

ILLICIT DRUG USE IN DUBLIN

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Abstract

Preliminary data are presented from a two-year qualitative study on the development of problematic drug use, which has been found to be spatially concentrated in the most marginalized areas of Dublin city. The study will assess the relationship between problem drug use, unemployment and socio-economic deprivation in these areas. Initially identified trends and patterns in the drug-using careers of Dublin's young adult population are described here, and the data is placed in the context of social and economic trends and policy responses to drugs. Uneven geographical development of visible drug problems mirrors the uneven geographical development of socio-economic disadvantage.

Introduction

Drugs have been a largely neglected field of study in Ireland, and little valid information is available on the prevalence, patterns and trends of illicit drug use. However, in April 1996 the Health Research Board commenced funding a two-year qualitative study to examine trends in illicit drug use and the relationship between problematic drug use, unemployment and socio-economic deprivation. Although the study is still in its infancy, this paper draws on existing research and initial results from the study to make some observations on illicit drug use in Dublin.

Development of Dublin's drug culture

Illicit drug use first came to public attention in the late 1960s, when LSD and cannabis were found to be most commonly used (Masterson, 1970). In the 1970s, glue sniffing and cider drinking were noted as being prevalent among school children, and tranquillizer and barbiturate use among adults (Flynn and Yeates, 1985). It was in 1979 that health and welfare workers first noted the growing trend in opiate use in the city, a year which is seen to mark the beginning of the first Dublin drugs epidemic. That epidemic was concentrated in small pockets of Dublin's inner city, areas with a history of poverty and disadvantage. Most residents experienced multiple levels of deprivation - high levels of unemployment, low levels of education, poor housing (mostly in local authority flat complexes) and a lack of facilities for young people.

Several small-scale community studies carried out there give an indication of the situation at the time. A report on a north inner city area found 10% of the 15-24 year age group using heroin (Bradshaw, 1985), while a similar study in a south inner city ward found a rate of 9% in the same age group, rising to 14% for young men (O'Kelly et al., 1988). These young opiate users belonged to an almost totally injecting drug culture, a phenomenon that was to have serious repercussions later.

By the mid-1980s, the opiate epidemic was seen to have reached a 'plateau'. Availability of heroin and other opiates remained concentrated predominantly in the inner city areas and was thought to be 'contained' there. As a result, drugs largely disappeared from the agenda of public debate for many years, and little support was forthcoming for the communities affected. Meanwhile, cannabis became increasingly available and popular in youth culture. A survey of post-primary school pupils showed the use of illicit drugs to have increased from 3% in 1970 to 14% in 1980 (Shelley et al., 1982). A more recent study has shown this trend to be continuing,

with a quarter of the pupils surveyed having tried cannabis at some time and 1 out of 10 having used it the previous month (Morgan and Grube, 1994).

By the early 1990s, an ecstasy/rave culture had developed on the Dublin youth scene. Initially, this fashion was centred around a few large dance venues in the city centre, but the trend has since spread to other urban centres and rural areas. Anecdotal evidence indicates that ecstasy and cannabis have become increasingly normalized among young people, transcending class and urban/rural divides.

More recently, a second opiate epidemic has developed in the city. Interviews with health and welfare workers tell of a new generation of teenage heroin users. Unlike their older counterparts they mostly smoke it - 'chasing the dragon'. This new generation have been found to be from the same marginalized inner city areas as before, as well as from the newer suburban public housing estates - many of them younger relatives of those involved in the first epidemic. Heroin is easily available on the streets in these areas, and at an all-time low price. A 'bag' or 'Q' of heroin - the standard street retail unit - now costs from IR £8 to IR£20 (22fl - 55fl), down 50% to 80% since the early 1990s. However, the quantity and quality of heroin in each bag varies across the city, with those at the cheaper end of the scale being poor value but attractive to those short of money.

Levels of use among the new heroin users have been seen to build up rapidly, with users moving to smoking two or more bags at a time, and often up to twelve bags a day. The life cycle of a heroin smoking career has been noted by many workers in the field to be around eighteen months. At this point injecting becomes a more viable financial option, since a lesser amount is used . intravenously, leastwise initially.

The cost of a drug habit ranges from IR£80 (220fl) to IR£200 (550fl) a day. Many users turn to dealing to finance their habit, selling for suppliers on a credit basis. An example of this practice is for the user to get a 'batch' (approximately sixteen Qs) on credit, selling ten Qs for IR£20 (55fl) each, and keeping six for personal use. The initial batch is then paid for with the IR£200 (550fl) earned, and the next batch is collected. Few users, however, seem able to maintain this level of control; the rest slide into debt with their supplier. Alternatively, users fund their habits from their own personal finances or from activities such as shoplifting, bag snatching, burglaries and prostitution.

Over the past few years, this drugs-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 crime/drugs-related murders, including that of the crime reporter Veronica Guerin (1996), have intensified public concern and fuelled media speculations.

Drugs, HIV and AIDS

A further legacy of the opiate epidemic may be seen in the rates of drug related HIV and AIDS. While the overall number of AIDS cases is relatively low in European terms (16.5 per 100,000 population (N = 577), injecting drug users account for the largest number of cases (42%), (Department of Health, Ireland, 1996) - one of the highest proportions in Europe (ECEMA, 1995). Much of this high rate may be explained by the injecting culture of the 1980s heroin epidemic, when knowledge of injecting hygiene and access to needle supplies were limited. In contrast, the trend in the UK at this time was for 'chasing the dragon' (Parker et al., 1988; Pearson et al., 1987). This phenomenon along with the (argued) success of public health interventions have been seen to account for the low prevalence of AIDS among IDUs in the UK (Stimpson, 1996).

However, despite the persistence of high rates of HIV and AIDS (and increasing rates of Hepatitis B and C) among injecting drug users in Ireland, policy responses have tended to focus on supply and demand reduction measures. More recently, a shift in emphasis towards harm reduction may be seen in the expansion of drug services providing methadone treatment and needle exchanges. However, there is little evidence from the interview respondents that risk behaviours among the drug using community have been minimised.

Table 1:

Cumulative AIDS Cases among Drug Injectors March 1995

| | N | Rate per 100,000 population |
|----------|----------|------------------------------------|
| UK | 614 | 1.0 |
| Scotland | 229 | 4.5 |
| Ireland | 209 | 6.0 |

Sources: Public Health Laboratory Service (UK); Scottish Centre for Infection and Environmental Health; Department of Health (Ireland)

Treated Drug Misuse

Since 1990 a drug misuse reporting system has been in operation, compiling, on an annual basis, data on drug users attending treatment. While these reports are the only systematic source of information on drug users - that is, those in treatment - a number of caveats need to be made with regard to the data. Firstly, not all treatment agencies submit data, so the figures underestimate the numbers in treatment. Secondly, not all drug users attend treatment, so the figures underestimate the total prevalence of drug use. Neither is it known how representative the data are of the drug-using population as a whole. However, while overall numbers are small, and far short of the estimated 7,000 opiate users in the city (500 per 100,000 residents), the data reveal trends which help towards understanding the drug-using culture in Dublin.

The rate of those attending treatment for the first time was found to have doubled (from 1.5 per 100,000 to 3.0 per 100,000) over the four-year period 1990-1994. Over 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 4 out of 10 were unemployed. Three quarters used an opiate - chiefly heroin - as their primary drug. Seven out of ten clients had first used their primary drug as a teenager and two thirds were daily users by the time they came into treatment. Over half of those coming into treatment had injected at some time, and 7 in 10 of these were currently injecting. The proportions who had ever shared needles had decreased over the four-year period from 70% to just under 40%, while only 10% admitted to currently sharing.

However, in view of the difficulty of defining sharing, as noted by Koester (1996) and others, the validity of these rates cannot be assured. These data are of particular interest with respect to the focus of the research study:

- a) since the first report (O'Hare and O'Brien, 1992), the profile of the typical drug user in treatment (male, single, depressed socio-economic background, low educational achievement, poor employment record) has remained unchanged;and

- b) when the data on area of residence of those attending treatment is viewed spatially, the clustering of drug users in treatment matches areas of known disadvantage in the inner city and outer estates.

| | Number of Total Treatment* | Number First-contact Clients |
|------|-----------------------------------|-------------------------------------|
| 1990 | 2037 | 624 |
| 1991 | 2359 | 450 |
| 1992 | 2555 | 668 |
| 1993 | 2919 | 859 |
| 1994 | 2978 | 1150 |
| 1995 | 3593 | 1396 |

Source: O'Higgins 1995

* 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 given year.

Disadvantage in Dublin

Areas are designated as disadvantaged on the basis of a number of criteria such as population age structure and age dependency ratio, levels of educational attainment, the proportions of people in the semi-skilled or unskilled occupational classes, low earnings capacity, unemployment, and high numbers of local authority rented homes. The impact of these factors may be experienced in different ways among different communities. For example, demographic changes had left an ageing and increasingly disadvantaged population in inner city areas, while in the newer outer estates rapid population increases have occurred, with service provision and amenities lagging far behind. In addition, where these areas have absorbed disadvantaged populations from other parts of the city, they have become the site of acute disadvantage. However, perhaps the most defining characteristic of disadvantage is the high rate of unemployment. In Dublin, unemployment rates in the disadvantaged areas can be seen to average at 33% and peak at 45%. However, if the rates are examined on an even smaller geographical basis (the District Electoral Division), the rate peaks at 55% - over three times the national average.

Conclusion

Evidence that the uneven geographical development of visible drug problems mirrors the uneven geographical development of socio-economic disadvantage is one of the chief concerns of the research currently being undertaken. A primary aim of the study is therefore to understand the role that social and structural processes play in this apparent parallel development.

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