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Secular Trends in Substance Use: The Conflict and Young People in Northern Ireland

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Published in The Journal of Social Issues, 2004, 60(3), 485-506.

The resolution of political conflict has led some to suggest that Northern Ireland will now face a range of social problems that have been ignored or suppressed by the Troubles. One such area is adolescent drug use. In this article, a review of a range of data sources shows that drug use, with few exceptions, has increased since the emergence of the ongoing peace process. Social and political changes and enhanced paramilitary involvement in the drugs trade appear to have somehow created an environment where drug use has flourished. In reviewing current drug policy and practice, the article highlights the lack of prevention, treatment, and harm reduction services established in Northern Ireland as a cause for concern.

The arrival of the paramilitary cease-fires in 1994 and the ongoing, yet sometimes faltering, peace process has led to a major transformation of the political and social landscape of Northern Ireland (NI). Alongside the declared cessation of political violence by paramilitary organizations, there has been substantial decrease in military security operations. This has included a significant reduction in troop levels, the demolition or vacation of almost half of all military bases and installations, and a reduction of over 50% in routine military patrols (Northern Ireland Office, 1999, 2002). In addition to the scaling down of the military operation within NI, police numbers have declined also. The Independent Commission on Policing for Northern Ireland (1999) recommended a decrease in police numbers from around 11,500 to around 7,500, including the phasing out of the police reserve. In March 2002 the effective strength of the Police Service of Northern Ireland was 6,976 regular officers, supplemented by an additional 3,195 reservists (Police Service for Northern Ireland, 2002). It was noted in the 2000/2001 inspection of the then Royal Ulster Constabulary (the name was changed to Police Service for Northern Ireland in November 2001) that the loss of police offices was not evenly spread across NI, with Belfast seeing the largest percentage decrease in officers (Her Majesty's Inspectorate of Constabulary, 2001). The report noted, also, that the reductions in staffing, accompanied by high sickness levels among officers, "will invite operational and management difficulties when the security situation, action by paramilitaries, and historical marches, still impose a resourcing problem on the Force" (p. 1).

The signing of the Good Friday Agreement in 1998 paved the way for the establishment of the Northern Ireland Assembly and its Executive Committee of Ministers, and the devolution of power from the UK government to locally elected representatives. Drug policy was included within this transfer of executive authority. However, certain aspects of that policy such as policing and prisons are reserved matters still under the direct control of the UK government in Westminster. The transition from a culture embroiled in political conflict to a more normalized society is a slow, complex, and sometimes painful process (see Cox, Guelke, & Stephen, 2000). In addition to resolving the long-standing problems associated with the sectarian and divided nature of Northern Ireland culture, it has been suggested that a decrease in political violence may be accompanied by a growth in so-called "normal" patterns of crime that were masked or, indeed, suppressed by

the Troubles (e.g., Independent Commission on Policing for Northern Ireland, 1999). It is argued here that one such area is adolescent drug use.

Historically, Northern Ireland has been regarded as a low drug use, low crime country compared to its Northern European neighbors (Brewer, Lockhart, & Rodgers, 1997; Mayhew & van Dijk, 1997). It has been argued that the anti-drug stance adopted by some paramilitary groups, particularly the Provisional Irish Republican Army (IRA), and high levels of police and military surveillance, may have operated to somehow suppress drug misuse within Northern Ireland until around the time of the cease-fires (McEvoy, McElrath, & Higgins, 1998). In particular, the absence of an established heroin market until very recently has been viewed as one of the few dividends of the Troubles (Higgins & McElrath, 2000). A logical extension to this suppression hypothesis suggests that a lessening of both formal and informal social controls that existed during the Troubles may have resulted in an increase in the distribution, sale, and consumption of illicit drugs used in the post cease-fire period.

Drawing on a range of available data sources, this article attempts to examine secular trends and patterns in adolescent drug use within Northern Ireland against the backdrop of the Troubles and the ongoing peace process. Rather than suggesting that peace is something that was achieved with the first IRA cease-fire in 1994, it is viewed as a gradual and ongoing phenomenon. Drug use trends and patterns observed over the past decade are examined with reference to the possible influences exerted by the Troubles and subsequent peace. Comparisons are made, where feasible, between Northern Ireland and its neighboring jurisdictions within the UK and the European Union. Where possible data are presented specifically on youth, however, other key indicators of drug use trends that do not delineate age categories are included also, where deemed appropriate. The article concludes with a review of current drug policy and practice in Northern Ireland and examines the extent to which Northern Ireland is placed to respond to any changes in its drug use landscape.

Analysis of Patterns and Prevalence of Drug Usage

Self-Report Surveys of Adolescent Drug Use

The UK government's drug strategy "Tackling Drugs to Build a Better Britain" (Department of Health, 1995, 1998) and its derivative "Drug Strategy for Northern Ireland" (Department of Health, Social Services and Public Safety, 1999) place emphasis on an evidenced-based approach to drug policy. Despite the importance of such evidence, in common with many countries, there is a far from complete picture of the extent and patterning of drug use throughout Northern Ireland. One important component of that picture is provided by repeat cross-sectional self-report surveys of drug use among young people (see Carroll, 1995; Frischer, Hickman, Kraus, Mariani, & Weissing, 2001; Harrison & Hughes, 1997; Ramsay & Percy, 1997, for a discussion of the methodological strengths and weaknesses of the survey approach to assessing adolescent drug use).

One of the first drug prevalence surveys conducted in Northern Ireland was the 1992 International Self-Report Delinquency Survey (ISRDS) coordinated by the Dutch Ministry of Justice (Junger-Tas, Terlouw, & Klein, 1994). Of the 241 young people, aged between 14 and 15, interviewed in Belfast (the capital of Northern Ireland), 7% reported a drug offence of either selling or using drugs, as did 18% of the 277 young people aged between 16 and 17 (Table 1). The main conclusion that can be drawn from this study is that while Belfast may have had a relatively low level of adolescent drug use compared with England and Wales in the early 1990s, it may have had a relatively high level compared with other European countries. The levels of property and violent offences were more comparable with other countries. This study would suggest that even with the Troubles, drug use and drug dealing was more prevalent among young people than other European countries/cities in the Netherlands, Portugal, or Spain. One problem of undertaking cross-national comparisons such as the ISRDS, is the relative size of the various jurisdictions. For large countries such as England, national drug prevalence estimates may mask considerable

regional variations in drug use behaviors. Comparing the 1994 British Crime Survey and Northern Ireland Crime Survey Drug components highlights this issue. While drug use in Northern Ireland was lower than that for England as a whole (18% compared with 23%), and considerably lower than that of regions such as London (32%), it was on a par with other regions such as the Midlands (16%; see Hauge, 2001; Ramsay & Percy, 1996). To an extent this supports the conclusion drawn from the ISRDS that while the level of social drug use within Northern Ireland during the early 1990s was somewhat lower than that experienced with the major urban conurbations of the UK, it was similar to that found in less urbanized areas.

Table 1. International Comparison of Drug Related Offending Behaviour (International Self-Report Delinquency Study, 1992)

	Drug Offences ¹		Property Crime ²		Violent Offences ³	
	14–15	16–17	14–15	16–17	14–15	16–17
Belfast (Northern Ireland)	6.6	18.1	21.2	26.7	29.9	24.5
England and Wales	7.7	26.6	14.8	16.4	17.5	20.0
Netherlands	3.9	15.3	27.3	34.3	36.6	36.4
Leige (Belgium)	3.4	7.0	37.4	26.1	39.1	31.8
Mannheim (Germany)	0.0	6.0	17.3	26.5	25.3	18.1
Switzerland	6.3	23.7	40.2	39.9	29.6	37.3
Portugal	4.9	11.2	22.7	22.4	36.7	27.4
Spain	4.8	13.1	21.9	23.2	42.4	40.9

Notes. ¹ Includes taking cannabis, taking other drugs, selling cannabis, and selling other drugs.

² Includes stealing from home, school-work, telephone booth, etc.; shoplifting; stealing car/bike/moped/motorbike; stealing from a car; pick-pocketing; snatch thefts; burglary; stealing other; selling stolen goods. Excludes graffiti, arson, and vandalism.

³ Includes carrying a weapon, threats for money, fighting/public disorder, beating up family, beating up non-family, hurting with weapons, graffiti, arson, and vandalism.

Sample sizes: Belfast $N = 518$; England and Wales, $N = 623$; Netherlands, $N = 440$; Leige, $N = 331$; Mannheim, $N = 158$; Switzerland, $N = 529$; Portugal, $N = 585$; Spain, $N = 1050$;

From Junger-Tas, J., Terlouw, J., & Klein, M. (Eds.). (1994). *Delinquent behaviour among young people in the western world: First results of the international self report delinquency study*. Amsterdam, Holland: Kugler Publications.

Two major cross-national surveys of school children have included NI samples, namely the European School Survey Project on Alcohol and Drugs (ESPAD; Hibell et al., 2000) and the Health Behaviour of School Children Survey (HBSC; Currie, Hurrelmann, Settertobulte, Smith & Todd, 2000). The ESPAD was conducted in 1995 and 1999 across 30 participating European countries. In 1995, 530 pupils aged 15 and 16 in five schools in Northern Ireland were interviewed as part of the ESPAD Study. In 1999, the sample was 723 students aged 15–16 across 71 schools (Millar & Plant, 1996; Plant & Millar, 2000).

The ESPAD survey confirms the findings that around the time of the ceasefires, in the mid 1990s recreational drug use among young people in NI (i.e., cannabis use) was considerably higher than in other European countries, excluding its nearest neighbors in the UK (Table 2). Use of cannabis among 15 and 16 year olds increased from 23% in 1995 to 33% in 1999. What is also of interest is that the upward trend in drug use recorded in NI, appears to run contrary to the declining trends in drug use exhibited in the rest of the UK (England, Scotland, and Wales) and the Republic of Ireland. England saw a decline of 5 percentage points, Scotland 12 percentage points, Wales 2 percentage points and the Republic of Ireland 5 percentage points in the level of reported cannabis use. Cannabis use trends in NI appear to be closer to those exhibited by other European countries such as Czech Republic, Italy, and Denmark. Likewise, the United States, as evidenced by findings from the comparable Monitoring the Future Survey (Johnston & O'Malley, & Bachman, 2000), shows an upward trend in cannabis use among young people. While it is apparent that increases in cannabis use are not exclusive to countries undergoing political and social change, as shown by the United States and other European countries, it is worth noting that the former Soviet Union countries of Eastern Europe covered by the ESPAD survey (i.e., Czech Republic, Ukraine, Croatia, Slovenia Slovak Republic, Poland, and Lithuania), that have made the transition from communist control to developing democracies, are experiencing similar trends of

increasing cannabis use. Increases in the rates of other drug use and risk behaviors in these post-soviet transitional countries is further evidenced by a recent report of the European Centre for Monitoring Drugs and Drug Addiction (2002). The report concluded that while these countries were traditionally transit regions for drugs (in particular heroin) on route from Asia to Western Europe, they were now increasingly a focus for major drug distribution themselves. The increasing popularity of some synthetic drugs has led to the exportation of these drugs from Western Europe to eastern post-soviet countries in recent years (European Centre for Monitoring Drugs and Drug Addiction, 2002).

Table 2. International Trends in Lifetime Cannabis Use Among 15 and 16 Year Olds (European Schools Survey Project on Alcohol and Drugs Survey 1995 and 1999)

Countries ¹	1995	1999
Northern Ireland	23	33
England	40	35
Scotland	53	41
Wales	32	30
Republic of Ireland	37	32
Czech Republic	22	35
Italy	19	25
Denmark	17	24
Ukraine	14	20
Slovenia	13	25
Croatia	9	16
Slovak Republic	9	19
Poland	8	14
Lithuania	1	12
Portugal	7	8
Sweden	6	8
Finland	5	10
USA ²	34	41

Notes.¹ Selected European Schools Survey Project on Alcohol and Drugs (ESPAD) countries only.

² The United States is not an ESPAD country, however on the key drug use measures it is possible to make tentative trend comparisons with the Monitoring the Future Survey, Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2000). *Monitoring the future national survey results on drug use, 1975–1999: Volume 1. Secondary school students*. Bethesda, MD: National Institute of Drug Abuse. Copyright permission granted by National Institute of Drug Abuse.

From Hibbel, B., Andersson, B., Ahlstrom, S., Balakireva, O., Bjarnson, T., Kokkevi, A., & Morgan, M. (Eds.). (2000). *The 1999 ESPAD report: Alcohol and other drug use among students in 30 European countries*. Stockholm, Sweden: The Swedish Council for Information on Alcohol and Other Drugs (CAN). Copyright permission granted by The Swedish Council for Information on Alcohol and Other Drugs (CAN).

Millar, P. M., & Plant, M. (1996). Drinking, smoking and illicit drug use among 15–16 year olds in the United Kingdom. *British Medical Journal*, 313, 394–397.

Plant, M., & Millar, P. (2000). Drug use has declined amongst teenagers in United Kingdom. *British Medical Journal*, 320, 1536.

One ESPAD finding worthy of serious concern is the high levels of inhalant use (glue, gas, aerosols, and nitrites) within NI (Table 3). NI has the highest levels of reported inhalant use of any European countries, and is higher than that reported in the United States. Some 26% of 15 and 16 year olds reported using inhalants in 1995 and 25% reported use in 1999. This is some 10% higher than the level of solvent use in England, 8% higher than Scotland, and 6% higher than Wales. This is further evidenced by the fact that NI has the highest standard mortality ratio for inhalants-related deaths across all UK regions (Field-Smith, Bland, Taylor, Ramsey, & Anderson, 2002). Given the acute and chronic health problems associated with inhalant use, alongside the risk of sudden death (see Advisory Council on the Misuse of Drugs, 1995, Haverkos & Doherty, 1988), these findings represent a major public health concern.

The final survey to be considered is the World Health Organisations Health Behaviour of School Children Survey (HBSC; Currie et al., 2000). This is a cross-national research study conducted in

26 European countries, as well as in Canada and the United States. While the study does not formally cover illicit drug use, drug use questions have been included in all three sweeps of the Northern Ireland HBSC, conducted in 1992, 1994, and 1998 (Health Promotion Agency for Northern Ireland, 2000). While the HBSC rates for drug use are lower than those recorded by the ESPAD study, they confirm the general upward trend in recreational and occasional drug use among young people in NI. Among year 12 pupils (aged 15–16), for whom three data points are available, drug use increased from 16% in 1992 to 28% in 1999 (Table 4).

However, in contrast to the ESPAD survey, the HBSC does not show an increase in drug use between 1994 and 1998, the period of the ESPAD increase, and in the case of year 10 pupils (aged 13–14) the HBSC shows a decrease in drug use. This may in part be due to the fact that the published HBSC prevalence rates for 1999 exclude inhalant use, and are therefore an undercount of all drug use as measured in previous years. A more recent survey, the Young People's Behaviour and Attitudes Survey (YPBA), which employs a methodology comparable with that used in the HBSC, shows that drug prevalence, both including inhalants and excluding them, has continued to increase (Table 4; Miller and Dowds, 2002). Therefore, the 1998 HBSC can be seen to represent a methodological modification rather than a leveling off or temporary dip in drug use trends.

Table 3. International Trends in Inhalant use Among 15 and 16 Year Olds (European School Survey Project on Alcohol and Drugs Survey 1995 and 1999)

Countries ¹	1995	1999
Northern Ireland	26	25
England	20	14
Scotland	22	17
Wales	18	19
Republic of Ireland	–	22
Czech Republic	8	7
Italy	8	6
Denmark	6	7
Ukraine	5	8
Slovenia	12	14
Croatia	13	13
Slovak Republic	6	7
Poland	9	9
Lithuania	16	10
Portugal	3	2
Sweden	12	8
Finland	4	5
USA ²	19	17

Notes.¹ Selected European School Survey Project on Alcohol and Drugs (ESPAD) countries only.

² The United States is not an ESPAD country, however on the key drug use measures it is possible to make tentative trend comparisons with the Monitoring the Future Survey, Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2000). *Monitoring the Future national survey results on drug use, 1975–1999: Volume 1. Secondary school students*. Bethesda, MD: National Institute of Drug Abuse.

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From Hibbel, B., Andersson, B., Ahlstrom, S., Balakireva, O., Bjarnson, T., Kokkevi, A., & Morgan, M. (Eds.). (2000). *The 1999 ESPAD report: Alcohol and other drug use among students in 30 European countries*. Stockholm, Sweden: The Swedish Council for Information on Alcohol and Other Drugs (CAN). Copyright permission granted by The Swedish Council for Information on Alcohol and Other Drugs.

Millar, P. M., & Plant, M. (1996). Drinking, smoking and illicit drug use among 15–16 year olds in the United Kingdom. *British Medical Journal*, 313, 394–397.

Plant, M., & Millar, P. (2000) Drug use has declined among teenagers in United Kingdom. *British Medical Journal*, 320, 1536. Copyright Permission granted by the BMJ Publishing Group.

Public Health Indicators and Risk Behaviors Drug use patterns within a location can be varied and do require different methodologies to research them. Surveys such as those described above are not the most successful means of assessing trends in problem drug use, in particular intravenous

use of substances such as heroin and other opiates (see Frischer et al., 2001). Escalation in this form of drug use represents a major challenge because of the threat it can pose to public health in the form of Human Immunodeficiency Virus (HIV) and other viral infections, such as Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV; Madden, Lamagni, Hope, Bennett, & Goldberg, 1997; Renton&Main, 1996;Van Ameijden, Van den Hoek, Mientjes, & Coutinho, 1993). Concerning intravenous drug use, these infections are largely blood-borne and can be transmitted by sharing of equipment among injecting drug users among other transmission routes. Analysis of public health data that will be described below, although imperfect, can contribute to building a picture of the scale and nature of problem drug use in an area. Data sources within this method range from addict notification data to mortality figures pertaining to drug use.

Table 4. Drug Use in Northern Ireland Health Behaviour of School Children Survey (HBSC) 1992, 1994, and 1998 and the Young People's Behaviour and Attitudes Survey 2000)

School Year Group	HBSC 1992 ¹	HBSC 1994 ¹	HBSC 1998 ²	YPBA 2000 ¹	YPBA 2000 ²
Year 83	–	3	3	13	4
Year 94	–	–	8	18	7
Year 105	–	14	12	26	16
Year 116	–	–	21	31	23
Year 127	16	26	28	39	33

Notes. Percentages of respondents who have ever tried drugs (including inhalants). Percentages of respondents who have ever tried drugs (excluding inhalants).

School year 8 pupils aged 11–12.

School year 9 pupils aged 12–13.

School year 10 pupils aged 13–14.

School year 11 pupils aged 14–15.

School year 12 pupils aged 15–16.

– = Not Available.

From Health Behaviour of School Children Survey (HBSC) Surveys 1991/2 1993/4 and 1997/8. Health Promotion Agency for Northern Ireland. (2000). *Illicit drug use in Northern Ireland—a handbook for professionals*. Belfast, UK: Author. Copyright permission granted for use of data by the Health Promotion Agency For Northern Ireland; YPBA Survey

Miller, R., & Dowds, L. (2002) *Drug and alcohol use amongst young people in Northern Ireland: Secondary analysis of drug and alcohol use surveys*. Belfast, UK: Department of Health, Social Services, and Public Safety. Copyright Permission granted by the Department of Health, Social Services and Public Safety.

Sample sizes: HBSC 1992 *N* = 804; HBSC 1994 *N* = 3,930; HBSC 1998 *N* = 6,589; YPBA 2000 *N* = 6,289

Table 5. Registered Drug Addicts in Northern Ireland by Age and Year

Age	1993	1994	1995	1996	1997	1998	1999	2000
<21	4	3	0	3	4	18	23	26
21–24	9	14	11	13	24	42	59	64
25–29	11	13	18	28	34	61	86	94
30–34	18	14	17	27	27	50	61	51
>35	38	43	50	49	73	89	77	67
Total	80	87	96	120	162	260	306	304

Note. From Department of Health, Social Services and Public Safety. (2001). Regional Drug Misuse Database progress report. Belfast, UK: Author. Copyright permission granted by the Department of Health, Social Services and Public Safety.

Notifications. Physicians in Northern Ireland are required to notify the Chief Medical Officer of the Northern Ireland Department of Health, Social Services, and Public Safety in writing if they attend a patient who they consider to be, or have reasonable grounds to suspect is, addicted to any of the specified control drugs (13 opioids and cocaine; see Health Promotion Agency for Northern Ireland, 2000; Mott, 1994 for further details of the notification process). Until March 1997, this information from Northern Ireland and equivalent data from other jurisdictions was compiled into the National Home Office Register of Drug Addicts to provide a UK-wide database. Since 1997, however, in all regions in the UK (excluding Northern Ireland) this database has been superseded

by the Regional Drugs Misuse Databases (RDMD; Corkery, 1997). These require a range of service providers including medical services, specialist drug agencies (statutory and voluntary), and penal institutions to report contacts with drug users who attend their services (Department of Health, 2001). In contrast to the rest of the UK and in keeping with its developmental position regarding drug use monitoring, Northern Ireland retained the Addict Index notification system until 2000 when it was replaced by the Regional Drugs Misuse Database for Northern Ireland (Department of Health, Social Services and Public Safety, 2002b).

Notwithstanding its limitations (see Frischer et al., 2001; Mott, 1994 for a detailed account), the Addicts Index provides a valuable indicator of the numbers of problem drug users in NI. Table 5 outlines the numbers of registered addicts in Northern Ireland by age. It is clear from the table that total notifications have risen substantially in Northern Ireland since around the mid 1990s coinciding with the cease-fire years. What is of particular note is the steady increase in the number of notifications among the younger age groups. Additionally, new notification data evidence a major increase since 1995, particularly in the under 21 age category. Heroin remains the main drug of abuse reported in the data.

In relation to the Drug Regional Misuse Database for Northern Ireland, this database is under development and, as with any new system, a range of difficulties have been experienced (Department of Health, Social Services, and Public Safety, 2001). However, available data would suggest that of the 969 individuals presenting for treatment in 2001/2002, forty-six percent were aged 25 or under. Nine percent were under 16 years of age at the time of referral (Department of Health, Social Services, and Public Safety, 2002b).

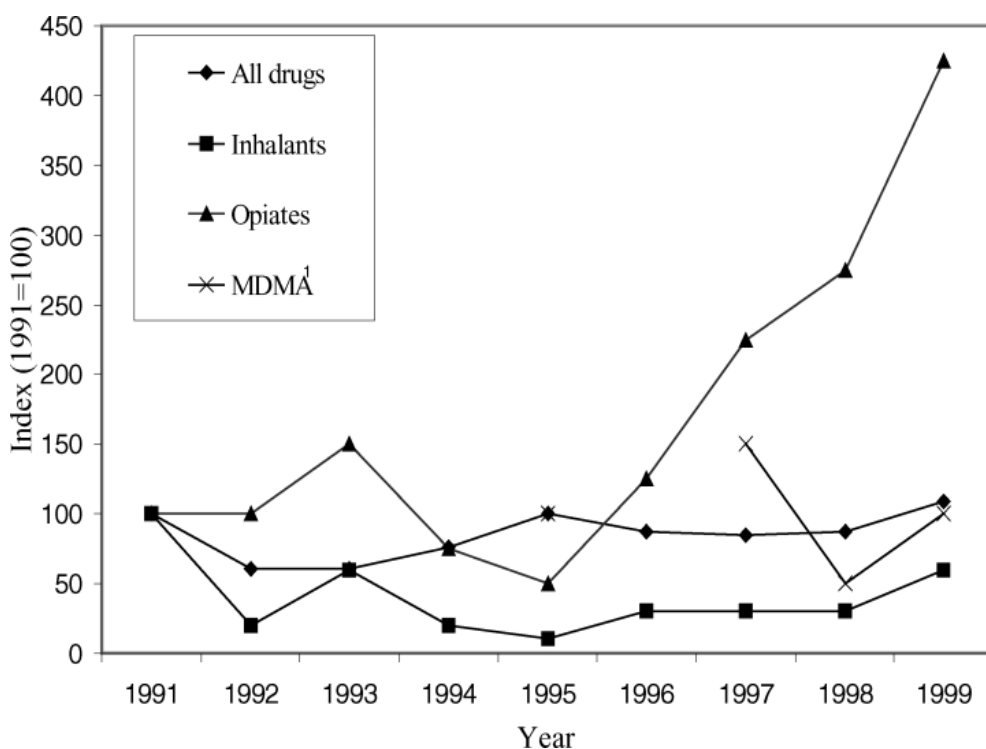


Fig. 1. Indexed trends in drug related deaths (1991–1999).

Notes. 3,4 methylenedioxymethamphetamine (MDMA) is the drug commonly referred to as Ecstasy. From General Registrar Office (Health Promotion Agency for Northern Ireland, 2000); Copyright permission granted by the Health Promotion Agency for Northern Ireland and The General Register Office. Field-Smith, M. E., Bland, J. M., Taylor, J. C., Ramsey, J. D., & Anderson, H. R. (2002). *Trends in deaths associated with the abuse of volatile substances*. London, UK: St. George's Medical School.

Mortality data. The number of acute drug-related deaths (overdoses) can be used as a simplistic way of assessing a country's drug situation. Figure 1 shows indexed trends in drug-related death in NI between 1991–1999. Counting drug-related deaths, however, is a complex process and

errors can occur (Advisory Council on the Misuse of Drugs, 2000). For example, in many cases, the relationship between drug use and death may not be direct and changes over time in the classification process may influence trends (Frischer et al., 2001). Rather than presenting the actual number of deaths, Figure 1 shows the indexed changes in the number of deaths over time (indexed year 1991). Overall, the levels of drug related deaths have remained fairly constant over time. However, since 1995 there has been a dramatic increase in opiate related deaths. Many of these deaths were in people under the age of 25. In relation to other drugs, 1997 registered the first ecstasy related deaths. Three young people died in that year.

Human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV). Other indicators often reflective of trends and patterns in heroin and injecting drug use and worthy of mention are HIV, HBV, and HCV prevalence. It must be noted that there is a range of modes of transmission for these viruses, most notably sexual transmission (both homosexual and heterosexual) also vertical transmission from mother to child (Intercollegiate Working Party for the Enhancing Voluntary Confidential HIV Testing in Pregnancy, 1998; McElrath, 2002a). On diagnosis, the mode of transmission is assigned to a specific category, thereby allowing epidemiological tracking of specific populations. Northern Ireland, even with only rudimentary harm minimization services (such as needle exchange programs), has the lowest rate of HIV infection in the United Kingdom (Higgins & Haw, 2002). In 2000, Northern Ireland had a cumulative total of only 207 cases (12 per 10,000 population), of which only 7 (3.4%) had a probable mode of transmission attributed to injection drug use (Communicable Diseases Surveillance Centre, Northern Ireland, 2001). The HIV total for the UK as a whole in 2000 was 43,774 (67 per 10,000 population), of which 8.4% are attributable to injection drug use. Similarly, rates for HBV and HCV remain low in Northern Ireland (Communicable Diseases Surveillance Centre, Northern Ireland, 2001). As yet adolescents have not been represented in the HIV statistics due to the very small numbers and the potential risk of identification. As outlined above, notification data from the addicts index and the Drug Misuse Database, however, are beginning to chart young, problem drug users. It is important, therefore, that health education and harm reduction strategies be introduced if Northern Ireland is to maintain these low levels of infection.

Law enforcement indicators. The final indicators to be considered provide overall context on the drug scene in Northern Ireland and are those relating to law enforcement, namely drug seizures recorded by the police. Drug seizures, like other drug use indicators, have limitations (Hser, 1993). The amount of drugs confiscated by the police may reflect, to a large degree, police priorities and operations rather than increased drug importation and distribution.

Figure 2 presents indexed trends in drug seizures between 1992 and 2000/2001. Over this period there is a 20-fold increase in cannabis and cocaine seizures. The increase in heroin and ecstasy are even more dramatic, with an increase of over 90-fold observed in ecstasy seizures and a 160-fold increase in heroin seizures. While there was a transfer in police resources and personnel from anti-terrorism operations to more ordinary crime detection—including drug use—following the cease-fires (McEvoy et al., 1998), this was likely to be offset to a degree by the reductions in overall police numbers and the decline in military security operations which, although they were not ostensibly targeted at drug importation, would have had an impact on this activity. Therefore, it can be surmised that the dramatic changes in drug seizures are unlikely to reflect changes in police operations alone, rather they represent genuine increases in the amounts of drugs now being imported into Northern Ireland

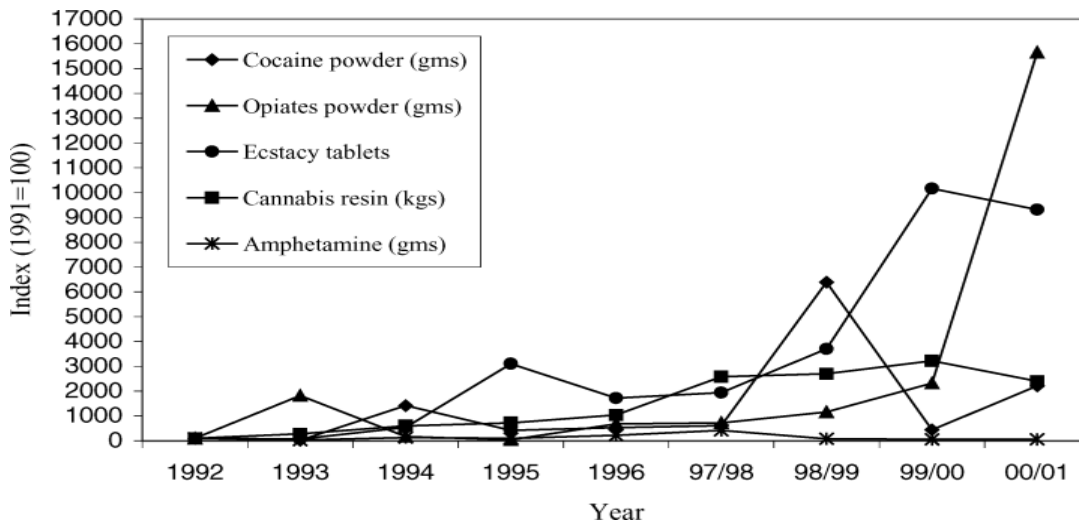


Fig. 2. Indexed trends in drug seizures (1992 to 2000/1).

Note. From Health Promotion Agency for Northern Ireland (2000). *Illicit drug use in Northern Ireland— a handbook for professionals*. Belfast, UK: Author.

Police Service for Northern Ireland. (2002). *Report of the Chief Constable*. Belfast, UK: Author.

Discussion

Over the past decade, Northern Ireland has witnessed the cessation of conflict and the emergence of the ongoing peace process. Over that same period, with a few exceptions, drug use indicators show an upward trajectory. Additionally, that drug profile is changing in that problem drug use, such as heroin, now features on our drug use landscape. The upward trend in recreational drug use among adolescents, apparent in much of the survey data reported above, appears to run contrary to the leveling off in drug use exhibited in the rest of the UK and in some parts of Europe. It could be argued that alongside more hazardous forms of drug use, such as increases in drugs such as cannabis, do not warrant particular policy attention as users are likely to mature out of use in early adulthood suffering little by way of serious health or social consequences. However, such findings should not be dismissed, as an increasing proportion of young people engaging in the occasional use of illicit drugs may result in the exposure of a larger number of individuals to problem drug use. However, the specific relationship between occasional use and problem use at the population level is not well understood (Silberesen, Robins, & Rutter, 1995).

As regards problematic drug use and heroin use, evidence from the various public health and law enforcement indicator data would unequivocally support the assertion that heroin use has dramatically increased since the mid 1990s. Of particular note is the steady increase in the number of opiate notifications among the younger age groups. Drug seizures data provides further evidence of the growth of a heroin scene.

Drug Use and the Cease-Fires

The key question still remains as to what extent the observed trends and patterns in drug use can be attributed to the cessation of political violence and the ongoing peace process within Northern Ireland. Given the social and political impact created by the transition toward peace in Northern Ireland society, it is difficult to envisage that no influence has been exerted. Attempting to disentangle this relationship requires consideration of a number of complex factors that have in combination somehow operated to facilitate an increase in drug use in more recent times.

The most important factor is considered to be the changing roles of the certain loyalist and republican paramilitary groups and their involvement in the drugs trade. The cessation of paramilitary activity has led to the necessary redeployment of paramilitary group members. There is increasing evidence to suggest that certain paramilitary groups members, particularly those from loyalist paramilitaries and fringe republican organizations, have invested their efforts in drug distribution and dealing and in the informal policing of that activity within their communities

(McDowell, 2001; Silke, 2000). Silke (2000) charts the history of certain loyalist groups and makes note of previous experience in the drug trade. As far back as 1991, he reports that the British Government estimated that the Ulster Defence Association and the Ulster Volunteer Force, both loyalist groups, earned in the region of £1 million annually between them from the drug trade. This has increased over the ensuing decade. Paramilitary groups like to maintain control in their given areas and, like Republicans, the loyalist paramilitaries engage in the informal policing of those working class areas from which they draw their support. However, on the whole loyalist groups tend to be less cohesive organizations than republican groups, where brigade heads (local commanders) are largely autonomous and self-reliant for funding (McDowell, 2001; Silke, 2000; McEvoy et al., 1998). As a result, extensive involvement in ordinary crime, including drug dealing, has been a systematic problem for loyalist paramilitaries since their inception (Dillon, 1989).

While the extent to which these paramilitary groups are involved in the direct large scale importation of drugs remains uncertain, law enforcement agencies are convinced that individual members of these loyalist groups are involved in drug distribution and dealing, both directly and also indirectly through “protecting” or “licensing” other dealers to operate in “their area” (McQuillan, 2001). A key element of the peace process has been the release of paramilitary prisoners back into Northern Ireland society. Some former loyalist prisoners have been reported to be under pressure to become involved in drug dealing (Silke, 2000). That said, the drugs issue is a source of major tension in loyalist ranks with some elements arguing for it to be eradicated (Silke, 2000). There have been some attempts to prevent drug trafficking with persistent warnings in the loyalist paramilitary magazines, however, the practice is apparently continuing (Bruce, 1995; McKittrick, 1994; McDowell, 2001). Indeed, a recent ethnographic study of crime in Belfast reported claims that much of the feuding between various loyalist groups, the source of much post cease-fire violence in Northern Ireland, has been in relation to the control of local drug markets (Brewer et al., 1997).

While most of the main republican paramilitary organizations, are publicly opposed to drug use and drug dealing, “unofficial” involvement by some is accepted. For example, dealing by The Irish National Liberation Army (INLA) had often been tacitly accepted. It has been suggested for some time that the INLA have been involved in serious non-political criminal activity including drug trafficking for some time. More recently, strong links between the INLA and large drug cartels the Republic of Ireland have been reported (Holland & McDonald, 1994; McDowell, 2001).

In regard to the Provisional Irish Republican Army (PIRA), McEvoy and colleagues (1998) concluded that both before and after the cease-fires it has been involved in policing of republican areas against the supply of drugs. Much of this policing has been orchestrated by means of beatings and murders perpetrated by a vigilante group calling themselves Direct Action Against Drugs, argued by many to be a flag of convenience for the IRA (Holywood, 1995; McDowell, 2001). Conscious of the anti drug stance of the United States and the need to portray a favorable image to potential American funders, the PIRA have made unequivocal statements about their own war on drugs (McDowell, 2001). The lack of involvement of PIRA in drug supply has been largely supported in government documentation (Northern Ireland Affairs Committee, 1996), and ethnographic research (Brewer et al., 1997). However, the PIRA is not without gain from the drug trade. Recognizing it as a lucrative business, it has been argued that they permit non-members to be drug traffickers in key sites throughout Northern Ireland for a percentage take of the profits (McDowell, 2001).

Therefore, as a tentative summation, it is argued that somehow the reconfiguration of these paramilitary groups in post cease-fire Northern Ireland has operated to change the dealing and distribution patterns of drugs. Perhaps by effecting a much larger, more aggressive, and unhindered marketing strategy than was previously possible while the conflict was underway. Additionally, even groups such as the IRA with their strong anti-drug ethos have found a means by which they can reap some gain from the business without being directly linked to it. Further research is required to examine the role, if any played by the various paramilitary groups in the burgeoning heroin market in Northern Ireland.

Such factors cannot be considered without reference to the raft of other law enforcement and overall social and cultural changes that have occurred as a result of the cease-fires. The considerable reduction in both police and military surveillance across NI, and in border regions in particular, that followed the signing of the Good Friday Agreement may have contributed to a favorable environment for major drug importation and distribution. The increases in drug seizures highlighted above may reflect increased drug trafficking rather than higher detection rates per se. Furthermore, urban centers such as Belfast and Londonderry/Derry have witnessed major changes in nightclub culture. As towns and city centers are perceived to be safer, more young people are going out at night. More money is being invested in licensed venues. At the core of much of this growth is a dance culture, which has close relationship with illicit drugs (McElrath & McEvoy, 1999).

While this study has identified a number of possible societal transformations associated with the ongoing peace processes in NI that may be influential in the changing patterns of adolescent drug use, its limitations are recognized. It is acknowledged that further work is needed in this area. Specifically, more complex theoretical and empirical models are required that provide greater definition of the relationship between the multiple macro social processes and secular trends in adolescent drug use, and that permit the testing of competing hypotheses regarding the main drivers of changing drug use at the macro level (see Anderson, 1995). At present the data available within NI does not permit this type of analysis. As a result, it is not possible to define in any precise fashion how the cessation of violence and the ongoing peace process has contributed to an increase in adolescent drug use, or the extent to which other social processes have also affected drug use rates (e.g., unemployment levels). However, it is highly likely that the peace process, and in particular the increased involvement of post cease-fire paramilitary groups in drug importation and distribution, is, and will continue to be, a major influence on secular drug use trends in NI.

The Future: Current Policy Responses to Adolescent Drug Use

Current NI drug policy is embodied in "The Drug Strategy for Northern Ireland 1999". Compared with preceding NI policy statements which have restated the relatively low prevalence of drug use (Northern Ireland Committee on Drug Misuse, 1986, 1995) this strategy, opens with the words "Northern Ireland has a drugs problem" (Department of Health, Social Services and Public Safety 1999, p. 5). The new strategy is derived from the overall British drug strategy of 1998 "Tackling Drugs to Build a Better Britain" and is largely complementary to those 500 Higgins, Percy, and Mc Crystal in place for the other UK jurisdictions; however, it is presented as being more developmental in nature (Drugscope, 2000).

The acknowledged lag between overall UK policy advances and those in place for Northern Ireland has meant that, in practice, Northern Ireland policy has differed greatly from general British policy. In particular, harm reduction strategies have been incorporated to some extent in British policy since at least 1984. The so called "British system" involves substitute prescription in order to attract drug users to services, to help stabilize the patient's lifestyle, to reduce harmful injecting and chaotic drug taking, as well as to remove the need to deal in drugs. It is argued that this, in turn, reduces the supply of drugs and the impact upon criminal offending in particular, acquisitive crime. Such practice has been rigorously and, in the main, positively evaluated (Gabbay & Jeffrey, 2000; McElrath, 2003).

The historically low prevalence of heroin use has meant that the new outbreaks in Northern Ireland have, by their nature, occurred in areas with few treatment, harm reduction, and information facilities for users. That said, evidence of the increases in an injecting drug scene have been forthcoming since at least 1996, yet Northern Ireland still does not for the most part permit methadone maintenance or any other substitute prescription. Furthermore, it is only since 2001, some five years after repeated reports of a sizeable injecting population (see McElrath, 2001, 2002b) that needle exchange schemes have been operational in a small number of sites in Northern Ireland (initially, two and, now, seven). The majority of the range of treatment modalities,

so well evaluated across the UK and Europe, is not available to date in Northern Ireland. The relatively recent entry of Northern Ireland onto the UK drug scene provides an opportunity for learning from experiences gained elsewhere. Indeed, recent history has provided some salutary lessons that must be contemplated. For example, the delay in introducing proper needle exchange schemes in Edinburgh, Scotland led to a major HIV epidemic among the injecting drug user community there in the 1980s (Roberston et al., 1986). While it appears that Northern Ireland is fortunate in regard to its low level of HIV infection to date, the rise of other infections such as the HCV provide evidence that sharing of infected injecting equipment is ongoing.

In addition to the under-development of treatment and harm reduction services, it is not surprising that there are few services specifically developed for adolescent users. Clearly there is a need for urgent enhancement for drug services for youth in keeping with the model proposed by the UK Governments Health Advisory Service (Gilvarry, 2001). This model calls for integration of the young persons substance misuse plan into all children's services. Clear links should be developed between the various branches of the support system for children such as education, health, social services, and criminal justice to ensure that all substance related problems are firmly imbedded into the whole system of children's services.

In regard to prevention, it is important that Northern Ireland learns from research that has indicated what actually works. While a considerable amount of drugs prevention has been undertaken in NI, doubts exist as to the overall effectiveness, as few have been based on successful models of prevention. For prevention efforts to be successful they must address risk processes at the individual, family, school, and neighborhood level (Coie et al., 1993; Hawkins, Catalano, & Miller, 1992). However, given the limited resources available to undertake such work, and the anticipated costs of mounting such prevention at a universal level, and the fact that most occasional drug users are likely to mature out of their drug use with little health or social complications, it is recommended that prevention is targeted specifically at reducing problem drug use and its health and social consequences. It is recognized that major obstacles exist to achieving this refocusing, including definitional issues, difficulties in the identification and measurement of problem drug use in adolescents, and a lack of research on the causal processes underlying the transition from occasional use to more harmful drug consumption patterns. While much is known about risk factors for occasional drug use, less is known about the developmental pathways from occasional to problem drug use and the causal processes that shape these pathways (Rutter, 2001). For prevention efforts to be effective it is essential that they target known risk processes. Longitudinal research essential to informed prevention initiatives has already begun in Northern Ireland (Percy, Higgins, McCrystal, & McSherry, 2002) but requires ongoing support. Additionally, further in-depth qualitative research of high risk youth such as those involved in injection drug use is required if we are to gain a more comprehensive picture of drug taking and risk behaviors.

Research has demonstrated that Northern Ireland is only one of many regions throughout the UK and Europe experiencing new outbreaks of heroin use and changing drug use patterns among young people (European Monitoring Centre for Drugs and Drug Addiction, 2001; Parker, Bury, & Egginton, 1998). A key challenge, however, is whether the onset and development of future drug use problems could be predicted thereby allowing drug hotspots to be highlighted, new drug use patterns to be identified and service responses targeted accordingly. Although the UK has seen significant advances in knowledge since the onset of its last major drug epidemic, specifically heroin, it is still falls short of achieving successful early-warning systems (Parker et al., 1998). What is in place in NI is less well developed again. It is only as recently as 1999 that Northern Ireland had its own database of treatment episodes (Drug Misuse Database) as discussed above, which has been in place for over a decade elsewhere in the UK.

In comparison to the situation in the UK, the United States has a more comprehensive drug use early warning network, comprising Drug Abuse Warning Network (DAWN), Arrestee Drug Abuse Monitoring (ADAM), and PULSE CHECK (Parker et al., 1998). The purpose of DAWN is to monitor trends in drug-related episodes and deaths derived from Accident and Emergency and

Coroners' Office data (Substance Abuse and Mental Health Services Administration, 2002), where ADAM provides a snapshot of the extent of drug use among the criminal justice system population—based on urine testing of arrestees (Hunt & Rhodes, 2001). Finally, PULSE CHECK reports on discussions with a wide range of ethnographers and epidemiologists working in the drugs field (Office of National Drug Control Policy, 2001).

Parker and colleagues (1998) drew attention to the lack of comparable data sources in the UK. Additionally, he argued that even with more sophisticated manipulation of current systems the best that can be achieved is a jigsaw of secondary indicators. Northern Ireland falls short of even that. New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) is operational in several places in England and Wales, and is currently being extended to Scotland (Bennett, 1998, 2000). It seems imperative that such a program is rolled out to Northern Ireland. One of the benefits of such a program is that it would provide data comparable with other regions of the UK and the United States (e.g., Taylor & Bennett, 1999). In the longer term, Northern Ireland should consider operating other systems comparable to those in the United States such as DAWN and PULSECHECK. Computerized projection of future heroin epidemics is currently being pioneered in the UK (Ditton & Frischer, 2001) and, again, Northern Ireland could benefit from eventually coming on stream with such initiatives.

Conclusion

While the cease-fires and the resultant peace process have brought a renewed hope for the whole of Northern Ireland, they have carried with them the potentially huge cost of escalating drug use among its youth. Surveys of young people, public health indicator data and law enforcement data reveal a complex drug-use pattern, yet with a few exceptions, they point to an increase in drug use coinciding with the cease-fires. Increases in paramilitary involvement in the drugs trade would suggest that the social and political changes that have occurred over recent years might have created an environment where drug use could flourish. The potential for this to occur in all post-conflict situations should be considered a serious risk. Northern Ireland is now developing a drug problem in line with other Western countries. What is of concern is that Northern Ireland does not appear at present to have the prevention, treatment, and harm reduction services in place to address these changes. Change is already apparent and drug policy in Northern Ireland is progressing. Central to that development was the appointment, in 2001, of a Drug Strategy Coordinator for Northern Ireland often referred to as the "Drug Czar" (for further information on the Drug Czar and their role within the Northern Ireland Alcohol and Drug Strategy see Department of Health, Social Services, and Public Safety, 2002a). It is incumbent upon the new Czar to further develop Northern Ireland's drug strategy and service response to keep abreast of the rapidly changing drug use landscape within Northern Ireland. A rapid response will be central to the success of this endeavor, in any post conflict situation. This requires remaining attuned to drug use as a potential problem, as well as providing finances to support research and policy, in already damaged social and economic circumstances.

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