ILLICIT DRUG USE IN IRELAND: AN OVERVIEW OF THE PROBLEM AND POLICY RESPONSES

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Problematic drug use, mainly regarding the use of opiates, has been identified as a major social problem in Ireland. Such problematic drug use has been found to be concentrated in Dublin's inner city areas and outer estates where poverty, multi-generational unemployment, high population density (particularly of young adults), and poor facilities are the norm. Policy responses, although acknowledging the environmental context of the drug problem, have tended to focus on the medical treatment of the individual, rather than tackling the wider social and economic issues.

Introduction

To date, few research studies on the patterns and prevalence of illicit drug use have been conducted in Ireland. Evidence identifies three main illicit drug-using groups; those whose main drug of use are either opiates (often mixed with benzodiazepines). Ecstasy, or cannabis. It is with the former group that most concern arises, for as noted in the recent governmental report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs:

> Ireland's drug problem is primarily an opiates problem - mainly heroin…[and] is principally a Dublin phenomenon (Department of the Taoiseach 1996:5).

Given the social problem that such opiate use entails for the individual, their families, local neighborhoods, and the wider society, this paper focuses on the development of such problematic drug use and the responses by policy makers and local communities. The paper draws on existing research as well as initial trends from a study on the environmental context of problematic drug use.[1]

The Development of an Opiate Drug Culture

In the 1960s and 1970s, research on the use of illicit drugs in Ireland found evidence of amphetamine (Walsh 1966), cannabis, and LSD use (Masterson 1970; Nevin et al 1971). However, neither these research studies nor indicators of drug use (i.e. seizures, prosecutions, and treatment) demonstrated a sufficiently widespread extent of use to warrant much concern.

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In 1979 a growing trend in the use of opiates was brought to public attention by health and welfare workers in Dublin. This trend was reflected in the increased number of heroin seizures, in prosecutions for possession and trafficking of heroin (Garda Siochana 1983), and in the numbers seeking and receiving treatment for opiate-related problems.

At the city's drug treatment center the number of clients receiving treatment increased by 200% in 1 year (table 1). Over the 5-year period 1979 to 1983 there was a staggering increase in client contacts from 182 to 1,028.

Table 1
Opiate-using Clients at the National Drug Treatment and Advisory Centre

	First Contact Clients	Recontact Clients	All Contacts
1979	56	126	182
1980	168	133	301
1981	310	187	497
1982	455	306	761
1983	451	577	1028
1984	321	626	947
1985	116	726	842

Source: Dean et al. 1985; Dean et al. 1987.

Interestingly, the epidemiology of this trend showed that the opiate users were not randomly distributed across the city's population, but disproportionately concentrated in Dublin's inner city areas where high unemployment, poverty, and deprivation were the norm (Dean et al 1983; O'Kelly et al. 1988). This scenario was similar to that found by Pearson et al. (1987) and Parker et al. (1988) in their research studies conducted in England at the same time.

Community studies conducted in these Dublin areas found up to 10% of the 15-24 year age group using heroin (Bradshaw 1985), with an even higher proportion (14%) of men in this age group using (O'Kelly et al, 1988). A study on an even smaller geographical scale, an inner city flat complex, found still higher proportions (30%) of opiate use among 15 to 19 year old males (Cullen 1990). In all the studies, heroin, diconal, and palfium were found to be the main drugs of use and intravenous drug use the predominant mode of administration (almost 100%). This trend for injecting heroin, which would have severs repercussions later, marked a significant difference from the heroin epidemic in England, as described by Pearson et al. (1987) and Parker et al. (1988), where the trend was for smoking the heroin (i.e., chasing the dragon).

Response to the Initial Crisis

In the early 1980s both the Eastern Health Board (the health services provider for the Dublin area) and the Government had established a number of committees to report on the drug problem. However, most of the subsequent action focused on legislative changes to reduce the supply of drugs. Little was implemented in the field of demand or harm reduction and treatment services remained predominantly

abstinence focused. Some years later, the Department of Health (1991:14) recognized the shortcomings of these responses which:

> tended to concentrate on supply reduction...they can only be effective if operated in tandem with comprehensive demand reduction policies.

In 1983, in the absence of an adequate response from the statutory bodies, residents of the inner city areas most affected by the opiate epidemic mobilized in a social movement called the Concerned Parents Against Drugs (CPAD). Initially, the activities of the CPAD focused on organizing vigils and patrols to halt visible drug dealing in their areas. Mass marches through the streets chanted 'pushers out' and community meetings were held to discuss responses to the problem. Drug pushers in the area were identified, confronted with their activities, and presented with the option of ceasing dealing or leaving the area. Those choosing to do neither were evicted from their homes.

Despite initial success in tackling the issue at a grass root level, the movement came into disrepute. Intimidation and attacks on user-dealers, the shooting of a CPAD activist, and police and media antagonism over the movement's alleged use of vigilante tactics and its connections with Sinn Fein and the IRA contributed to the movement's decline in the mid 1980s.

However, by this time the opiate epidemic in Dublin was seen to have reached a plateau. Dean et al. (1987) noted that several indicators of drug misuse, such as treatment figures, seizures, and prosecutions, showed a marked decline over previous years. They attributed this decline to a range of factors, including the introduction of more punitive legislation for drug-related offences, the success of the drug squad in dealing with major drug dealers, a greater public awareness about the dangers of drug misuse, as well as the success of the Concerned Parents movement.

The failure of the statutory authorities to respond to the crisis has been perceived by some critics as indicative of a policy of containment of the drug problem in the inner city areas. Others, such as Cullen (1990:284) suggested that the statutory authorities' perception of 'the dangers' of community type responses was reinforced by the CPAD's activities and influence in the inner city and contributed to their unwillingness to deal with community groups and the deficiency of statutory responses.

Ironically, Butler (1991:220) noted that an unpublished (but leaked) report by the Special Government Task Force on Drug Abuse (1983) had acknowledged that 'drug problems in Dublin were largely explicable in terms of the poverty and powerlessness of a small number of working class neighborhoods.' Consequently, this Task Force had proposed using a number of indicators (drug prevalence, high crime and unemployment rates, poor and overcrowded housing, low levels of educational attainment, lack of social and recreational amenities, etc.) to identify Community Priority Areas. These areas were to be targeted with additional financial resources to tackle disadvantage, for example for the establishment of youth and community projects. However, these proposals were omitted from the published press releases on the findings of the Task Force, which, in contrast, suggested that drug problems were randomly distributed in society and could be explained in terms of individual personalities and choices. Subsequently, for many years the drugs issue, by and large, disappeared from the agenda of public debate. Some years later a government minister recalled that:

> The nation woke up to the problem, briefly. And then it turned away, turned a blind eye to a nasty but contained problem. Yet the problem never went away (URRUS 1996)

HIV and AIDS: The Legacy of the Opiate Epidemic

Although Dean et al. (5987) had outlined indicators that suggested the opiate epidemic had reached a plateau by the mid-1980s, they had warned against complacency. Their study of problematic drug users had noted that 85% of clients had needle marks and, by 1985, 27% had tested HIV positive.

In Ireland intravenous drug use has been the main source of transmission of the HJV virus. Although the overall number of AIDS cases *(N=577)* is low compared to other European states,42.7% of cases are intravenous drug users (IDUs), one of the highest rates in Europe, only surpassed in France, Italy, and Spain. (European Centre for the Epidemiological Monitoring of AIDS 1995). Furthermore, using comparable data from the United Kingdom and Ireland, the proportion of IDUs among AIDS cases is found to be six times higher in Ireland than in the United Kingdom (table 2).

Table 2
Cumulative Cases of Intravenous Drug Users among AIDS Cases, March 1995

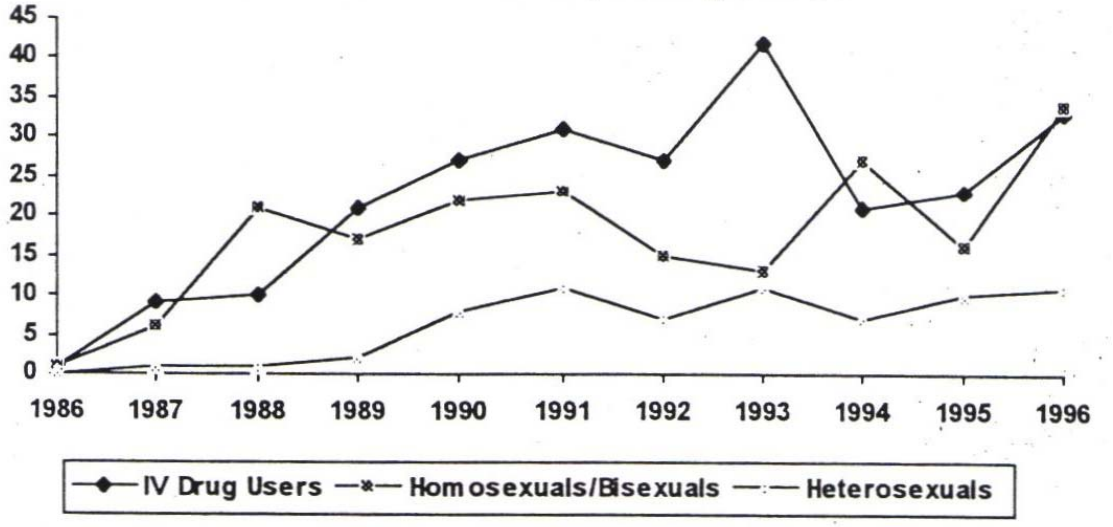
	N	Rate Per 100,00 Population
United Kingdom	614	1.0
Scotland	229	4.5
Ireland	209	6.0

Sources: United Kingdom Public Health Laboratory Service; Scottish Centre for Infection and Environmental Health, Department of Health (Ireland).

This high proportion of IDUs among AIDS cases in Ireland may be explained by two social phenomena in the 1980s. First, the culture of intravenous drug use grew at a time when both information on injecting hygiene and access to needle supplies were limited. Second, there was a tendency among young homosexual men to emigrate from Ireland to cities such as London, where attitudes toward homosexuality were more liberal.

The persistence of high rates of HIV and AIDS (and increasing rates of hepatitis C) among IDUs (fig. 1), as well as initial trends from the ongoing research, show little evidence that there has been a reduction in risk behaviors with regard to safer injecting and safer sexual practices among the drug-using community. Consequently, there is little expectation that these rates will fall substantially. Indeed, a prediction study of the number of AIDS cases in Ireland in the year 2001 calculated that there would be 1,850 cases overall, 59% of which would be IDUs (Kelly 1984).

Figure 1
Number of AIDS Cases, Ireland, 1986-96



Source: Department of Health

Furthermore, as a result of the interrelationship between intravenous drug use and AIDS in Ireland, the epidemiology of HIV and AIDS reveals a clustering of cases that closely resemble the spatial distribution of heroin users. Neighborhoods in the inner city that traditionally have been sites of poverty and disadvantage, and more recently of drug-related harm, have now, in addition, been identified 'as having particular problems in terms of HIV/AIDS transmissions' (Department of Health 1991:8).

The Development of Drug Policy

Official concern regarding the transmission of the HIV virus has greatly affected the development of drug policy and the provision of drug services in Ireland, as it had elsewhere- The first 20 years of Irish drug policy was noted by Butler (1991) as being one of remarkable consensus on the validity of a total abstinence strategy. However, the cognizance of the association between injecting drug use and the HIV virus required a major shift in policy focus. This new policy paradigm was described in the seminal *Government Strategy to Prevent Drug Misuse* (Department of Health 1991:17) as follows:

> the prevention of transmission of the HIV virus in this country must include strategies developed to deal with the drug misuse problem. These strategies must be community-based, client-orientated and, given the serious nature of the problem, of necessity, innovative. They must include emphasis on outreach programmes involving counselling, methadone maintenance and needle exchange. Advice on risk reduction services generally must form an essential part of any such strategies to minimise the spread of the disease.

The strategy called for the Health Boards to coordinate their AIDS and drug misuse programs. Statutory and voluntary agencies working in the drug related field

(such as education, training, and criminal justice) were to coordinate their activities in the form of Community Drug Teams (CDTs). However, despite the comprehensive range of proposals for tackling drug problems and the location of the problem in 'specific areas of Dublin with poor housing and high levels of unemployment' (Department of Health 1991:8), the follow through was comparatively limited. For example, only two CDTs were established, of which only one survives to the present day.

Butler (1991, 1996) suggests that because the rationale for the shift in policy focus was primarily due to fears of HIV transmission from IDUs into the general population, rather than a result of a radical ideological shift, not only did changes in service provision occur slowly, but they were marked by conflict and ambivalence in service delivery.

Illicit Drug Use in the 1990S

In the early 1990s an Ecstasy/rave culture developed on the Dublin youth scene. Initially this fashion was centered around a few large dance venues in the city center, but the trend has since spread to other urban centers. Evidence indicates that the use of Ecstasy and cannabis has become increasingly normalized among young people, transcending class and urban/rural divides.

By the mid-1990s, a second opiate epidemic was seen to have developed in Dublin with the identification of a new generation of young heroin users. This trend is reflected in the numbers of those receiving treatment for drug problems[2] (table 3).

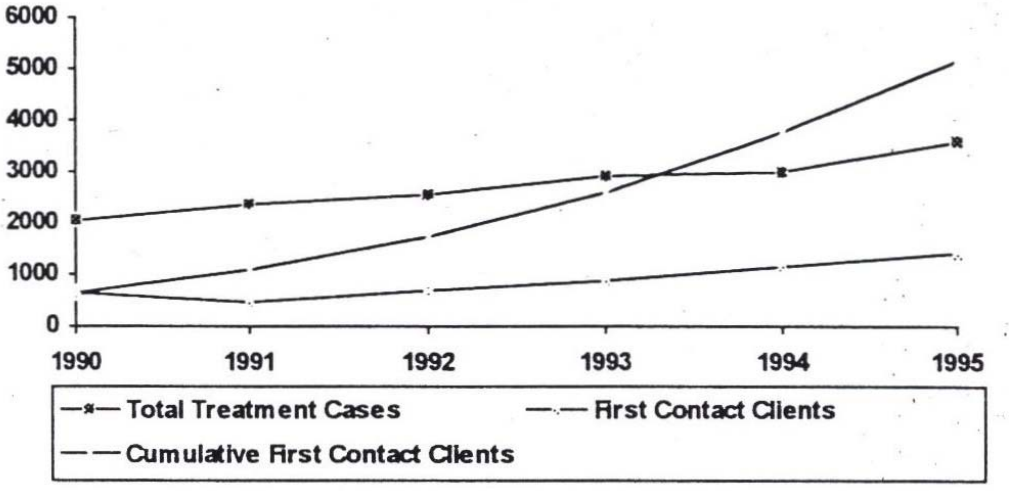
Table 3
Treated Drug Misuse in Dublin

Year	N Total Treatment[a]	N First Contact Clients
1990	2,037	624
1991	2,359	4,50
1992	2,555	6,68
1993	2,919	8,59
1994	2,978	1,150
1995	3,593	1,396

Sources: O'Higgins 1996; O'Higgins and Duff 1997.
[a]Total treatment figures refer to the number of cases in treatment and not to the number of people. An individual may receive treatment more than once in a year.

However, these figures fall short of the estimated 7,000 opiate users in the city (500 per 100,000 population) and a more revealing increase may be seen in the cumulative number of first contact clients in treatment (fig. 2).

Figure 2
Treated Drug Misuse, Dublin 1990-95



Sources: O'Higgins 1996; O'Higgins and Duff 1997.

In a recent review of the Treated Drug Misuse data, O'Higgins (1996) noted that the rate of those receiving treatment for the first time was found to have doubled (from 1.5 to 3.0 per 100,000) in the 4-year period from 1990 to 1994. Three quarters of the clients used an opiate (mainly heroin) as their primary drug. Seven out of ten had first used their primary drug as a teenager and two-thirds were daily users by the time they came into -treatment. More than half of these first contact clients were teenagers and a similar proportion had left school at 15 years and under. Three-quarters of the clients were living with their family of origin and 8 of 10 were unemployed:

More than half of those coming into treatment had ever injected and 7 in 10 of these were currently injecting. The proportions of those who had ever shared needles and syringes had fallen over the 4-year period from 70% to just under 40%, whereas onlyi0% admitted to currently sharing. However, in view of the difficulty in defining sharing as noted by Koester (1996) and others, the validity of these rates cannot be assured.

In addition, the profile of the typical drug user in treatment—male, single, and from a depressed socioeconomic area with low educational achievement and a poor employment record—was seen to have remained unchanged since the first report on treated drug misuse. By O'Hare (1992).

This second heroin epidemic has attracted a great deal of political and public attention. One facet of this attention has been on the alleged connection between Ecstasy and opiate use following a number of young opiate users coming into treatment having first smoked heroin to come down from Ecstasy. However, what has since become apparent is that those Ecstasy users who moved on to opiate use are, in the main, young adults from the marginalized inner city and suburban public housing estates where heroin is readily available and at an all time low price. A bag of heroin, the street retail unit, has quartered in price since the beginning of the decade from IR£40 (US$27) to £IR10 (US$7). Unlike the first generation of opiate users, the initial trend among the young users has been for heroin smoking. However, the life-cycle of their heroin smoking careers has been noted by many field workers to be around 18 months, at which point

injecting the drug becomes a more viable financial option with a lesser amount, leastwise initially, required for intravenous use.

The cost of a such a heroin habit tends to range from IR£80 (US$53) to IR£150 (US$100) a day. Evidence from the current research study shows many users turning to drug dealing and other criminal activities to finance their habit. Over the past few years this drug-crime nexus has been one of the main subjects of public debate—a popularly quoted estimate (not substantiated) is that 75% of crime is drug related. In addition, a number of drug-related murders, including that of the crime reporter Veronica Guerin in 1996, have intensified public concern and fueled media speculations on the impact of illicit drug use on Irish society,

Response to the Current Crisis

Since 1996 a further shift in drug policy has been noted, one that appears to be rooted in appeasing public concern over drugs and crime. In a recent review of drug services, Farrell and Buning (1996:7), described this policy shift as a move from a HIV generated response to:

> a broader concern about all aspects of drug misuse with a particular concern about the links between drug misuse and crime, and community safety and community well being.

Central to this policy shift is the belief that the rate of drug-related crime may be lowered by bringing problematic drug users into treatment. Consequently, government policy (and funding) is for service provision to be expanded to the extent that by 1997 the waiting list for treatment will have been eliminated (Department of Health 1996; Eastern Health Board 1997). However, the emphasis on medicalized services, mainly methadone maintenance or detoxification programs, has been criticized for not tackling the environmental context of the drug problem.

On the street, local community groups have taken the initiative in developing programs for heroin users, often on shoestring budgets, relying heavily on voluntary workers and with lime statutory support. The anti-drug movement has been revived in areas with visible drug scenes. They have achieved success in dissipating open dealing, and, in conjunction with the Dublin Corporation (the statutory housing body), in the eviction of drug-dealing tenants from their areas. Although, again, their activities have been subject to accusations of vigilantism due to a number of assaults (resulting on one death) on alleged drug dealers.

The most recently published policy document (the report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs) provides scope for optimism with the official recognition that the drug problem has been:

> concentrated m communities that are also characterised by large-scale social and economic deprivation and marginalisation. The physical/environmental conditions in these neighbourhoods are poor, as are the social and recreational infrastructures. Abuse and addiction are associated with crime-There are problems of related disease, AIDS and Hepatitis. Life in these estates for many has become ‘nasty, brutish and short’ (Department of the Taoiseach 1996:).

Consequently, the report proposes creation of multi-agency local drug task forces to develop and coordinate strategies in designated areas of disadvantage, in a previous partnership approach similar to that of the Drug Action Teams in the United Kingdom. However, coordination at the local level needs to be complemented with a partnership at the policy level.

As MacGregor (1996:20) suggests:

> There is a need to link drugs policy to policies on housing, income maintenance, employment, education. To deal with poverty, unemployment and other forms of social deprivation and inequalities...to impact on institutions like the family and neighbourhood and on social control processes, rather than aiming primarily to bring about behaviour modification in particular individuals.

Indeed, the 1996 Ministerial Task Force report noted that the lack of an integrated response from government departments had been a key difficulty in tackling the multidimensional drugs problem.

Conclusion

Evidence in Ireland has found that problematic drug users are disproportionately concentrated in Dublin city areas marked by poverty, multi-generational unemployment, high crime rates, high population density (particularly of young adults), local authority housing (often of poor quality) with a high turnover of tenancies; and poor social and recreational facilities. However, policy responses have been slow to acknowledge the environmental context of the problem.

Recent policy recommendations have taken a more "holistic approach to tackling the problem and there is room for optimism that the coordination of relevant policies and services may avoid the outcome cautioned by Stimson (1995:18);

> while drug policies might try to minimise harm, the contexts of drug use in urban settings may contribute toward maximising harm for the individual drug users and the community.

Notes

1. In April 1996 [be author commenced funding a 2-year qualitative study designed to examine trends in illicit drug use and to assess the nature of the relationship between problematic drug use, unemployment and socioeconomic disadvantage. The study is funded by the Health Research Board. Ireland. The views expressed in this paper are those of the author and do not necessarily reflect the views of the Health Research Board.

2. Since 1990 a drug misuse reporting system has been in operation, compiling, on an annual basis, data on illicit drug users attending treatment. However, although the annual reports provide us with our most systematic source of data on drug misuse in Dublin, a number of caveats need 10 be made. First, not all treatment agencies submit data, so the figures underestimate those in treatment. Second, not all drug misusers attend treatment, so the figures underestimate the total prevalence of drug use.

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