 b (1)	3.5 (1)	
	1 c (1)		
	1 d		
	1 e		
	2		
	3		

Figure 2: Schematic outline of treatment facilities involved in the CMR of Amsterdam (See also Figure 1, page 36)

-----  
(1) = CMR participation

## B. INDICATORS

### B.1 First treatment demand

The data of the CMR in Amsterdam do not provide information on demand for treatment. They rather deal with the number of persons who have been treated with methadone for the first time. Monitoring is only carried out after application for treatment and actual provision of methadone have taken place. The persons taken on for treatment are primarily opiate addicts. Data on first treatment are presented in Table 2 of Appendix I. In this table data are presented by first year of treatment and year of treatment.

### B.2 Hospital admissions

Data on hospital admissions are presented in Tables 3, 4 and 5 of Appendix I. The data have been divided into three different categories of sources:

- a. official hospital statistics (Table 3);
  - b. statistics from the registration programme for addicts for whom "guidance was requested" (Table 4);
  - c. data concerning the admission of drug addicts into psychiatric hospitals and specific drug clinics (Table 5).
- a. Official discharge data are rather low when only primary diagnoses with the requested ICD codes are used. Upon request data on discharge diagnoses with ICD codes 292,304 and 305, 2-9, as a secondary diagnosis, have also been made available. Included in this information are data on admissions to Psychiatric Sections of University Hospitals.
  - b. Diagnoses described for persons admitted to hospitals via the registration programme for whom "guidance was requested" refer to admission diagnoses.
  - c. Data concerning the admission of drug addicts into psychiatric hospitals and dry clinics must be requested from the Ministry of Health. ICD codes are used. Data for 1982, 1983 and 1984 have been requested.

Notes on hospital admissions as an indicator:

- Accessibility and rapidity are affected by institutional slowness: data requested in August 1985 were received in part in January 1986.
- Availability: Some financial charges are made.
- Reliability is dependent upon whether drug addiction is considered a major or minor problem and is reported.
- Double counting does occur inasmuch as persons in category c may also be present in category a. It is to be assumed that all persons of category b also occur in category a; however reliability is not very high. The persons in category b were admitted with more than one diagnosis per person.

### B.3 Viral Hepatitis

Cases of viral hepatitis have been monitored for some years by the Public Health Institute of Amsterdam (GG&GD) which requests information from general practitioners. Even though monitoring on this basis does not guarantee a complete record, it is assumed that over 75% of the cases are reported. No other statistical source of information on hepatitis is to be found in Amsterdam. Table 6 in Appendix I presents data for 1983 and 1984 by age and by source of infection.

### B.4 Drug-related deaths

Amsterdam does not have an automatic system for reporting deaths caused by drugs. Official statistics do not give numbers concerning drug-related deaths. In general people may die either a natural or unnatural death. The body of any person who has died an unnatural death will be examined by the coroner of the Municipal Medical Health Service (GG&GD). In the case of doubt as to the cause of death, the pathologist of the court of justice will further examine the body, the result being passed on to the police rather than to the coroner. Numbers presented either by the police or by the coroner of the GG&&GD for unnatural deaths related to drug abuse mainly refer to overdose diagnoses and may, therefore, be considered valid.

Data concerning deaths from causes indirectly related to drug abuse are less systematically collected, eg hospital deaths due to heart failure caused by septic endocarditis, liver or kidney disfunction, homicides, deaths resulting from traffic accidents. These cases are often not recorded in hospital statistics as resulting from drug abuse.

Table 7 in Appendix I presents data on deaths of drug takers in Amsterdam.

### B.5 Police arrests

In Amsterdam no official statistics on police arrest data are available. The existing police information system is a monitoring system operating for the Ministry of Justice and is based on cases rather than persons. The main objective of the system is to identify persons possibly involved in a particular case. Drug addicts may be arrested either because of offences against the Opium Law or because of criminal activities. Addicts arrested for criminal activities in general will be held under arrest at the district police stations. Addicts arrested for offences against the Opium Law will in general be, transferred to the main police station.

Arrested persons are only recorded by the police monitoring system after having been charged and prosecuted. Thus only a small proportion of the total number of arrested persons will enter the monitoring system of the police. The medical monitoring system (CMR) on the other hand is concerned with drug addicts on all levels, both for criminal activities and offences against the Opium Law (without charge, with charge etc).

Medical examiners of the Public Health Institute visit both the main police station and the district police stations twice a day. The addicts to be examined are listed by the police. Even though all arrestees not being charged will normally leave the police station within six hours, they may still be examined by a physician when they are listed by the police and still under arrest on arrival of this physician. Figure 3 is a schematic presentation of this situation.

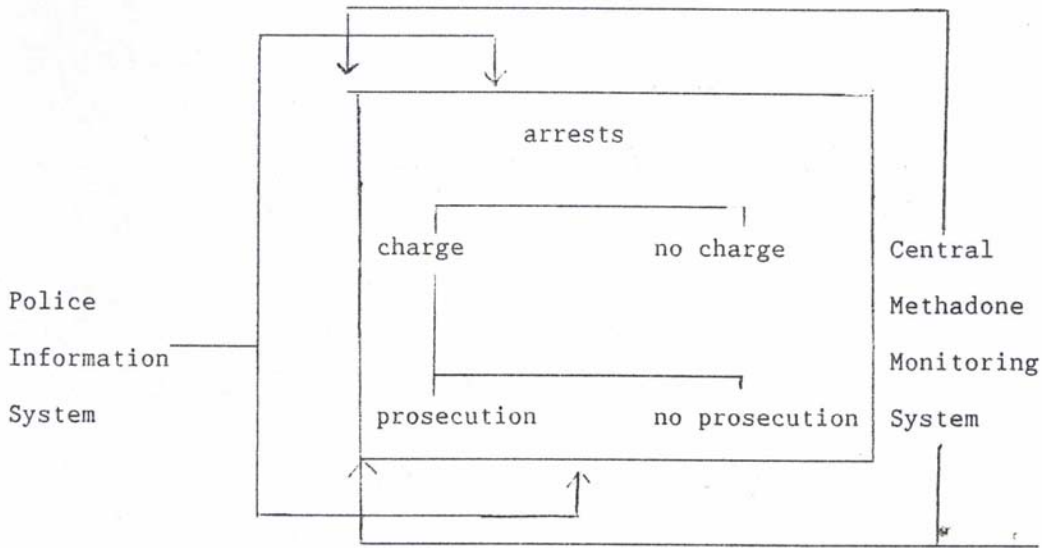


Figure 3: Schematic presentation of police arrest information sources for two monitoring systems.

Even though both monitoring systems are concerned with arrested drug addicts, the subpopulations each system deals with may or may not be related to each other. From the fact that arrested adults are listed by the police to be medically examined it may be concluded that the Central Methadone Monitoring System is very much dependent upon police policy: an unknown variable which influences the reliability and validity of the assembled information.

Table 8 in Appendix I presents data both on the number of drug users arrested by the police, divided into persons arrested and persons charged, and the number of addicts treated by medical doctors during their arrest. It is shown that only a small number of the total number of arrested drug addicts have been medically examined and treated.

Systematic registration of medical treatment given to drug addicts on an individual basis over five years resulted in a description of this group of addicts. The drug takers originated from no less than 70 different countries. From the start: of this programme the number of treated drug users gradually increased by some 250-300 persons a year extending to a total of 1,656 in 1982. This increase mainly consisted of drug takers originating from the Netherlands and the Federal Republic of Germany. Distribution according to age clearly showed an increase in the average age at arrest. An increase in the number of young clients originating from South European and North African countries (migrant workers) pointed towards problems of the second generation migrant workers.

Data also showed certain trends. However, because of the isolated nature of data on police arrests in comparison with data from other treatment programmes for drug addicts in Amsterdam, no sound conclusions could be drawn.

Since 1983 data on police arrests have been incorporated into the CMR monitoring system.

Table 9 in Appendix I gives the proportion of persons having been treated during police arrest. This table shows that during 1984, 2,321 arrestees were treated (35.1% of the total number of treated persons). Half of this group (1,211 = 52.2%) was known by the monitoring system because of participation in other treatment programmes during 1984; 47.8% (1,110) were seen in the CMR in 1984 only because of their arrest.

Even though these data still have to be further analysed, they do seem to have relevance for prevalence studies. If police-arrest data had not been registered, 5,509 would have been the total number of registered persons in 1984 instead of 6,619!

Table 10 in Appendix I gives the total numbers of persons arrested for offences against the Opium Law, by drug involved. This table shows that the largest proportion were arrested because of opiates and cannabis. As monitoring has continued over the years, the proportion of "heroin" arrestees has increased significantly from 64.0% in 1977 to 74.8% in 1985. The proportion of arrestees involved with cannabis ' has decreased significantly from 26.7% in 1977 to 20.1% in 1985.

#### B.6 Imprisonment

Registration of drug addicts in houses of detention still has to be developed. Some data have been available as is shown in Table 11 of Appendix I. Dutch imprisonment data in general are not very useful as an indicator, not only because of the low reliability of the data. Numbers of addicted persons present in a prison at a certain moment (point prevalence) do not tell us anything about the drug scene outside the prison. Because of lack of "rooms" it is possible for a convicted person to spend his/her time in jail one year later than the moment of conviction.

#### B.7 Seizures of illicit drugs

Seizures of illicit drugs are very much dependent upon the amount of information available and the specific activity of the Narcotic Squad in a specific year. No official statistics exist. However, figures are mentioned in ("unofficial") monthly records of the Chief of the Narcotics Squad. Data are presented in Table 12 of Appendix I. Because of the character of these data the validity as an indicator by itself is very low.

#### B.8 Price/purity of illicit drugs

Hardly any statistical information is to be found. Some data have been recorded in private monthly records. Data are presented in Table 13 of Appendix I. Because of the unofficial character of these data the validity and reliability as an indicator will be very low.



### B.9 Survey data

So far survey studies have not been very popular in Amsterdam. These studies have only been performed infrequently and on specific subjects only. Therefore no information on trends is available from this kind of study. Tables 14 and 15 present information from two studies described in Section A.4 of this report.

### B.10 Other indicators; comments on AIDS

This year an extensive study will be performed concerning the presence of the AIDS virus among drug addicts. Approximately 800 addicts will participate in this study, including heroin-addicted prostitutes. The research design will be comparable to the design of a former study among 1,500 homosexual men, a research project which has run for over a year now. It is not yet known whether data will be published, and if so in what form.

### Emergency data

In 1984 the CMR monitored the transport of drug addicts by ambulance to emergency rooms of hospitals. Data are presented in Table 16 of Appendix I. Emergency room visits may be divided into two categories:

- own initiative
- by way of ambulance transportation.

So far no data have been available on drug addicts attending emergency rooms at their own initiative.

The data from Table 16 give an impression of the extent to which the health system is occupied with drug addicts. They show however that only 11.8% of the transported persons were admitted to hospitals;

35.4% were not transported at all. The usefulness of these data as an indicator is still doubtful and will have to be examined further.

## C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

### C.1 Use of indicators in the city

Heroin indicators should provide drug abuse treatment planners and practitioners, law-enforcement officials, health professionals and governmental agencies with information on which to base policy and programme-planning strategies regarding the heroin problem in any country or city. The indicators most frequently used (such as: first treatment demand, police arrest, hospital admissions, imprisonment, deaths, cases of hepatitis, emergency room visits, etc) are believed to have a distinct albeit indirect relationship with heroin trends. Although the exact interrelation of the various indicators or between the indicators and heroin use or activity is unknown, the indicators are thought to reflect general variations in heroin trends.

The reliability of an indicator depends on two features: rapidity (amenability to analysis) and quality (ability to account accurately). Patterns of drug use in a community can alter so rapidly that conventional methods of survey of indicators often do not adequately assess the dynamics of the situation. It would be a mistake to assume that the whole development in a particular geographical area could be clarified by one single indicator.

A research project such as the multi-city study not only requires a theoretical framework but also a method by which the different data or different indicators can be made comparable both per country (city) between the different indicators and per indicator between the different countries (cities). It has therefore been decided within the group of epidemiology experts to work on the six most easily available indicators: first treatment demand, police arrests, hospital admissions, imprisonments, deaths and cases of hepatitis.

Continuity of data collection and centralisation of data storage should be considered of great importance. So far long-term monitoring has rarely been attempted, although the importance and usefulness of central monitoring systems is acknowledged nowadays. As far as the multi-city study is concerned, some cities will have data available from these systems. Amsterdam uses a centrally organised monitoring system specifically based on methadone treatment data.

In general the nature of a monitoring system depends on the purpose for which it is used. In most cases it tends to be administered by an official or government body and is therefore mostly not suitable as a research tool. If a system has been developed specifically as a research tool, a great deal of information usually available from official bodies is missing.

The specific nature of the CMR derives from the fact that, although administered by the official Community Public Health Service (GG&GD), the system has been developed and organised as a research tool. Because of the large range of treatment facilities available, the system may include a considerable amount of data relevant to epidemiological research. This does not mean, however, that such a system could, or should, act as a complete information and advisory service on all aspects of drug taking, research, treatment, rehabilitation and policy. Rather it is envisaged that the system would complement, both qualitatively and quantitatively, the functions served by other existing organisations and data collecting systems.

C.2 Relationship between indicators

The "ideal" framework of the CMR could be represented by the chart in Figure 4:

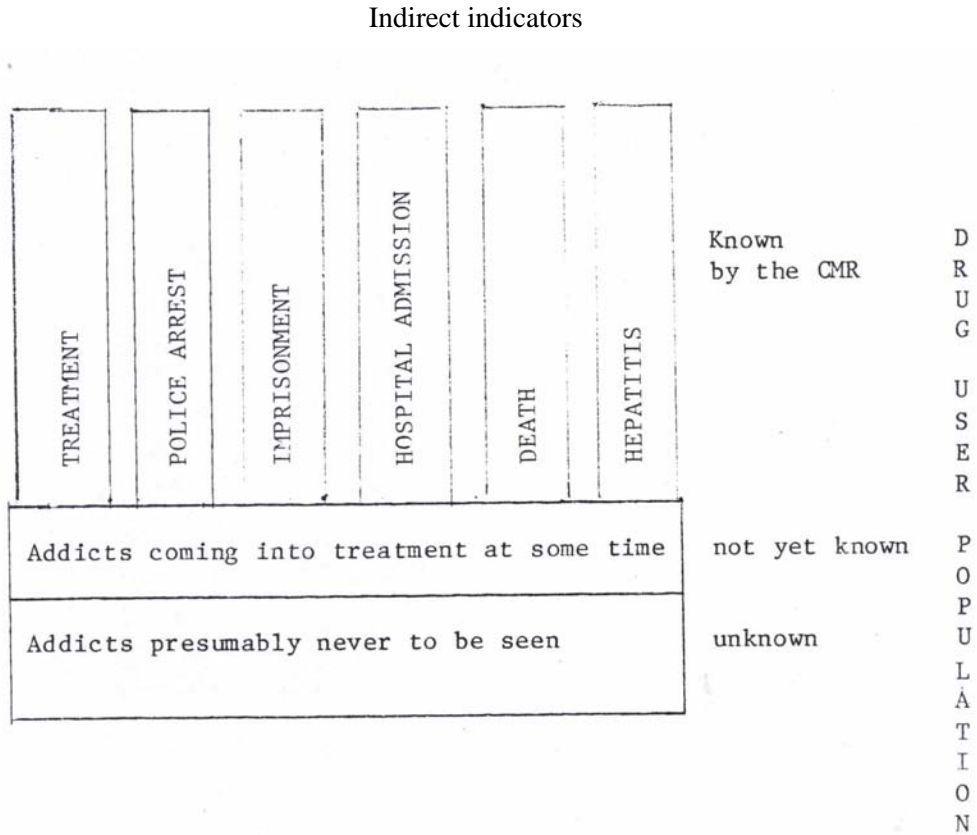


Figure 4:

Schematic "ideal" framework of the CMR

It is suggested in Figure 4 that if data on the different indicators were assembled systematically in relation to the CMR, the CMR might turn into an instrument of great value to epidemiological research.

As has been shown, all kinds of data on the different indicators have been available. However, there does not seem to be a logical association between the numbers on the different indicators. For example it is not known whether the numbers come from the same population or from different populations. Only a few numbers have been assembled in relation to the CMR and thus from a comparable population.

Even though the CMR still has to be further developed, the epidemiological value of the system seems to be full of promise. As a result Amsterdam proves to be an interesting partner in the multi-city study. By means of the monitoring system used, data on the chosen different indicators will be directly comparable over time, which is of great epidemiological value. Participation of Amsterdam in the multi-city study obviously appears to be very important both for epidemiological research at city and national level and for epidemiological research at international level.

## CONCLUSIONS

Information presented in this report has shown the usefulness of a central monitoring system for epidemiological research. Because of the presence of such a system in Amsterdam, it does seem quite feasible to carry out a research project based on indicators. However some problems will have to be solved.

As might be expected some indicators have a greater utility and relevance than others and some are more easily at hand. It seems worthwhile to investigate further the possibility of continuous systematic monitoring of some of them.

Even though the CMR seems to be full of promise as an epidemiological research tool, it lacks a structural and organisational framework within which its participation in any epidemiological research project can be arranged. The main objective of such a structural framework should be to establish formal data-gathering procedures for the different indicators and guarantee the interest of the authorities concerned.

APPENDIX I

DATA

Table 1: Population figures for Amsterdam by age and sex

- A = absolute numbers  
 B = percentages  
 C = comparison between the total of 1983 and the total of 1975  
 m = male  
 f = female

A.

age group	1975			1983		
	m	f	Total	m	f	Total
15	65,773	62,995	128,768	48,213	46,518	94,731
15-19	27,774	26,924	54,698	21,836	21,700	43,536
20-29	76,488	72,902	149,390	69,975	69,311	139,286
30-39	47,036	42,106	89,142	59,828	53,244	113,072
40-49	39,644	40,920	80,474	36,650	33,761	70,411
50+	106,939	141,553	248,492	90,297	125,191	215,488
Total	363,654	387,400	750,964	326,799	349,725	676,524

B.

age group	1975			1983			C
	m	f	Total	m	f	Total	
15	8.76	8.39	17.14	7.13	6.88	14.00	-3.14
15-19	3.70	3.58	7.28	3.23	3.21	6.44	-0.84
20-29	10.18	9.70	19.89	10.34	10.25	20.59	+0.70
30-39	6.26	5.61	11.87	8.84	7.87	16.71	+4.84
40-49	5.28	5.45	10.64	5.42	5.00	10.41	-0.23
50+	14.24	18.85	33.09	13.35	18.51	31.85	-1.24
Total	48.42	51.58	100.00	48.31	51.72	100.00	

km2

207.49

207.60

Table 2: Total number of clients registered by the CMR per year of treatment and according to first year treatment was requested  
[Figures available to date]

First year of treatment	Year of treatment				
	1981	1982	1983	1984	1985
1981	3,531	2,267	1,915	1,751	1,512
1982		2,143	1,150	902	800
1983			2,657	1,065	870
1984				2,901	1,393
1985					2,092
Total	3,531	4,410	5,722	6,619	6,657
Rates per 1,000 (age range 15-39)	11.9	14.9	19.3	22.4	22.5

Table 3: Official hospital statistics based on discharge diagnoses

292 = drug psychosis  
 304 = drug dependence  
 305 (2-9) = non-dependent abuse

ICD	1981		1982			1983			1984
	Total		m	f	Total	m	f	Total	
292 Prim.			7	4	11	4	2	6	
Sec.			8		8	2	2	4	
Sub-total	9		15	4	19	6	4	10	
304 Prim.			16	9	25	21	11	32	
Sec.			91	84	175	99	69	168	
Sub-total	206		107	93	200	120	80	200	
305 Prim.			8	6	14	15	6	21	
Sec.			182	99	281	212	94	306	
Sub-total	25		190	105	295	227	100	327	
Gen. total	240		312	202	514	353	184	537	
Rates per 100,000	34				73			79	
per 1,000 age range 15-39	0.8				1.1			1.1	

NB: Data for 1984 are not yet available



Table 4: Data on hospital admissions

Number of persons admitted to hospitals under the registration programme for whom "guidance was requested" and number of admission diagnoses

	1981			1982			1983			1984		
	m	f	Total	m	f	Total	m	f	Total	m	f	Total
Number of persons	86	97	183	88	73	185	196	119	315	217	152	369
Rates per 1,000 (age range 15-39)	0.6			0.6			1.0			1.0		
Number of admission diagnoses	223			227			400			457		

\*

**Table 5:** Hospital admissions: Official statistics from psychiatric sections of University Hospitals (UH), General Hospitals (GH) and Drug Abuse Treatment Clinics (DATC). Statistics are based on primary discharge diagnoses: 292 = drug psychoses; 304 = drug-dependence; 305 = non-dependent abuse.

	1982			1983			1984		
	M	F	T	M	F	T	M	F	T
<u>ICD: 292</u>									
GH + UH	14	3	17	10	2	12	12	2	14
DATC	1		1	10	2	12	12	2	14
Sub-total	15	3	18						
<u>ICD: 304</u>									
GH + UH	32	8	40	22	11	33	33	5	38
DATC	40	13	53	224	57	281	165	55	220
Sub-total	72	21	93	246	68	314	198	60	258
<u>ICD: 305</u>									
GH + UH				9	1	10	6	4	10
DATC				9	1	10	3	1	4
Sub-total							9	5	14
General total	87	24	111	265	71	336	219	67	286
per 1,000 (age-range 15-39)	0.3	0.1	0.4	0.9	0.2	1.1	0.7	0.2	1.0

Source: Medical Chief Inspectorate of Public Mental Health

**Table 6:** Recorded cases of hepatitis B by age and source of infection in 1983 and 1984 (GG&GD-Amsterdam)

1983 Source, of infection

AGE	Medical intervention	Drug use	Tattoo	Homosex. contact	Heterosex. contact	Unknown	Total
0-14	1	-	-	-	-	6	7
15-19	-	-	3	1	1	3	8
20-24	-	6	3	16	1	19	45
25-29	-	5	-	11	2	9	27
30-34	2	4	-	5	-	7	18
35-39	-	4	-	8	-	3	15
40-49	-	-	-	2	1	6	9
>50	1	-	-	1	1	7	10
Total	4	19	6	44	6	60	139

Rate per 1,000

Age range 15-39

1984 Source of infection

AGE	Medical intervention	Drug use	Tattoo	Homosex. contact	Heterosex. contact	Unknown	Total
0-14	-	-	-	-	-	4	4
15-19	-	4	1	-	-	2	7
20-24	-	10	1	9	-	3	23
25-29	-	5	-	7	3	6	21
30-34	-	2	-	4	-	2	8
35-39	-	2	-	4	-	5	11
40-49	-	-	-	4	2	5	11
>50	2	-	-	1	1	7	11
Total	2	23	2	29	6	34	96

Rate per 1,000

Age range 15-39

Table 7: Deaths of drug takers in Amsterdam as registered by the police and the CMR  
 (\* = overdose as registered by the police)

Country	Published by the police							Published by CMR and police (*)		
	1978	1979	1980	1981	1982	1983	1984	1985		
Netherlands	9	12	14	15	12	20 (21*)	35 (20*)	26 (19*)		
Surinam	1		2			4	4 (1*)	3 (2*)		
Fed. Rep. of Germany	3	1	10	13	12	10 (19*)	45 (35*)	13 (10*)		
Other	5	6	18	6	7	37 (13*)	30 (17*)	13 (11*)		
Total	18	19	44	34	33	71 (53*)	114 (73*)	55 (42*)		
Rate per 1,000 Age range 15-39	0.1	0.1	0.1	0.1	0.1	0.2 (0.1*)	0.4 (0.2*)	0.2 (0.1*)		

Table 8: Total number of drug users arrested for offences against the Opium Law, number charged and number treated by a medical doctor during arrest

Year	Number of persons		Number of persons medically examined and treated		
	arrested	charged		Abs.	%
		Abs.	%	Abs.	%
1976	1,618	906	56.0		
1977	1,375	426	31.0	653	47.5
1978	1,660	390	23.5	1,091	65.7
1979	1,752	319	18.2	1,053	59.5
1980	1,655	314	19.0	1,243	75.1
1981	2,855	423	14.8	1,549	54.3
1982	3,024	546	18.1	1,656	54.7
1983	2,517	486	19.3		
1984	3,351	853	25.5	2,321	69.3
1985	3,418	680	19.9		

Source: Annual reports of the Municipal Police of Amsterdam  
Central Executive Narcotics Squad

Source: CMR – Monitoring of the Police treatment project of the GG&GD

Table 9: Police-arrest treatment data in relation to other treatment data Source: CMR Amsterdam 1984

	Treated during police-arrest		
	No.	% of total treated during police-arrest	% of total treated population (N = 6,619)
Not seen in other treatment in 1984	1,110	47.8	16.8
In treatment with:			
Public health institute	998	43.0	15.1
Drug centres	12	0.5	0.2
General practitioners	88	3.8	1.3
Combination of facilities	113	4.9	1.7
Total	2,321	100.0	35.1

Table 10: Number of persons arrested for offences against the Opium Law, by drug involved

\* (opiates = heroin, opium and methadone; cannabis = hashish and marijuana)

Year	Opiates*	Cannabis*	Cocaine	Amphetamines	LSD	Total
1977	880	367	49	51	28	1,375
1978	1,128	425	65	24	18	1,660
1979	990	579	139	28	16	1,752
1980	881	353	299	87	35	1,655
1981	1,572	661	483	70	69	2,855
1982	1,768	516	551	120	69	3,024
1983	1,540	297	549	85	46	2,517
1984	2,387	217	671	46	30	3,351
1985	2,558	686	83	62	29	3,418

Source: Annual reports of the Municipal Police of Amsterdam Central Executive Narcotics Squad

Table 11: Imprisonment data

	1982		1981		
	Total	Dependent on drugs	Total	Dependent on drugs	Treated with Methadone
“Amsterdam Demersluis”	1,794	636 (38.0%)	2,575	697 (26.4%)	?
“Amsterdam Singel”	426	75 (18.0%)	448	126 (28.1%)	120

Table 12: Amounts in grammes\* of drugs seized

	1981	1982	1983	1984	1985
Opium	211	955	4	181	24
Morphine	5,892	453	0.2	88	4
Heroin	29,626	46,500	51,000	70,000	175,000
Cocaine	6,680	9,000	21,150	47,000	15,000
LSD (“trips”)	4,389	48,535	2,752	7,182	53,000
Hashish (kg)	1,981**	869	1,775	6,750	1,150
Marijuana (kg)	2,216	2,200	200	5,924	740
Hash oil	397	1,945		600	
Amphetamine	24,197	11,595	45,000	383	125,000
Amphetamine (tablets)	1,190	2,500	60,000		
Methadone (tablets)	9,508	5,395	5,750	5,503	4,350
Methaqualone (mg)	4,158	5,000	7,000	500	
Methaqualone (tablets)			13		
Psilocybine	133	835	260	88	105
Amphepramone (mg)	10,490	7,000			6,100
Dextromoramide		40		0.3	
Dextromoramide (tablets)	80	37	20		200

\* Unless otherwise indicated

\*\* Includes one case of 1,500 kg

Source: Annual reports of the Municipal Police of Amsterdam Central Executive Narcotics Squad

Table 13: Prices of drugs per gramme\* in Dutch guilders (A) and ECUs (B)

A

	1982	1983	1984	1985
Heroin	175-250	135-180	135-150	75-100 (Chinese) 125-150 (other)
Cocaine	150-200	125-150	140-175	120-175
Hashish	4-6	5-7.50	5-10	5-10
Marijuana	3-5	3.50-7.50	3.50-7.50	3-5
Amphetamine	15-20	10-15	7.50-15	6-12.50
Methadone (tablet)	2-2.50	1-?	2-5	1-2.50
LSD (trip)	3.50-5	1.50-2.50	1.50-2.50	1.50-3

B

	1982	1983	1984	1985
Heroin	67.3-96.2	51.9-69.2	51.9-57.7	28.8-38.5 (Chinese) 48.1-57.7 (other)
Cocaine	57.7-76.4	48.1-57.7	53.8-67.3	46.2-67.3
Hashish	1.5-2.3	1.9-2.9	1.9-3.8	1.9-3.8
Marijuana	1.2-1.9	1.3-2.9	1.3-2.9	1.2-1.9
Amphetamine	5.8-7.7	3.8-5.8	2.9-5.8	2.3-4.8
Methadone (tablet)	0.8-1.0	0.4-?	0.8-1.9	0.4-1.0
LSD (trip)	1.3-1.9	0.6-1.0	0.6-1.0	0.6-1.2

\* Unless otherwise indicated.

Source: Annual reports of the Municipal Police of Amsterdam Central Executive Narcotics Squad



Table 14: Use of drugs in percentages by drug takers known at the Mental Health Department of the GG&GD of Amsterdam

(Since one and the same person often uses more than one type of drug, the sum of percentages is higher than 100)

Drug	19707 %	1971 %	1972 %	1973 %	1979-80 %
Opium	34	46	39	32	-
Heroin	7	4	21	30	93
Hashish	29	26	18	20	48
LSD	41	28	24	17	1
Amphetamines	4	7	7	10	2
Cocaine	28	32	29	24	35
Total N	220	271	335	377	632

Table 15: The most significant results of the survey on the extent of the use of cannabis, alcohol and tobacco by young people aged 15-24 (N = 1,306) performed by the National Government in 1983

- 12% of young persons in the age group 15-24 years had used cannabis at least once. The life-time prevalence percentage calculated according to national representativeness was 15.
- The older the respondents the higher was the figure: 27, for the age group 15-16 years and 30% for the age group 23-24 years.
- Compared with the study carried out by the CBS (Central Bureau for Statistics) in 1979-80 among Dutch youth aged 13-24 years, there was an increase in the use of cannabis. Of the youth 19-24 years in the CBS study 11% had used cannabis, in the recent study the figure was 21%.
- The life-time prevalence of cannabis use among pupils and university students was 8%, the students having an exceptionally high percentage of 36.
- In the sample, 27% of the unemployed had used cannabis at least once, while the percentages for those who worked full or part-time were 17 and 14 respectively.
- Current use of cannabis was lower than having used cannabis at one time or another. Approximately 5% of the sample could be considered as current users. This means that 55% of those who had ever used cannabis did not continue to do so.
- The regular users of cannabis (once a week or more) represented 1.6% of the entire sample.
- The highest percentage of current users was encountered among students and the unemployed: 18% and 13% respectively.
- There was quite some misunderstanding about the use of cannabis: 21% admitted to not knowing how to use it, in addition 22% thought it was injected.
- In general, knowledge of drugs as expressed by being able to name them spontaneously had increased since a survey carried out in 1976.
- The use of other drugs occurred to a limited extent.

Table 14: Use of drugs in percentages by drug takers known at the Mental Health Department of the GG&GD of Amsterdam

(Since one and the same person often uses more than one type of drug, the sum of percentages is higher than 100)

Drug	1970 %	1971 %	1972 %	1973 %	1979-80 %
Opium	34	46	39	32	-
Heroin	7	4	21	30	93
Hashish	29	26	18	20	48 <sup>or</sup>
LSD	41	28	24	17	1
Amphetamines	4	7	7	10	2
Cocaine	28	32	29	24	35
Total N	220	271	335	377	632

## APPENDIX II

### GLOSSARY OF TERMS AND DEFINITIONS

#### Drug abuse

The use of drugs with unacceptable high health risks for the user and the environment. The term is used with a great deal of imprecision.

#### Drug addict

Refers to persons who are addicted to the use of opiates and is also used with a great deal of imprecision.

#### First treatment demand

Refers to drug users who receive treatment for the first time by provision of methadone. Persons taken on for treatment are primarily opiate addicts.

#### Hospital admission

As far as official hospital statistics are concerned, the term adheres to the WHO definition of “a stay in the hospital lasting one night or more, irrespective of whether the patient is admitted for the first time, readmitted ... or transferred from another hospital”.

#### Drug-related deaths

Refers to the unnatural deaths of drug users diagnosed as “overdose” after examination by either the coroner of the Public Health Institute or the pathologist of the Court of Justice.

In other cases the term refers to the deaths of drug users indirectly related to drug abuse.

#### Police arrests

Refers mainly to the number of persons arrested by the police in the very first phase of the police procedure of charging with committing a specific offence under for example the Opium Law.

Not all arrested persons are subsequently charged.

### APPENDIX III

#### REFERENCES

1. "New drug policy adjusted and elaborated upon". City of Amsterdam, December 1984 (English).
2. "Municipal plan for drug treatment assistance 1985-1986". City of Amsterdam, December 1984 (Dutch).
3. "Policy on drug abuse" "Letter from the Secretary of State for Welfare, Health and Cultural Affairs". 1982-1983, Session 17867, No. 1 (English).
4. "Medical treatment programmes of the GG&GD: a research proposal". GG&GD, August 1984 (Dutch).
5. G van Brussel and A J de Roij-Motshagen: "Medical assistance to drug addicts at police stations in Amsterdam, 1977-1979". Med. Cont., 47, 1476-1479, 1980, (Dutch).
6. R A Champion and D S Bell: "Monitoring trends in drug use". The Int. J. of Add. 15 (3), 375-390, 1980.
7. E Engelsman, E van de Poel and A J de Roij-Motshagen: "Contribution of the representatives of the Netherlands to the meetings in Strasbourg on: Development of administrative monitoring systems for the assessment of public health and social problems related to drug abuse". Note, April 1983 (English).
8. H Mahler: "The monitoring process has been set in motion". World Health Forum, vol. 5, 1984, pp 98-103.
9. W G Mulder, "Background of drug use in the Netherlands". Feiten 15, 1979, 4 July, 65-71 (Dutch).
10. Th. Sluys and A J de Roij-Motshagen: "Social guidance for drug addicts during admission to hospitals 1977-1979". Med. Cont., 46, 1441-1447, 1980 (Dutch).
11. G Sijibing: "Use of drugs, alcohol and tobacco". SWOAD report, June 1984 (Dutch with a summary in English).
12. S Wat: "Central registry of drug abuse" The Int. J. of Add. 20 (12) 279-298, 1985.

Blank page

REPORT ON DRUG MISUSE IN DUBLIN

by

Ms A O'Hare

	<u>Page</u>
A. <u>DESCRIPTION OF THE CITY</u>	
1. History of drug misuse .....	72
2. General policy; legislation .....	73
3. Demographic information .....	74
4. Surveys on drug misuse .....	75
5. Treatment and social care systems/facilities .....	78
6. Control systems and resources (law enforcement).....	81
7. Monitoring system .....	82
B. <u>INDICATORS</u>	
1. First treatment demand .....	83
2. Hospital admissions .....	83
3. Viral hepatitis .....	84
4. Drug-related deaths .....	84
5. Police arrests .....	85
6. Imprisonment .....	85
7. Seizures of illicit drugs .....	85
8. Price/purity of illicit drugs .....	86
9. Survey data .....	86
10. Comments on AIDS .....	87
C. <u>ASSESSMENT OF THE USE AND VALUE OF INDICATORS</u>	
1. Use of indicators in the city .....	88
2. Relationship between indicators .....	89
D. <u>CONCLUSIONS</u> .....	90
Appendix I: Data .....	91
Appendix II: Glossary of terms and definitions ... ..	100
Appendix III: References .....	102

## A. DESCRIPTION OF THE CITY

### A.1. History of drug misuse

All available evidence suggests that serious drug misuse in Dublin is of fairly recent origin. One of the earliest investigations showed that only 0.9% of all admissions to the Dublin public psychiatric hospital facilities in 1962 had a diagnosis of amphetamine dependence. (1) In Dublin, however, the problem of drugs escalated in the mid-1960s as groups of young people raided hospital pharmacies, chemists and dispensaries to obtain drugs, mainly amphetamines. These raids and subsequent prosecutions received widespread publicity and amid growing concern the Minister for Health set up a Working Party in 1968 to establish the extent of drug abuse in Ireland.

Its report in 1971 revealed that there had been a three-fold increase in the number of people known by the Gardai (police) to be abusing drugs in Dublin from 350 in 1969 to 940 in 1970. The actual number of persons involved was considered to be much greater. There had also been a change in the pattern of misuse. Whereas originally a variety of drugs were involved including amphetamines, barbiturates and tranquillisers, the drugs most commonly misused in 1970 were cannabis and lysergic acid diethylamide (LSD). While the Working Party found no evidence of any significant misuse of heroin, they added that “the position should not be viewed with complacency”. (2)

By 1982, the drug scene had changed again and the report of the Task Force on Drug Misuse in the Eastern Health Board area (in which Dublin is situated) concluded that there had been a recent epidemic of drug misuse, mostly heroin, in that area. (3) Again evidence from sources such as the National Drug Advisory and Treatment Centre (the only medical treatment centre in Dublin) or, as it is commonly referred to, the Jervis Street Drug Centre and the Garda Drug Squad, referred only to known drug users.

In 1983 a study to ascertain the prevalence of both treated and untreated cases of drug misuse in a defined inner Dublin city area was carried out by the Medico-Social Research Board. The findings showed that 107, of young people aged 15-24 had used heroin during the time period under review, many injecting the drug daily. 77% of the sample were attending for treatment at the Jervis Street Drug Centre. (4) However this inner city area could not be regarded as representative of the city and a later study in a more typical area showed that 2.2% of the same age group 15-24 had been using heroin (5).



The number for both all and first attenders at the Jervis Street Drug Centre for whom opiate (predominantly heroin) was the principal drug of misuse peaked in 1983. This represented a near five-fold increase for opiate users since 1979 (6). Since then all available data from sources like the Treatment Centre, the Garda Drug Squad, as well as information from surveys and for viral hepatitis suggest that the position of drug misuse has stabilised in Dublin.

## A.2 General policy; legislation

While a number of statutes exist, such as the 1961 Poisons Act, which controls the sale and availability of drugs, the Misuse of Drugs Act 1977 was introduced to modernise the Dangerous Drugs Act 1934 and deal with the escalating drug situation in Ireland. It was the first positive response to the Working Party Report on Drug Abuse in 1971, another being the creation of the Health Education Bureau in 1975 which has introduced special education programmes in particular at school level, to deal with drug problems.

The principal provisions of the Misuse of Drugs Act 1977, implemented in 1979 were:

- increased penalties for 'drug offences';
- greater control over those who have a right to prescribe controlled drugs;
- recognition of the difference between cannabis and other drugs;
- direction to judges to obtain medical and social reports on persons convicted of certain drug offences with a view to ascertaining their needs;
- extension of garda powers and a change in the law relating to
- evidence in certain cases.

This latter provision takes into account the previous weakness in the law concerning powers of search. The nature of drug crimes poses special difficulties in obtaining evidence. The victim in other crimes is often co-operative with the gardai, but in the case of drug-related crimes is likely to see the gardai as threatening his supply of drugs. Even when illicit drugs are seized the Garda Drug Squad has difficulty in obtaining sufficient evidence to charge those suspected.

Legislation under the Medical Preparations (control of amphetamine) Regulations, 1970, prohibits the manufacture, sale and distribution of amphetamines; certain of their derivatives and preparations containing such substances, subject to certain conditions. The Minister for Health has power to grant a licence to allow the supply of amphetamine to a patient who requires it for treatment. Such supplies can only be obtained from a central depot. The idea was to reduce the supply of legal amphetamines into the black market through forged prescriptions, excessive prescribing or burglaries from pharmacies.

In response to evidence of growing heroin use the government established a special Government Task Force of Ministers in April 1983. Ministers of State at the Departments of Health, Education, Justice, Environment, Foreign Affairs and Labour were asked to look at the question of drug misuse with particular reference to inner-city areas in Dublin. In August 1983 they submitted their recommendations to the government in areas of law enforcement, education, health, community youth development and research. Directly arising out of their recommendations the following changes occurred;

- the Misuse of Drugs Act 1984 came into operation, providing for harsher prison sentences and higher fines for drug-related offences;
- the Criminal Justice Bill 1983 was drawn up to deal more effectively with serious crime including drug offences;
- “life skills” programmes by the Health Education Bureau were introduced in a number of schools on a pilot basis;
- a Diploma Course in Addiction Studies in Trinity College Dublin was established;
- research projects were undertaken by the Medico-Social Research Board;
- a National Co-ordination Committee on Drug Abuse was set up to advise the government on an ongoing basis on general issues regarding prevention and treatment of drug misuse.

On 1 March 1985 the non-controversial sections of the Criminal Justice Bill were enacted, reflecting perhaps the public disquiet and the expressed concern among the gardai that certain sections of the bill should not come into operation without a ministerial order and until an independent complaints tribunal had been established.

A general policy statement on the treatment of drug users was contained in the recent government report 1984 on “the Psychiatric Services – Planning for the Future”, which recommended that the approach to the drug problem should be community-based with inputs from both medical and social personnel together with voluntary organisations (7).

### A.3 Demographic information

For the purpose of this study Dublin city is defined as the census area of greater Dublin which comprises Dublin County Borough, Dun Laoghaire Borough, their north and south suburbs with a population in 1981 of 915,115. The area of greater Dublin is almost co-terminous with that of Dublin county and contains approximately 27% of the country’s population. The area of greater Dublin is 504 km<sup>2</sup>. The total number of persons unemployed in Ireland (data for the greater Dublin area are not available) in January 1986 was:

	<u>Number</u>	<u>%</u>
All ages	240,405	18.0 of labour force
Aged 15-24	73,900	30.7 of those unemployed

Between 1971 and 1981 the population increase for the greater Dublin area was 12.7%. The following table gives 1981 census information on the sex and age distribution of the area.

Greater Dublin area 1981

Age and Sex. Numbers

	Male	Female	Total
/_5	133,948	127,618	261,566
15 - 19	47,469	49,682	97,151
20 - 29	78,282	84,491	162,773
“ 30 - 39	55,740	58,092	113,832
40 - 49	42,863	46,002	88,865
50 +	79,736	111,192	190,928
Total	438,038	477,077	915,115

A.4 Surveys on drug misuse

Prior to the 1960s no survey work was carried out in Ireland on the problem of drug taking as its misuse then was largely confined to a small number of medical and para-medical personnel and to patients who had become dependent on prescribed drugs.

One of the earliest studies of drug misuse in Dublin was carried out in 1962 on patients admitted to the Dublin public psychiatric hospital. 18 admissions or 0.9% of all admissions for that year had a diagnosis of amphetamine-dependence (8).

In the 1970s three further studies (with a sample size of 50 in each case) were conducted again, on patients attending Dublin state psychiatric facilities. The demographic and social characteristics of the drug users in the three studies were found to be very similar. The majority were male, single, with an average age of 19.3 years, of urban origin, from large family size, with poor educational qualifications and coming largely from problem family backgrounds; 90% were unemployed at the time of interview or prior to admission to

treatment. A high proportion, 44%, had convictions prior to drug taking. Drug use had started at an average age of 16 years. All had used cannabis and LSD. 56% had used heroin and other opiates, 32% having used them intravenously (9).

In 1970 and 1971 a survey of 5,483 post-primary school students (aged 12 to 18 years) in Dublin showed that 2.3% of these students (more boys than girls) claimed to have experimented with drugs on at least one occasion, Cannabis was the commonest drug taken by 78 students, LSD and amphetamines by 15 and 10 students respectively, while 11 students said they had taken heroin, morphine or opium (10). A follow-up of the Dublin school survey a decade later in 1980 and 1981 (N = 5,178) showed a five-fold increase in drug use among the students. 11% of the sample had now experimented with drugs or 20% aged 16 and over and 9% aged under 16 years. The most frequently used drug was again cannabis for 485 students or 9% of the sample, the second most common drug used was heroin – for 50 of the students. Other drugs taken included cocaine, LSD, glue, tranquillisers, bananas/mushrooms, with only two students using amphetamines. Almost 15% of boys compared to 8% of girls had experimented with drugs but it should be noted that boys were over-represented in the study sample by almost 1,000 (11).

A study of drug misuse in a defined inner city area was carried out in 1982-1983. Information was collected through interview, using the snowball approach, with all drug users resident in the area. The interviewers were known and trusted by the residents. Findings revealed that 10% of young people had used heroin, many daily, during / the study period. The area investigated was a deprived one with a history of high unemployment, crime and social problems. The following profile of the group N = 88 emerged:

- male-female ratio of 1.5:1;
- poor educational and work record, 73% unemployed at time of interview;
- almost all were heavy smokers, less than half were drinkers;
- one-third were from families in which drink was a problem;
- many had been arrested, often more than once, for offences either connected or not connected with heroin use;
- approximately 64% had been in prison;
- 70% of heroin users, most of whom injected intravenously, also used other drugs commonly administering them, eg diconal, with heroin (12).

One of the objectives of a later study 1983-1984, in a Dun Laoghaire Borough area was to provide a basis for comparison between heroin misuse in this more representative area of the city and that found in the inner city study. The methodology used was similar in both studies. Findings showed that 2.2% of persons in the Dun Laoghaire area aged 15 to 24 were abusing heroin, considerably less than the proportion (10%) found in the inner city area. The profile of the study group, N = 35, was as follows:

- male/female ratio of 2:1;
- majority from families with a low socio-economic status;
- three-quarters never passed an examination, 80% unemployed at time of interview;
- over 80% currently smoking cigarettes;
- almost one-third reported a history of alcoholism in their families;
- over three-quarters had been arrested and three-fifths had served sentences. Those arrested were more likely to have been arrested for the first time before using drugs;
- typical progression in drug use was from nicotine to alcohol to cannabis to heroin (13).

In a study of the "Characteristics of heroin and non-heroin" users in a north central Dublin area 1984", a control group, of 88 persons. matched by sex and age from the same inner city area as the heroin users previously identified, was interviewed using the original questionnaire with some minor changes. The principal differences between the users and controls were that the heroin users were more likely to come from a disturbed family background where one or both parents were dead or where there had been a family drink problem. They also had a much poorer educational and employment record (14). A three year follow-up study of the group of heroin users N = 88 in the inner city area is in press. The principal finding shows that approximately 25% of the original group were no longer using drugs at the time of interview (15).

A survey of "The opiate epidemic in Dublin 1979-1983", jointly undertaken by the Medico-Social Research Board and Jervis Street Drug Centre, analysed the development of opiate misuse and the characteristics of patients attending Jervis Street. Information for the study came from the case records of the patients concerned. A follow-up of that study for the years 1984 and 1985 is in press. Findings from the two surveys show that:

- the number of first contacts for whom opiates, predominantly heroin, was the principal drug of misuse rose from 56 in 1979 to 455 in 1982, falling to 116 in 1985 (Table Appendix 1);
- the number of re-contacts for opiate misuse continues to rise from 126 in 1979 to 682 in 1985;
- males exceeded females by a ratio of more that 3:1;
- in 1984, three-quarters of all admitted opiate users had needle marks;
- 55% of opiate users had been on drugs for three or more years prior to their first treatment contact in 1984;
- the number of attenders was highest in 1983 showing a treated rate for the greater Dublin area of 3.5 per 1,000 of the population aged 15 to 39, for all forms of drug misuse - predominantly opiate (16).

#### A.5 Treatment and social care systems/facilities

As already stated the only medical treatment centre for drug abuse in Dublin is the Jervis Street Drug Centre. As a recent diversification of its services ten counsellors (social workers or nurses) have been appointed in the Eastern Health Board area who refer persons with drug problems to the Jervis Street Service or who may at times be requested by them to counsel specified persons. The Jervis Street Centre liaises closely with the drug rehabilitation services in Dublin, notably the Coolemine Therapeutic Community and the Rutland Centre. Additionally, treatment is provided in the Dublin psychiatric hospitals and the committal prisons. Persons who are dependent on drugs also present themselves at the accident and emergency departments of general hospitals, usually because of problems relating to their dependency. Some general hospitals have a special interest in treating hepatitis. Drug abusers can also seek treatment from their general practitioners.

Under the present Health Act all persons in Ireland are eligible to in-patient hospital services in public wards free of charge. Whereas persons who are medical card holders (those with low incomes generally) approximately 37% of the population, are entitled to general practitioners services free of charge, the rest of the population pay for such consultations.

##### 5.1 The Jervis Street Drug Centre

The Drug Advisory and Treatment Centre at Jervis Street Hospital, established on a recommendation in the interim report (1969) of the Working Party on Drug Abuse, opened in 1970. In 1975 the Department of Health designated the unit as a national centre to provide in-patient and out-patient treatment. The same year a nine-bed intensive care detoxification ward was opened. The centre provides a 24-hour treatment and advisory service to drug users, their families and other interested persons seven days a week. These services include a medical and psychiatric assessment, psycho-therapy and counselling support, and referral to other agencies. The standard therapeutic approach used in Jervis Street for the treatment of those dependent on opiates and synthetic opiates is the methadone maintenance programme provided in the linctus (oral) form, rather than tablets or ampoules. Patients are kept on as low a dose as possible i.e. between 25-30 mg or approximately 10-25% of comparable British or US dosages. This low dosage is seen as having a correspondingly low addiction level and a milder withdrawal with a decrease in the severity of unwanted effects of the drug (17).

##### 5.2 Hospital treatment

###### Psychiatric admissions

Patients are admitted to Irish psychiatric hospitals under the Mental Treatment Act 1945, either in a voluntary or temporary capacity the majority or approximately 88%, are admitted as voluntary patients today. According to the "Activities of Irish psychiatric hospitals and units" there were 116 admissions of Dublin city residents with a primary or secondary diagnosis of drug misuse to psychiatric hospitals both public and private in 1983. The vast majority for drug dependence ICD 304 (18). Clearly these admissions represent only a small proportion of the hospitals' case load. No information is available regarding out-patient attendances at Dublin hospitals, with the exception of St. Loman's – a public hospital, which had 11 contacts in 1983.

### General hospital discharges

The hospital in-patient enquiry scheme collects and analyses information on discharges from Irish general hospitals. In 1984 there were 180 discharges of patients resident in Dublin city with a primary or secondary diagnosis of drug misuse. The majority of these would refer to patients from the nine-bed detoxification unit attached to the Jervis Street Drug Centre, again mostly with a drug dependence •diagnosis. Patients are admitted to other general hospitals with drug problems, usually a secondary diagnosis, and patients requiring treatment for a primary drug diagnosis are generally transferred to Jervis Street Hospital. The Dublin maternity hospitals reported an increase in the number of drug dependent pregnant women from four in 1980 to 54 in 1984 and 48 in 1985. The majority are heroin-dependent (19)

### Accident and emergency admissions

In association with the Eastern Health Board Task Force a survey was undertaken in Dublin hospitals during September 1982 to look at patients presenting to accident and emergency departments with problems of drug use. Only patients abusing illicit or controlled drugs were included, para-suicides did not form part of the study. 14 hospitals participated in the Dublin area and the findings showed that 80 separate persons using drugs attended their accident and emergency departments during the four week period. The number is possibly an underestimation as casualty personnel admitted that cases may have been missed when the departments were particularly busy. The majority of patients were between 16 and 25 years. The youngest was 14 years. The majority, or 69%, of patients admitted using heroin. The principal reasons for attendance at casualty were an accidental overdose, 28%, followed by trauma in 20% of cases and by sepsis in 19% of cases. 24% of those attending required admission to hospital, the remaining 76% were discharged after treatment. It was established that only 1.5% of these cases were currently attending the Jervis Street Drug Centre, 48.5% not currently attending and 50% had never attended.

### Hepatitis admissions

It is now well documented that hepatitis B is frequent among intravenous drug abusers. In the three Dublin hospitals which treat such patients concern has been expressed at the recent increase in numbers. In 1979 the number of Dublin drug users who were hepatitis B surface antigen (H Bs Ag) positive was 7, this rose to 168 in 1982 and in 1985 the number dropped to 91 (20).

### 5.3 General practitioner care

Information was sought from 40 general practitioners in the Dublin area for the Eastern Health Board Task Force Report 1982 regarding the number of drug users seen by them (21). These numbers varied from none in the previous 12 months to 15 per week. The number seen appeared to relate to the policy of the practice concerning drug users. Doctors known to be "sympathetic" would generally see a larger number than those who were not. Doctors' responses varied in how they

treated their drug patients. Some would refer them immediately to the Jervis Street Drug Centre, others would provide long-term maintenance with opiates and supply syringes and needles to decrease the risk of hepatitis. In 1985, a small number (approximately four) were the subject of a special enquiry by the Department of Health for their prescribing practices to drug users. One doctor was issued with a special direction under the Misuse of Drugs Act 1984 to cease prescribing.

It is believed by some people that middle class patients prefer to seek treatment from a general practitioner or a consultant psychiatrist rather than attend the free treatment service in Jervis Street Drug Centre.

#### 5.4 Rehabilitation facilities

The following organisations, all voluntary, except for the day centre, Usher's Island, offer rehabilitation programmes to drug users. They liaise closely with the Jervis Street Drug Centre.

##### Coolmine therapeutic community

Coolmine provides a drug-free residential programme similar in concept to many in the United States, for example, Daytop Village, New York. There has been an increase in the numbers who contacted the centre from 246 in 1981 to approximately 660 in 1985. Not all contacts are accepted for the residential programme. In 1985, 97 were accepted and joined those already on the programme which in that year catered for 191 persons. Of those on the 1985 programme 78% were primarily opiate users and the average age was 24 years. 30% in 1985 left the programme against staff advice. In 1980 the percentage was 50.

In 1981, Coolmine established parent groups mainly in the Dublin area to provide neighbourhood awareness of the extent and problem of drug misuse. Those groups have since evolved into an independent voluntary body or National Federation for Community Action against drugs (CAD). Coolmine has also set up a day programme for groups who do not require residential care.

##### The Rutland Centre

The centre provides a residential and after-care programme for substance abusers after detoxification. In the period March 1981 to August 1982 8% of the 329 admissions were primary opiate abusers; from January to December 1983 the proportion was again 8% rising to 15% for the same period in 1984, and dropping to 13% in 1985. The principal attenders at the centre are those who misuse alcohol, gamble or are cross addicted to both alcohol and tranquillizers or sedatives. Persons selected for the 4-6 week residential drug programme are those considered capable of responding to the programme, generally young opiate users with concerned persons in their lives and who have not developed a pattern of persistent anti-social behaviour. On discharge from residential care clients have access to a range of services designed to meet their needs for rehabilitation and growth. This after-care programme lasts for a period of 1 1/2 years. In 1983, 45% of the primary opiate abusers did not complete the programme, in 1984 the percentage was 43% and due to a change in policy and a difference in mode of terminating treatment the percentage dropped to 16 in 1985.



The principal day centres in Dublin which offer rehabilitation in one or more forms and which may cater exclusively or in part to drug users include: the Talbot Day Centre; the Anna Liffey Project; the Mater Dei Counselling Centre; the Eastern Health Board Day Centre, Usher's Island and Narcotics Anonymous.

#### A.6 Control systems and resources (law enforcement)

##### 6.1 The Garda Drug Squad

This squad was formed in 1968 with a strength of one detective sergeant, and three detective gardai. A national service of 45 members with at present 33 of those in the Dublin Drug Squad from a detective inspector down. Members of the drug squad receive special training in relation to their duties and in the implementation of drug legislation. They work in close liaison with special divisional units throughout the country and with customs officials, with other police forces and with Interpol concerning international drug traffic.

##### 6.2 Juvenile liaison scheme

This scheme has been in operation since 1963 in each garda division throughout the country providing an alternative to prosecution, subject to certain conditions, for young offenders aged under 17. Juvenile liaison officers are appointed on the basis of their experience, and aptitude in dealing with young people and because of their involvement with general community affairs. Each appointee undergoes a course of training designed to familiarise him/her with all facets of youth work. The supervision of juvenile offenders and potential delinquents is a feature of the scheme as well as talks and lectures to youth groups. In 1986 there are 35 members of the Garda Force employed in the operation of this scheme in Dublin.

##### 6.3 Courses for members of the Gardai

Drug courses which have been ongoing at Garda Headquarters since 1981 continue and at the end of 1984 a total of 1,948 members of the Garda Síochána of all ranks had undergone this course, over 1,000 of those from the Dublin area.

##### 6.4 Garda community relations

The objectives of the community relations section are to establish ways and means of fostering good relations between the Gardai and the community and to advise the public on how to protect itself and its property against criminal attack, including drug related crime. The neighbourhood watch concept is currently being implemented in all parts of Dublin and the rest of the country.

##### 6.5 Talks and lectures on drug misuse by members of the Gardai

As in previous years the demand for members of the Gardai to give talks and lectures on drug misuse continues to increase. This is obviously due to the greater public awareness of the drug problem. In 1984 a total of 1,135 talks and lectures were given mainly in the Dublin area.

## 6.6 Dublin committal prisons

The three Dublin prisons to which drug users are committed are St. Patrick's Institution, Mountjoy male prison and Mountjoy female prison. A survey of persons in these institutions identified as drug "addicts" by the prison medical services increased from 41 in 1981 to 69 in 1982 (22). The estimate for 1983 was 108. A more up-to-date estimate is not available. The profile of the drug "addicts" in the 1981 study showed that a high proportion came from broken homes of large family size. The majority of the "addicts" had left school before the age of 15 and had a poor employment record (23).

Various treatment programmes operate within the prison services notably a methadone one, available to drug users who enter prison while still addicted. The professional service of psychiatrists, psychologists, social workers and probation officers are available to individuals seeking counselling. The staff is also involved either individually or as a team when early release is sanctioned for persons to attend therapy (residential or day care) or return home subject, perhaps to the constraint of attending Jervis Street for drug screening. Voluntary groups, like Narcotics Anonymous, come into the prisons, usually on a weekly basis, to assess the suitability of persons interested in participation in their various programmes.

### A.7 Monitoring system

The first basic requirement of a monitoring system is the existence of a data gathering process from all sources relevant to the situation or problem in question, for example, misuse of drugs in Dublin. The establishment of this data gathering process requires co-operation between the various in-put sources and a central agency or person to arrive at agreement on definitions used, as well as ensuring regular, complete and accurate return of information. These collected data could then provide an accurate picture of drug misuse in Dublin at given points in time, and would, in addition, allow for assessment of changes over time and highlight areas where further in-depth research might be required. An evaluation of existing treatment/control policies should be feasible and if required the creation of new intervention ones.

In Dublin, some components of a monitoring system exist, for example, the treatment and rehabilitation services return data to the Department of Health although as far as is ascertainable only the Jervis Street Drug Centre does so on a regular basis. The prison services and the Gardai report to the Department of Justice. When the National Co-ordination Committee was set up senior representatives from the Departments of Health, Justice, Education, Foreign Affairs and the Environment 'were among the appointees to the committee with the specific brief of advising the government on an ongoing basis of general issues regarding the prevention and treatment of drug misuse. This necessitates at a minimum a set of descriptive statistics regarding relevant aspects of the drug situation. As far as this is known this committee has not got these basic data.

The Medico-Social Research Board has, since 1982, liaised with the Jervis Street Drug Centre, and jointly published considerable detail on the characteristics of the drug users attending the centre. The Board also has information from the surveys it has carried out in Dublin and, in addition, collects data on an informal basis from the Garda Drug Squad, from the Virus Reference Laboratory on hepatitis and from the principal rehabilitation centres.

## B. INDICATORS

### B.1 First treatment demand

In Dublin first treatment demand corresponds to first treatment received. This service seems likely to continue, in particular, as there is some evidence to suggest that the number seeking treatment for the first time has stabilised. Information presented for this indicator, Table 1, Appendix 1, refers to patients in receipt of treatment from the Jervis Street Drug Centre, the primary treatment centre in Dublin, providing medical and also certain types of social care. While this treatment is largely provided on an out-patient basis, a nine-bed unit is also available for those who require residential care. As only approximately 7% of the Jervis Street attenders live outside the greater Dublin area rates are given per 1,000 population for this area for persons aged 15 to 39. In 1979 the 1st contact rate was 0.3, this increased to 1.7 in 1982, maintained the same rate for 1983, and dropped to 1.4 in 1984. Patients attending the centre all receive an ICD 9 diagnosis. The most commonly occurring diagnosis accorded to patients for the years under review was for opiate misuse, namely ICD 9 304.0; i 304.7; and 305.5.

Information presented here does not include drug users receiving treatment for the first time while in prison, in a psychiatric hospital or from general practitioners. While the number treated in prisons or psychiatric hospitals prior to their first treatment contact with Jervis Street is generally regarded as small, the position concerning general practitioners is unclear. Middle class drug users may prefer to go to a general practitioner for treatment rather than avail of the free service in Jervis Street where the majority of attenders come from the lower socio-economic groups.

It was not possible to obtain information from general practitioners for their drug-user patients. At least four are known to be prescribing in a way that causes concern to the Department of Health. One general practitioner who set himself up as director of a drug treatment centre has recently been the subject of an enquiry under the Misuse of Drugs Act 1984. There is a known small overlap of patients attending both Jervis Street and certain Dublin general practitioners. In addition, some drug users undoubtedly receive their first treatment, usually methadone, from a general practitioner.

### B.2 Hospital admissions

Tables 2 and 3 provide details of admissions to psychiatric hospitals and discharges from general hospitals respectively, by sex, of Dublin city residents with a drug diagnosis. Both tables show ICD codes for primary and secondary diagnoses. Data are shown for the years 1981 to 1983 for psychiatric admissions and 1981 to 1984 for general hospital discharges. Both sets of data show a remarkable stability for the years under the review. The rate per 1,000 of the catchment population aged 15 to 39 for both sexes was a uniform .5 each year for general hospital discharges, while the rate was either change in the pattern of drug misuse seen from some of the other

indicators over a similar time period. It is important to note that the data refer to admissions and discharges and that the numbers involved are probably quite small. Other points of interest are the small number of secondary drug diagnoses for psychiatric admissions. As far as general hospital discharges are concerned while there were no secondary diagnoses for drug psychosis and drug dependence quite a "high proportion were recorded for the non-dependent category. The possible explanation is that those without a secondary diagnosis were primarily the Jervis Street patients from the nine-bed detoxification unit while the others were discharges from other general hospitals where they had been admitted with a primary diagnosis other than that of drug misuse. For both sets of data and for each year male rates were higher than female ones.

The only information for persons with drug problems presenting to accident and emergency departments of hospitals (see section A5.2) comes from a four week study carried out in 1982. Perhaps the most interesting finding from this study was that for the 80 persons identified only 1.5% were current attenders at the Jervis Street Drug Centre, 48.5% were not current attenders and 507, had never attended.

### B.3 Viral hepatitis

Results from H Bs Ag tests probably provide the best indicator of intravenous drug use. The virus reference laboratory in the Department of Medical Microbiology, University College Dublin, obtains specimens from drug users with hepatitis from all hospital admissions throughout the country from which a serological profile is derived. Information for Dublin city residents who were H Bs Ag positive is shown on Table 4 for 1979 to 1985 by month. The rate per 1,000 of the catchment population aged 15 to 39 rose from 0 in 1979 to .5 in 1981 and has since then dropped to .3 for 1982 to 1984 and 1985 was .2.

### B.4 Drug-related deaths

Accurate comprehensive information on drug-related deaths is difficult to obtain. The first approach made by the Dublin centre to access these data was to request the Central Statistics Office for a special computer print-out for deaths in the catchment area with specified ICD 9 codes associated with drug deaths, such as; suicide and self-inflicted poisoning by drugs or their pharmaceutical preparations, ICD E950; and viral hepatitis ICD 070.2 and 0.13. Ireland uses the international form of medical certification from which the underlying cause of death is coded to ICD 9. This ascertainment of drug-related deaths was discontinued as it was felt that some deaths recorded might relate to drugs other than the controlled or illicit ones and as the underlying cause of death was coded, it was possible to miss out on the fact that it was drug-related, for example, the case of death by asphyxia of a known heroin user. The second approach was to obtain an annual list of deaths of drug users known to Jervis Street Drug Centre and the Dublin Drug Squad. This list has the limitation of not including those deaths unknown to the named sources.

The number of drug deaths in Dublin established through the above procedure were: nine in 1982; 12 in 1983; 13 in 1984 and 12 in 1985.

### B.5 Police arrests

In Ireland statistical information from the police is available for persons charged and not for those arrested for drug offences. The number of persons charged (Figure 1) rose from less than 300 in the Dublin area to a peak of 1,389 in 1983 and declined to 1,105 in 1984. Table 5 shows the drug offences with which persons were charged for the selected years of 1977, 1982 and 1984, again for the Dublin area. For each of the three years more persons (approximately one third) were charged with cannabis resin-related offences than for any other offence. Whereas only one person was charged with a heroin offence in 1977, the number in 1982 was 199 and in 1984 329.

### B.6 Imprisonment

Up to the end of 1984 persons sentenced under the Misuse of Drugs Act 1977 were given a maximum sentence from the lower courts of 12 months, which with remission usually involved an eight and a half month stay in prison. Under this Act few persons were sentenced directly for drug misuse, but rather for drug possession. Many persons, however, imprisoned for larceny or breaking and entering, are found to be drug users while in prison. A survey of persons in the three Dublin committal prisons (see section A6.6) identified as drug “addicts” by the prison medical services increased from 41 in 1981 to 69 in 1982. The estimate for 1983 was 108. A more up-to-date estimate is not available.

One of the most significant changes brought about by the Misuse of Drugs Act 1984 which amended and extended the principal Act of 1977 was the amendment of section 28. The former mandatory obligation of the court to obtain a medical and a social report for the convicted person has been made optional in the 1984 Act. This has been seen as a possible shift in the focus of care for drug users from the community to prison. In many cases after mandatory reports were furnished the court was empowered to permit the person concerned to enter into a recognisance under certain conditions, for example, that he would receive medical care or attend specified clinics under supervision. Without these mandatory reports and the delay involved, the case may be dealt with straight away and the person committed to prison. In 1985 there has been a drop of about 50% in the number of mandatory orders requested. These recent changes in legislation make it more difficult to compile accurate data on drug users in prison.

### B.7 Seizures of illicit drugs

A combined figure for the number of seizures in Ireland by both the Gardai and the customs officials is presented in Table 6. In 1984, 30 of the 1704 seizures were made by customs officials. This figure may understate the part played by the customs officials as many of the seizures are made jointly with the Gardai and sometimes a customs official will allow a suspect to pass through, for example, the airport to be later arrested by the Gardai.

The customs officials seize drugs of importation mainly at airports, docks and harbours. They pass on information of their seizures to the Department of Justice on a quarterly basis, who in turn give the data to the Gardai. Information on the number of seizures made and particulars of the drugs seized is published annually in the Garda report on crime. Most of the drugs seized in Ireland are for sale and distribution within the country, principally in Dublin. Drugs seized are analysed and tested for purity in the forensic laboratory in the Department of Justice.

Table 6 gives particulars of drugs seized by the Gardai and customs officials during the years 1979 and 1981 to 1984. It can be seen that the number of seizures peaked in 1983 at 2,278 but dropped back to 1,704 in 1984.

The most significant trend is that for heroin which increased at a startling rate until 1982. A smaller rate of increase between 1982 and 1983 (9%) was followed by the first sign of decrease (62%) in 1984.

Seizures of cannabis and cannabis plants were highest in 1979, and of cannabis resin in 1981. Since then, these seizures have levelled off, and had dropped considerably by 1984.

Seizures of cocaine, amphetamines and LSD rose until 1982 and decreased in subsequent years. Similarly, seizures of barbiturates and synthetic opiates peaked in 1981 and then decreased.

#### B.8 Price/purity of illicit drugs

Some information is available on the current (March 1986) price and purity of certain illicit ie unlicensed or controlled, drugs in Dublin. The price given is in Irish pounds and is that pertaining at 'street level' (Table 7).

#### B.9 Survey data

Findings from drug surveys or studies carried out in the Dublin area, described in some detail in section A4 of this report, provide some useful indications of drug misuse and the characteristics of the users. School survey data and information from the Jervis Street Drug Centre all point to an acceleration of drug misuse in the 1980s, peaking in 1982/83 with some evidence of stabilisation since then.

Apart from the school survey data where cannabis emerged as the principal drug of misuse, all recent sources show heroin, administered intravenously, as the preferred drug for the majority of drug users -although it should be noted that most are polydrug users. The demographic and social characteristics of the drug users are very similar. The majority are male, single, from a depressed socio-economic background, with low educational achievement and a poor employment record. Many come from problem family homes and have been in trouble with the law often before their involvement with drugs. Apart from the school surveys many of the recent studies have been seen as investigating populations or areas that are not representative of Dublin as a whole. This is true in part. It has already been noted that the attenders at the Jervis Street Drug Centre come predominantly from the lower socio-economic classes and the startling finding of 10% of young people misusing heroin related to a deprived inner-city area. In Dun Laoghaire, where a similar investigation took place, by comparison only 2.2% of young people were found to be heroin users. This may have something to do with Dun Laoghaire being a more representative area of Dublin, but on the other hand, the heroin users in that study had the same characteristic of those found in the inner city area. Perhaps in Dublin, drug users come predominantly from the lower social classes or else studies carried out so far have not been successful in obtaining information from middle class users.

B.10 Comments on AIDS

In 1984 a detailed AIDS monitoring system was established by the Department of Health, identical with that used by WHO and the EEC. Antibody positive testing for AIDS started in the virus reference laboratory of University College Dublin in September 1985. Up to November of the same year results from 240 intravenous drug users tested showed that 30% were positive.

## C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

### C.1 Use of indicators in the city

Information for nine indicators of drug misuse has been presented and commented on. The indicators which have been shown to provide the most complete and reliable information on drug activity in Dublin are:

- first treatment demand
- viral hepatitis
- police arrests
- seizures and
- survey data.

#### First treatment demand

In the Dublin context first treatment demand refers to first treatment received. Data for this indicator comes entirely from the Jervis Street Drug Centre, the primary treatment centre in Dublin. The advantages of this information are that it has been regularly available from 1979 onwards and is the only reliable ongoing source which provides detail on trends and of the drug users' characteristics. One of the disadvantages of using this source as the sole indicator of first treatment contact is that it provides an incomplete picture, largely portraying the pattern of drug misuse among the lower socio-economic groups. Additional information is required, in particular, from general practitioners, and also from accident and emergency services, and from prisons on their first treatment contacts. If the data gathering system could be expanded to produce more complete and hence more valid information on first treatment contact then care would have to be taken to avoid double counting.

#### Viral hepatitis

Results from H Bs Ag tests are available for Dublin city drug users from 1979 to 1985 which can be seen as giving a useful indication of drug misuse in the city among intravenous drug users. Available evidence suggests that the majority of drug users in Dublin are mainly heroin users, but this pattern of drug misuse may change over time.

#### Police arrests

In Ireland statistics are available for persons charged by the police and not for those arrested. Regular sets of data can be obtained on request to the Garda Drug Squad for persons charged in Dublin by type of drug offence. The limitation of this indicator is that it is likely to measure certain types of drug misuse, for example, heroin, and perhaps also refer to offenders from the lower socio-economic classes. Middle class persons misusing cocaine are unlikely to be detected, let alone charged for this offence.



## Seizures

Data presented in this report on seizures by the Gardai and customs officials refer to the country as a whole. However, as most drugs entering the country are destined for the Dublin area and as drug activity is largely confined to Dublin information on seizure provides a crude barometer on the supply/demand situation and also on how successful the Gardai and customs officials are in making such seizures.

## Survey data

Considerable detail from school surveys and from small studies has been collected over the past years. These data are valuable in establishing the current extent of drug misuse in Dublin, predominantly among young people, and providing insights into their social and environmental backgrounds. However, future surveys or studies need to ensure that clear definitions, rigorous methodologies (preferably those already tested in international studies) and representative areas of investigation are adopted to accumulate accurate and comparable data on all basic aspects of drug misuse.

## Other indicators

Hospital admissions, drug-related deaths, Imprisonment and price/purity of illicit drugs did not seem to be as useful indicators of drug activity as those just commented on. Some of the reasons for this were: insufficient available data for imprisonment, and price/ purity of illicit drugs; small numbers, as in the case of drug-related deaths, as well as concern that the procedure did not cover all such deaths; and lack of representation, as with hospital admissions, where this treatment form is seldom used.

### C.2 Relationship between indicators

Figure 2 presents information for selected indicators, hepatitis Bs Ag, seizures, first treatment contact and persons charged between 1980 and 1984 – including 1985 for hepatitis – using 1980 as the base. Here a relationship can be seen between these indicators, with three showing a peak in 1983, the fourth, or hepatitis indicator datum, having peaked earlier in 1981. All four indicators depict a decline in their respective drug activities between 1983 and 1984, and for 1983 to 1985 for H Bs Ag positive cases. Further ongoing statistics for these indicators are necessary to determine whether or not this trend and relationship is a stable one.

Estimates of an overlap of drug users identified in community studies who had received treatment from the Jervis Street Drug Centre; been in prison; and arrested (not charged) by the police are available. These crude data point to a relationship between most of the selected indicators of drug misuse in Dublin and show the value of obtaining more precise and integrated sets of data. A case register approach would be an ideal research tool to follow a cohort of drug users through the various forms of treatment/control services.

#### D. CONCLUSIONS

Information presented in this report confirms that it is feasible to carry out an epidemiological study of drug misuse in Dublin using selected indicators. As might be expected certain indicators have a greater utility and relevance than others in establishing an accurate picture of drug activity and measuring changes over time. Figure 2 reveals a correlation between four of the selected indicators, hepatitis, seizures, first treatment contact and persons charged by the police showing a decline for drug activities, which these indicators represent, from a former peak in 1983. This position confirms the general belief among professionals that drug misuse has stabilised. However, it is too soon to be complacent as an unpublished finding from the Medico-Social Research Board reveals that in 1984, 20% of opiate users and 26% of other drug users had been seven or more years on drugs prior to contact with the Jervis Street Drug Centre. This finding also highlights the importance of collecting information on untreated cases of drug misuse in the community.

Certain limitations have been noted in the material available for this report principally:

- incomplete information for some indicators, for example imprisonment and,
- under-representation of middle class drug users which could be corrected through, for example, the availability of data from general practitioners.

These limitations and the general efficiency of collecting and collating drug data could be enhanced by the formal establishment of a data gathering procedure, the forerunner of a monitoring system already discussed. The National Co-ordination Committee for Drug Misuse, set up by the government, would seem to be in an ideal position to take on board this objective.

APPENDIX I

DATA

TABLE 1

*JERVIS STREET DRUG STUDY 1979-1985. ALL PATIENTS INCLUDING OPIATE USERS\*. FIRST AND RE-CONTACT. NUMBERS AND RATES PER 1,000 POPULATION AGED 15-39. \*\**

	1979	1980	1981	1982	1983	1984	1985
<i>Ist contact:</i>	114	250	410	633	650	506	387
<i>All Patients</i>							
<i>Opiate Abusers</i>	56	168	310	455	451	321	116
<i>Re-contacts</i>							
<i>All Patients</i>	180	179	233	371	664	712	753
<i>Opiate Abusers</i>	126	133	187	306	577	626	682
<i>All Contacts</i>	294	429	643	1004	1374	1218	1146
<i>N</i>							
<i>Rates</i>							
<i>Ist contacts</i>	0.3	0.7	1.1	1.7	1.7	7.4	-
<i>All contacts</i>	0.8	1.2	1.7	2.7	3.5	3.3	3.7
* (ICD Codes 304.0, 304.7, 305.5)							

\*\* Approximately 7% of the Jervis Street attenders live outside the greater Dublin area.

TABLE 2.  
 ADMISSIONS TO PSYCHIATRIC HOSPITALS OF DUBLIN CITY RESIDENTS WITH A DRUG DIAGNOSIS. SEX, 1981-1983.  
 NUMBERS AND RATES PER 1,000 POPULATION AGED 15 TO 39

SEX ICD	1981			1982			1983		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
292 Prim.	7	1	8	2	4	6	6	7	9
Sec.	0	0	0	0	0	0	0	0	2
Sub-total	7	1	8	2	4	6	6	7	11
304 Prim.	53	23	76	43	20	63	43	29	72
Sec.	1	4	5	1	0	1	1	2	10
Sub-total	54	27	81	44	20	64	43	31	82
305. 2-9 Prim.	4	1	5	4	2	6	13	5	18
Sec.	2	0	2	0	0	0	0	5	5
Sub-total	6	1	7	4	2	6	13	10	23
Gen. Total	67	29	96	50	26	76	72	44	116
Rates	0.4	0.2	0.3	0.3	0.1	0.2	0.4	0.2	0.3

292 = Drug Psychosis  
 304 = Drug Dependence  
 305. 2-9 = Non-dependent Abuse

TABLE 3  
DISCHARGES FROM GENERAL HOSPITALS OF DUBLIN CITY RESIDENTS WITH A DRUG DIAGNOSIS. SEX, 1981-1984.  
NUMBERS AND RATES PER 1,000 POPULATION AGED 15 TO 39

Sex ICD	1981		1982		1983		1984 <sup>1</sup>		Total
	Male	Female	Male	Female	Male	Female	Male	Female	
292 Prim	0	1	2	1	1	0	1	2	3
Sec.	0	0	0	0	0	0	0	0	0
Sub-total	0	1	2	1	1	0	1	2	3
304 Prim	114	36	103	52	127	53	100	57	157
Sec.	0	0	0	0	0	0	0	0	0
Sub-total	114	36	103	52	127	53	100	57	157
305. 2-9 Prim	5	1	4	4	4	5	2	4	6
Sec.	5	7	10	4	4	2	11	3	14
Sub-total	10	8	14	8	8	7	13	7	20
Gen. Total	124	45	119	61	136	60	114	66	180
Rates	0.7	0.2	0.7	0.3	0.8	0.3	0.6	0.3	0.5

292 = Drug Psychosis

304 = Drug Dependence

305. 2-9 = Non-dependent Abuse

TABLE 4

HBS Aq POSITIVES AMONG DUBLIN DRUG ADDICTS 1979-1985  
NUMBERS AND RATES PER 1,000 POPULATION AGED' 15 TO 39

	1979	1980	1981	1982	1983	1984	1985
JAN.	0	2	21	17	15	18	7
FEB.	0	0	12	8	12	14	4
MAR.	0	0	24	10	12	10	9
APR.	0	5	13	9	5	11	4
MAY	0	2	21	12	13	8	9
JUN.	1	1	10	10	9	6	5
JUL.	0	2	19	7	6	10	5
AUG.	1	4	8	14	10	3	11
SEPT.	1	0	11	11	12	6	4
OCT	2	3	7	11	14	3	17
NOV.	0	8	12	9	12	8	5
DEC.	2	8	10	5	5	1	11
TOTAL	7	35	168	123	125	98	91
RATES	0.0	0.1	0.5	0.3	0.3	0.3	0.2

Mean Age 21.7 years (range 14-34 years); male/female ratio: 4.4:1

Mean duration of IV drug abuse = 3 years.

Source: Personal communication. Dr. A.G. Shattock, Virus Reference Laboratory, University College, Dublin.

TABLE 5

*DRUG OFFENCES – PERSONS CHARGED IN THE DUBLIN METROPOLITAN AREA BY TYPE OF DRUG 1977, 1982 AND 1984. NUMBERS.*

---

	<u>1977</u>	<u>1982</u>	<u>1984</u>
<i>Cannabis Resin</i>	89	443	379
<i>Cannabis</i>	34	170	152
<i>Heroin</i>	1	199	329
<i>Morphine</i>	9	8	3
<i>Opium</i>	1	2	1
<i>Barbiturates</i>	36	6	7
<i>Synthetic Narcotics</i>	71	60	21
<i>Cocaine</i>	2	28	23
<i>LSD</i>	3	20	15
<i>Psilocin</i>	0	4	8
<i>Amphetamines</i>	7	18	5
<i>Other offences under The Misuse of Drugs Act 1977</i>			
<i>Forged Prescriptions</i>	-	4	98
<i>Importation of Drugs</i>	-	16	17
<i>Cultivation of Cannabis Plants</i>	-	24	18
<i>Cultivation of Opium Plants</i>	-	-	1
<i>Allow premises to be used for Drug Abuse</i>	-	23	28
<i>Total</i>	253	1,025	1,105

\* Source: *Personal Communication Garda Drug Squad*

TABLE 6

*PARTICULARS OF DRUGS SEIZED IN IRELAND BY THE GARDAI AND CUSTOMS OFFICIALS COMBINED 1979.1961 to 1984*

Type of Drug	1979	QUANTITY SEIZED		2583 2984	
		1981	1982		
<i>Cannabis</i>	422.475 kg	44.38 kg	48.472 kg	44.56 kg	2.65 kg
<i>Cannabis Resin</i>	17.7 kg	1646.53 kg	172.668 kg	485.86 kg	12.52 kg
<i>Cannabis Plants</i>	2209	1186	1356	1865	840
<i>Hash Oil</i>	4.7g	129.33g	25.39g	0.369	1.086g
<i>Opium Plants</i>	-	5	-	-	80
<i>Cocaine</i>	29g	82.39g	409.07g	97.37g	80.17g
<i>Heroin</i>	5g	170.134g	1264.35g	1379.04g	525.14g
<i>Opium</i>	52g 30t	.001g	73.47g	-	120g
<i>Morphine</i>	409 80t 100amp. 260ml	15.18g 320t 222amp. 3500ml	1526.72g 145amp 17t	3.58g	124t
<i>Psilocin</i>	-	568.82g	821.42g	139.2g	274g
<i>LSD</i>	211t	1604t	2445t	415t	579t
<i>Barbiturates</i>	14199t	92651 54g	8259t	100t	1047t
<i>Amphetamines</i>	2g 135t	331t 104g	122.59g 500t	105.58g	1.36g
<i>Sythetic Opiates</i>	1632t 146 amp.	30 amp. 5389t	1808t	821t	850ml
<i>Number of Seizures</i>	N/A	1204	1873	2278	1704
Amp =Ampoule; t = tablet; g = gramme; kg = kilogramme; ml = millilitre					
Source: Adapted from the Garda Siochana Reports on Crime 1979, 1981 to 1984.					



TABLE 7

ILLICIT DRUGS. STREET PRICE\* AND PURITY\*\*. DUBLIN. MARCH 1986

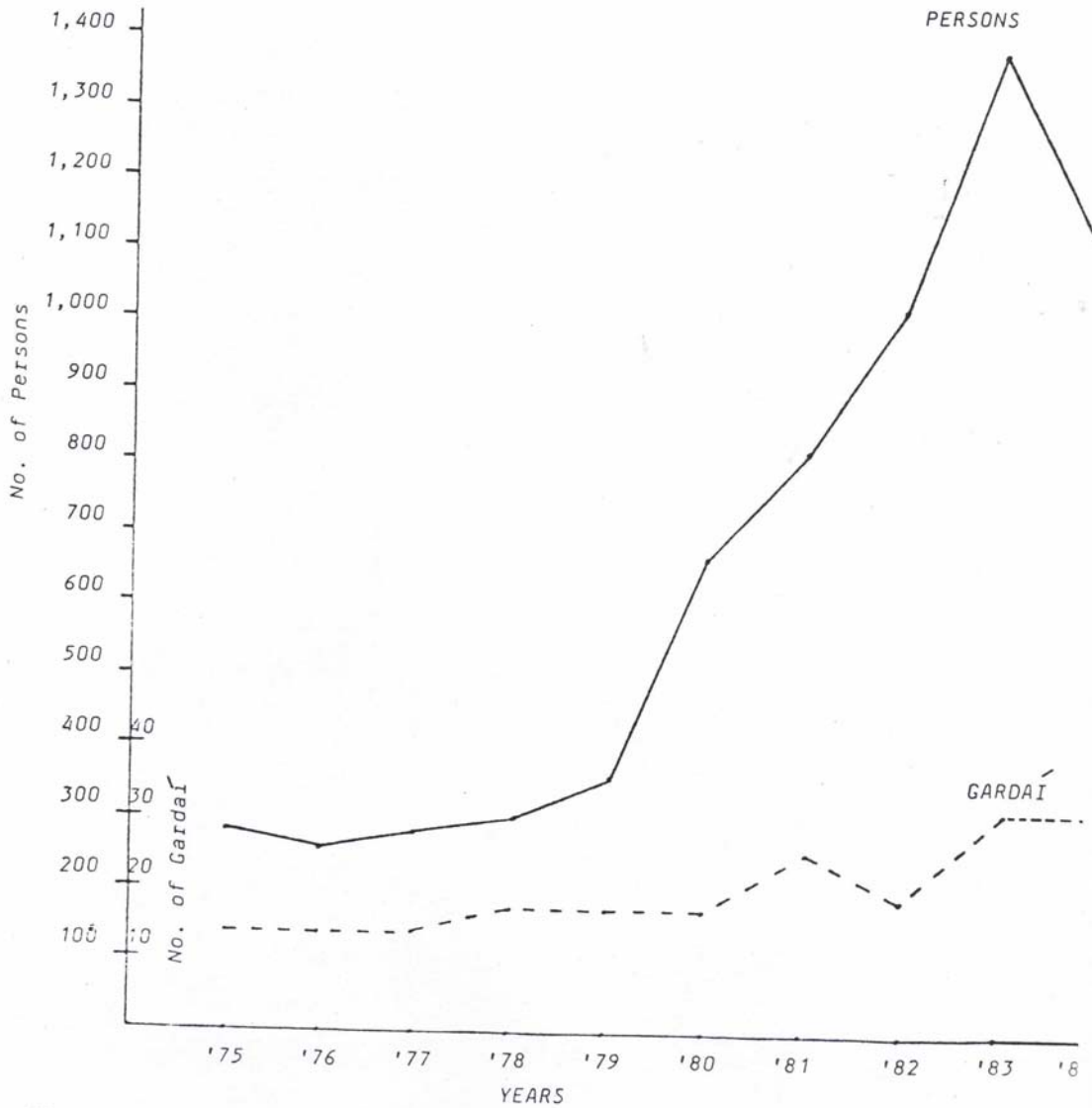
	<u>PRICE RANGE*</u>	<u>PURITY**</u>
HEROIN	IR £200-300 per gramme	Varies between 3-70% Average 22% pure
COCAINE	IR £200-260 per gramme	40-50% pure
CANNABIS	IR £80-100 per ounce	As pure as made by producer
AMPHETAMINES	IR £100-150 per gramme	80% pure

SOURCE: Personal Communication \*Garda Drug Squad and

\*\*Forensic Science Laboratory,  
Department of Justice.

FIGURE 1

NUMBER OF PERSONS CHARGED WITH DRUG OFFENCES IN THE DUBLIN METROPOLITAN AREA AND NUMBER OF GARDAI IN DRUG SQUAD 1975 TO 1984.



SOURCE: Personal Communication Garda Drug Squad

FIGURE 2: Trends in Hepatitis Bs Ag., Seizures, First Treatment Contact and Persons Charged. 1980-1985. Index : 1980 = 100

