

Study 2: Are the MQF drug users different to their Dublin peers?

The objectives are to measure any differences between the index Merchant’s Quay F (MQF) cohort and other Dublin drug users, known to the drug treatment services in 1985. A random sample of one hundred drug users from Dublin, but excluding any from the Merchant’s Quay F Ward, were identified from the records of Trinity Court in the year 1985 and form the Trinity Court (TC) cohort. The areas studied were the socio-demographic characteristics, drug use history, viral infections including HIV and mortality.

Table 7.35: Socio-demographic characteristics

Date of birth	Trinity Court Cohort	MQF Cohort	Comments
1950 and before	4 (4%)	1 (1.3%)	38% of the Trinity Court cohort were 25 years or more in 1985. The MQF Cohort is older. 45% were 25+ years in 1985 However this is not statistically significant ($\chi^2=3.76$, $df=4$, $p=0.440$).
1951-55	13(13%)	11 (14.1%)	
1956-60	21 (21%)	23 (29.6%)	
1961-65	40 (40%)	42 (53.8%)	
after 1965	12 (12%)	1 (1.3%)	
Total	100 (100%)	78 (100%)	
Gender			Gender breakdown is 4:1 in the TC cohort and 3:1 in the MQF cohort. This is not statistically significant. ($\chi^2=0.487$, $df=1$, $p=0.485$)
Male	80 (80.0%)	59 (75.6%)	
Female	20 (20.0%)	19 (24.5%)	
Total	100 (100%)	78 (100%)	
First Address	From most Dublin Postal districts.	From MQF Ward, Dublin 8.	
Last Address	88 (88%) Dublin 10 (10%) in the UK 2 (2%) other	74 (95%) Dublin 4 (5%) in the UK	
Total	100 (100%)	78 (100%)	
Civil Status			More members of the MQF Cohort are married. This is to be expected, as they are older, however the differences in the groups are not significant ($\chi^2=5.857$, $df=3$, $p=0.119$)
Single	57 (57.0%)	32 (41.0%)	
Married	20 (20.0%)	24 (30.8%)	
Co-habiting	16 (16.0%)	12 (15.4%)	
Other (separated, widowed, other)	7 (7%)	10 (12.8%)	
Total	100 (100%)	78 (100%)	

Table 7.35 continued.

	Trinity Court Cohort	MQF Cohort	Comments
Number of children			Total number of children born to the TC cohort is 89 per 100 persons. Total number of children in the MQF cohort is 112 per 78 persons. The differences are not significant (<i>chi2</i>=3.805, <i>df</i>=3, <i>p</i>=0.283)
Nil	12(12.0%)	5 (6.4%)	
One	18(18.0%)	18(23.1%)	
Two	15(15.0%)	12(15.4%)	
Three or more	13(13.0%)	18(23%)	
[Not recorded]	[42 (42.0%)]	[25(32.1%)]	
Total	100(100%)	78(100%)	
Employment			Less of MQF Cohort in employment, however this is not significant (<i>chi2</i>=4.658,<i>df</i>=1, <i>p</i>=0.031)
In work	17(17.0%)	4(5.1%)	
Unemployed	74 (74.0%)	58 (74.4%)	
[Not recorded]	[9 (9.0%)]	[16(20.5%)]	
Total	100(100%)	78(100%)	
Prison Record			More of the MQF Cohort had a prison record, however this is not statistically significant (<i>chi2</i> = 0.132, <i>df</i>=1, <i>p</i> = 0.7170)
Yes	65 (65.0%)	60 (76.9%)	
No	13(13.0%)	14(17.9%)	
[Not recorded]	[22 (22.0%)]	[4(3.1%)]	
Total	100(100%)	78(100%)	

The MQF cohort is slightly older than the TC cohort is, and the gender breakdown is 3:1 male to female in the MQF cohort and 4:1 in the TC cohort. There is little difference in the last known address of either group in that the majority of both groups stayed in Dublin, with 12% of the TC cohort moving out of the country compared with 5% of the MQF cohort.

More of the MQF group are married, that is 31% compared with 20% (TC cohort), they have more children, less work experience and more of them have been to prison. However none of these differences are statistically significant, therefore as far as broad socio-demographic characteristics are concerned the MQF cohort is similar to other drug users of the same era. This supports previous studies that show Dublin drug users largely came from a relatively deprived background, with little work experience and a probability of a prison sentence.

Drug use history

The two cohorts have a similar history of age of first illicit drug use (see table 7.36), however the MQF cohort started using heroin at an earlier age (see table 7.37). This difference is statistically significant ($p = 0.03$). The MQF cohort also started to attend the drug treatment centre at an earlier time than the TC cohort did. This probably reflects their earlier start in using heroin (see table 7.38)

There is no statistical difference between the two cohorts as to their last year of attendance at the drug treatment centre, however 40% of the TC cohort had not attended since 1985 compared with 24.4% of the MQF cohort. This was the only drug treatment centre until 1993 and one of its functions since then is to keep a central register of those in treatment for drug problems. The individuals in the TC cohort who did not attend since 1985 were not on this register in 1995.

More women in the MQF cohort have a recorded history of drug use in pregnancy than in the TC cohort, that is 12 (63.3%) in MQF cohort compared with 7 (35%) in the TC cohort. The figures, however, are too small to show any statistical difference.

Table 7.36 Age of first illicit drug.

	Trinity Court	MQF cohort	Comment
10-14 years	16(16%)	11 (14.1%)	There is no significant statistical difference between the two groups as to the age at which first illicit drug use took place. ($chi^2 = 6.80$, $df = 3$ and $p = 0.078$)
15-19 years	51 (51%)	53 (67.9%)	
20 - 24 years	24.(24%)	12(15.4%)	
25 and over	09 (9%)	02 (2.6%)	
[Total]	[100.(100%)]	[78(100%)]	

Table 7.37 Age of 1st heroin use

	Trinity Court	MQF cohort	Comment
10-14 years	04 (4%)	01 (1.3%)	The MQF cohort started using heroin at an earlier age than the TC cohort did. 66.7% by the age of 20 years compared to 53%. This is statistically significant ($chi^2 = 8.73$, $df = 3$ and $p = 0.033$)
15-19 years	49 (49%)	51(65.4%)	
20 - 24 years	32 (32%)	23 (29.5%)	
25 and over	15(15%)	03 (3.8%)	
[Total]	[100(100%)]	[78(100%)]	

Table 7.38: Year first attended drug treatment centre

	Trinity Court Cohort	MQF Cohort	Comments
1974- 1978	4 (4%)	8(10.3%)	88.5% of MQF cohort had attended by 1984, where as only 50% of the TC cohort had attended. This is a statistically significant difference $p < 0.001$
1979- 1983	47 (47.0%)	61 (78.2%)	
1984- 1993	49 (49.0%)	9(11.5%)	
	Total 100(100%)	Total 78 (100%)	

Table 7.39: Year last attended drug treatment centre

	Trinity Court Cohort	MQF Cohort	Comments
Pre 1986	40 (40.0%)	19(24.4%)	There is no significant difference between the two groups as regards to their last attendance at the drug treatment centre, ($chi^2 = 4.32$, $df = 2$ and $p = 0.11$) However 40% of the TC cohort have not attended since 1985, where as this figure drops to 24.4% for the MQF cohort.
1986- 1990	26 (26.0%)	22(28.2%)	
1991 - 1995	34 (34%)	34(43.6%)	
[Total]	[100(100%)]	[78(100%)]	

Virus infections.

There is a greater number of the MQF cohort with a history of jaundice compared with the TC cohort, 45% of MQF cohort with 29% of TC cohort. This is reflected in the numbers who are sero-positive for hepatitis B antibodies, 57.6% in MQF cohort compared with 32% of TC cohort. The difference is statistically significant ($p=0.003$).

In both groups there is a high number of tests recorded for hepatitis B antibodies, which reflects the routine nature of such tests on attendees at the clinic.

Table 7.40: History of virus infections

History of jaundice	Trinity Court Cohort	MQF Cohort	Comment
Positive Negative [Not recorded] { Total }	29 (29%) 55 (55%) [16(16%)] [100]	35 (45%) 24(31%) [19(24.4%)] [78(100%)]	The MQF cohort have a stronger history of jaundice, which is statistically significant ($\chi^2 = 8.62, df = 1, p = 0.003$)
Test for Hepatitis B Tested No test [Not recorded] [Total]	 85 (85%) 4 (4%) [11(11%)] [100(100%)]	 71(91%) 1 (1.3%) [6 (7.7%)] [78(100%)]	There is a high level of test requests recorded for both groups, which reflects the routine nature of such tests in the clinic. There is no significant difference between the groups. ($\chi^2=1, df=1, and the p = 0.259$)
Result of Hepatitis . B test Positive Negative [No test or record] [Total]	 32 (32%) 50 (50%) [18(18%)] [100(100%)]	 45 (57.6%) 25(32.1%) [8(10.3%)] [78(100%)]	57.6% of the MQF cohort are sero-positive for the Hepatitis B virus, as compared to 32% of the TC cohort This is statistically significant ($\chi^2 = 9.64, df=1 and the p = 0.002$)
Test for Hepatitis .C Tested No test Not recorded Total	 14 (14%) 5 (5%) 81 (81%) 100	 6 (7.7%) 2 (2.6%) 70 (89.7%) 78	The routine testing for Hepatitis had only been introduced into this service in 1994? Therefore there are too few recorded to make any comment.
Result of Hepatitis C test Positive Negative Not recorded Total	 12(12%) 1 (1%) 87 (87%) 100	 6 (8%) 1 (1.3%) 71 (91%) 78	See comment above. There are only 20 records of Hepatitis C tests between the two cohorts of which 18 are sero-positive. This is an early indication of the high level of hepatitis infection amongst injecting drug users.

Table 7.40: continued.

Test for HIV	Trinity Court cohort	MQF cohort	Comment
Tested No test [Not recorded] [Total]	48 (48%) 7 (7%) [45 (45%)] [100]	53 (67.9%) 02 (2.6%) 23 (29.5%) 78	A greater % of MQF has been tested, but this is not statistically significant. (<i>chi2 = 3.025, df = 1 and p = 0.082</i>)
Result of HIV test Positive Negative Not recorded Total	20 (20%) 27 (27%) 53 (53%) 100	41 (52.6%) 12(15.4%) 25 (32.0%) 78	There is a significant difference in the level of HIV infection recorded in the two groups. 52.6% of the MQF group are HIV positive as compared to 20% in the TC group. (<i>chi 2 = 12.68, df = 1, p < 0.001</i>)
Drug use in pregnancy Positive Negative Not recorded Total	7 (35%) 4 (20%) 9 (45%) 20	12(63.1%) 01 (5.3%) 06(31.6%) 19	There are more women who had a recorded history of drug use in pregnancy in the MQF group but the numbers are too small to be of any significance.

Comments:

53% of the MQF Cohort tested positive for HIV compared with 20% of the Trinity Court Cohort. However, for 53 of the 100 of the Trinity Court cohort there was no record of any test or result. Therefore 20 of the 47 of the Trinity Court cohort, who were tested for HIV infection and for whom there are documented results, tested positive (43%).

41 of the 53 of the MQF group were HIV positive (77%).

More females in the MQF Cohort used drugs during pregnancy.

Table 41: Deaths

Deaths	Trinity Court Cohort	MQF Cohort
Yes	14 (14%)	14(18%)
No	30 (30%)	31 (40%)
Not recorded	56 (56%)	33 (42%)
Total	100(100%)	78 (100%)
Year of death		
1985-1989	3	2
1990 -1995 inclusive	7	10
Year not recorded	3	2
Total	14	14

Summary

The medical records held in Trinity Court Drugs Treatment and Advisory Centre show that the MQF cohort is slightly older than other Dublin opiate users who attended the service in 1985. The gender breakdown is similar. The MQF Cohort are less likely to have left the country since 1985, more of them are married. They have more children, are less likely to be employed and a greater percentage hold a prison record.

The members of the MQF group were known to the Drug services from an earlier time, and are more likely to have attended over a fifteen-year period. They were more likely to have used illicit drugs, used them at an earlier age, and they were more likely to have used heroin at an earlier age.

Medical history:

More of the MQF group gave a history of jaundice and more had been tested, and were positive for Hepatitis B. Only a small percentage of both groups were recorded as having had a blood test for Hepatitis C. Those who did test were more likely to be positive for the Hepatitis C virus.

More females from the MQF group gave a history of drug use during pregnancy. There were an equal number of deaths recorded in both groups, however in both groups there are large numbers where there is no record.

Forty percent (40%) of the Trinity Court cohort have not attended since 1985, and 24% of the MQF cohort have not attended since this time.

Study 3: To compare and contrast the experience of the index cohort to others from the same community, within the same age range, who were non-drug users in and before 1985

The objectives of this study are to establish any differences between the index cohort (MQF cohort) and an age-matched sample of non-opiate users drawn from the same community (comparison cohort). The population of Merchants Quay F Ward, between the ages of 15 and 34 years, is 984 persons in 1986, according to the census figures. (C.S.O.1986)

The comparison cohort is made up of all the non-opiate users, within the same age range as the index cohort, from the Merchants Quay F Ward who attended the author's medical practice in 1985. This numbers 201 persons, that is 201 of 984 or 20% of the Ward population between the ages of 15 and 34 years attended the author's practice in 1985.

Table 7.41: This table compares the socio-demographic characteristics of the MQF cohort (cases) the comparison cohort (non-opiate users) and the census figures (1986) for the MQF Ward

(See overleaf)

Table 7.41: Comparison of socio-demographic characteristics of MQF cohort, comparison cohort and the Ward (MQF).

	MQF cohort cases (%)	Comparison cohort non-opiate users '85 (%)	Ward Census figures 1986 (15-34 years)
Total	82 (100)	201 (100)	984 (100)
Male	62 (76)	103 (51)	402 (41)
Female	20 (24)	98 (49)	582 (59)
Age	1985	1985	1986
15-24 years	47 (57)	93 (46)	472 (48)
25-34 years	35 (43)	108 (54)	512 (52)
Employment			
At work	10 (12.2)	70 (35)	420 (42.6)
1 st job seeker	6 (7.3)		39 (4)
Unemployed	50 (61)	73 (36.3)	205 (21)
Student			102 (10)
House duties	15 (18.3)	45 (22.3)	204 (21)
Unable to work	1 (1.2)	4 (2)	14 (1.4)
No record		9 (4.4)	
Marital status	1985		1986
Single	61 (74.4)	*	596 (60.6)
Married	12 (14.6)	*	357 (36.3)
Separated	8 (9.8)	*	30 (3.0)
Widowed	1 (1.2)	*	1 (0.1)
Total	82 (100)		984 (100)

*There are no accurate figures for this comparison cohort for 1985 or 1986.

The marital status of individuals has been updated in their medical records as they attend the practice, and as 60% of this group have attended in the last five years it is not possible to be certain of their status in 1985.

The majority of the comparison cohort, that is 180 of the 201, had an address in St Teresa's Gardens, the local authority flat complex in the Ward. All were from the Ward. Eighty-one of the 82 opiate users from the MQF cohort also had an address in

St Teresa's Gardens. The majority of both groups came from the same community within the Ward, that is St Teresa's Gardens and therefore shares the same socio-demographic profile.

In the comparing the three groups the male to female ratio is closer in the comparison and the census figures ($\chi^2=7.37$, $df=1$ and $p=0.007$), however these two groups are significantly different to the ratio pertaining in the MQF cohort group. ($\chi^2=14.22$, $df=1$, $p< 0.0001$). This probably reflects the fact that young males are greater risk takers than their female peers.

General practice workload studies have shown that there is a higher attendance rate amongst females than males in this age range (Fry J. 1979). However attendance rates are not the same as registration and it might be that the higher percentage of males in the comparison cohort compared to the census figure is more a reflection of the particular GP practice patient profile. This practice had a large number of patients, over 3,000 who are covered by the General Medical Services. The majority of its workload is made up of patients entitled to care under this scheme. By definition they are of low income and have a higher level of medical and social morbidity than do the rest of the general population. The first name on the medical card is the head of the household and so many men would be registered with the practice but would not have attended regularly (Lyons).

Table 7.42: The outcomes of certain key behaviours in the MQF cohort and the Comparison cohort

	Merchants Quay F Cohort	Comparison Cohort
Opiate drug use	82 (100%)	8 (4%)
HIV infection	51 (68%)	2 (1%)
Mortality	27 (33%)	4 (2%)
Total	82 (100%)	100 (100%)

Eight individuals, out of the comparison cohort, have a recorded problem with opiate drug use since 1985. One female used opiates occasionally in 1984 but was not identified in the original study. The other seven started drug use since 1985 (5 females, 2 males)

Only two persons from the comparison cohort are known to have HIV infection. The source of HIV infection in the first case is most likely to be through the sexual route, as this man has a history of sex with other men. The second case was probably infected through injecting drug use.

Four of the comparison cohort (2 males and 2 females) is known to have died by 1995. Both females died of neoplastic disease, one male from acute ischaemic heart disease and one committed suicide.

Summary

The total number of persons with detailed records from the comparison cohort and the index cohort amounts to 283, all in the age-range 15 year - 34 years.

There were 984 persons in this age range in the Ward in 1986 (Census figures 1986). This represents 29% of the Ward population (age range 15-34 Years).

The majority of the comparison cohort and the index cohort (MQF cohort) all lived in the one local authority-housing complex and therefore share certain social and physical influences. However their experience with drug use, HIV infection and mortality are markedly different. The markedly increased level of HIV infection and mortality in the index cohort (MQF cohort) result from injecting opiate use.

Conclusion

The high levels of HIV infection and mortality in the MQF cohort are as a result of injecting drug use.

Chapter 8

Discussion

“Science is always a socially negotiated and socially interpreted endeavour.”

‘We should be aware that sometimes underneath (the cool description of scientific research and its brilliant discoveries, there are intense human dramas.’

Peter Gould (1993). “The Slow Plague”

The thesis describes the emergence and consequences of illicit drug use in one Dublin community between the years 1979 and 1995. It comprises of a longitudinal descriptive study (study 1), which is supported by two comparative studies; which compares the study cohort with other Dublin drug users (study 2) and a community based cohort (study 3). The research was undertaken by a general practitioner and is the only such study executed in the Irish context. The researcher’s position as a general practitioner, actively serving the medical needs of this community and those adjacent to it, brings a unique perspective to both the recognition and identification of the major factors associated with what has been described as an “epidemic of heroin use”. (Dean G. (ii) 1985) To understand how this study adds to the body of knowledge and understanding of problem drug use within Dublin it is necessary to recognise the unique role of the general practitioner within the practice of medicine. Further it is important to recognise the potential of the research methods used to ask significant questions of people and conditions, not immediately available to other researchers but accessible through the particular vantage point of general practice.

The Work of General Practice

In 1974 a group of family doctors drawn from the academies of general practice from twelve European nations met in Leeuwenhorst to describe the work of the general practitioner or family doctor as follows:

“The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique...”

The document then describes this work and where it takes place, it continues:

“Prolonged contact means he (the GP) can use repeated opportunities to gather information at a pace appropriate to each patient and to build a relationship of trust which he can use professionally...”

Finally:

“He will recognise that he has a responsibility to the community.”

The Leeuwenhorst description has been followed by a statement from the World Organisation of National Colleges, Academies and Academic Associations of general practice/family physicians (WONCA 1991) and by the Royal College of General Practitioners which published a report “The Nature of General Practice”(RCGP 1996). These statements reflect the changing nature of general practice, however the Leeuwenhorst definition is still closest to the reality of Irish general practice. The Leeuwenhorst description, of which only selected parts are reproduced here, is still widely accepted within Europe as the definition of the work of general practitioner (Leeuwenhorst 1974).

The selected parts quoted above show that general practitioners, through their work over many years with individuals and families from a defined geographical area, are in a unique position to witness the unfolding of ill-health and disease from its earliest manifestations through all stages until resolution or death. The GP is also witness to the psychosocial effects of illness on the individual, his or her family and its effects on the wider community. Therefore the general practitioner is able to bring a unique perspective to the epidemiology of certain diseases and disorders. Marinker in an article on “Medical Practice” in the British Medical Journal states:

“The medicine of general practice has to be most closely applied to the configuration of the culture which it serves.” and further *“ general practitioners (who) work on the boundary between clinical manifestations and the idiosyncratic life of our individual patients”* (Marinker 1983).

This study is an individual general practitioner’s observations on the problems caused by illicit drug use first seen in his practice in 1979 and systematically recorded since that time. The main study instruments used were two similar questionnaires collected at two different time periods, ten-years apart.

Research in General Practice

Individual general practitioners have made significant contributions to various aspects of medicine through simple observations over long periods of time. William Budd, a country family doctor first described typhoid fever in 1873 (Budd W. 1873). James Mackenzie (1853-1925) a general practitioner, who practised in Burnley in the heart of the industrial North of England at the turn of the century, described many conditions affecting the cardiovascular system. He did this by careful observations, over many years, which he recorded and published in peer reviewed medical journals. He received the acclaim of the profession and was rewarded with a position in the prestigious Edinburgh medical faculty, his alma mater, and further was appointed “Physician to the Queen in Scotland” (Mackenzie J. 1916).

William Pickles was a country general practitioner who served a group of three small villages in rural Yorkshire from 1913 until he retired in 1964, six months before his eightieth birthday. He made meticulous notes of observations on a number of common infectious diseases, their incubation period and routes of transmission, over his lifetime in general practice. His book describing this work has become a medical classic. In the book he describes the work of a general practitioner as follows:

The general practitioner is in the forefront of the battle and his experience must necessarily be personal and vital. No consulting physician can ever have the opportunity to follow the whole course of such a disease as epidemic myalgia in the same way as the general practitioner, because of the latter’s more intimate association with his patients.” (Pickles W. 1939).

William Pickles became the first President of the Royal College of General Practitioners (London) in 1953. He was so honoured by his peers in recognition of his seminal work. Another general practitioner W.G. McBride, practising in Australia, first pointed to the link between congenital abnormalities in newborn babies and the ingestion of Thalidomide by their mothers during pregnancy. His suspicions and observations were reported in a letter to the Lancet in 1961. (McBride, W. 1961)

“There is a long tradition of recording morbidity in British general practice, which has produced impressive evidence about the frequency with which different sorts of

illnesses are met by doctors in the community, and we can relate these to base populations, so that we may calculate crude measurements of incidence and prevalence". (Marinker1983)

Records of patient's consultations, made over many years by general practitioners, have long been recognised as a potentially rich source of morbidity data. (Fry J.1979 Hodgkin K.1978). Several studies have collected information from large numbers of general practitioners over long time periods resulting in the accumulation of very significant material, which has contributed to the knowledge about particular conditions, and the impact of certain treatments on the community. The best known of such studies is the RCGP study on the combined contraceptive pill usage by women attending general practice. This study was first started in 1970 and is still collecting data. (RCGP 1974)

General practitioners are the main source of data for the National Morbidity Survey in Britain, these annual surveys have added greatly to the understanding of ill health in the community. (McCormick A.1995)

General Practice research into problem drug use

In Britain, following the Brain Committee's recommendations of 1965, general practitioner involvement in the treatment, maintenance and care of drug users was effectively halted (Stimson & Oppenheimer 1982). The subsequent Dangerous Drugs Act of 1967 gave legislative effect to the Brain Committee's proposals and led to general practitioner involvement being actively discouraged and their role reduced to one of referring problem drug users to the drug clinics which were run by specialists, usually psychiatrists. These clinics largely offered detoxification to the addicted drug users; there was little maintenance treatment offered. (Glanz A. 1994) In Ireland two services developed; the Drugs Advisory Treatment Centre sited in Jervis St Hospital in Dublin which offered medical care and the Coolmine Therapeutic Community which offered social and psychological support within a 'therapeutic community', modelled on the 'Day Top' organisation in America. Both these services advocated 'abstinence' as the long-term answer to the drug use problem. (Butler S. 1991).

This type of clinic based care for problem drug users was different to the care offered in the 1950's and 1960's by general practitioners and other doctors. It was more

concerned with controlling the levels of addiction in society and less concerned in responding to individuals wants or needs, that is it was more public health control than personal care. Through the 1950's and early 1960's the addicts were largely middle-class and were addicted usually as a result of therapy prescribed by doctors. However by the mid-1960's the number of heroin users had greatly increased and now constituted a "*distinct sub-culture within society*" (Glanz A. 1994). Prior to the Dangerous Drugs Act doctors were free to prescribe with few controls, after the Act the clinics took over the responsibility for treating addicted patients. The new treatment system was geared to "*social control of the addiction*" (Stimson & Oppenheimer 1982). This clinic based system worked reasonably well up until the late-1970's because as Robertson puts it there was in reality "*little problem - little service*" (Robertson R. 1994).

Throughout the 1970's the drug problem increased slowly in Dublin, but was not of obvious concern to the authorities, although it was apparent and alarming to local community activists (Bowden M. 1982). However by 1979 there was a definite, visible and growing problem, which rapidly escalated over the next few years. This can be deduced by the increasing number of people charged with possession of heroin and the numbers attending the drug treatment centre. See table 8.1 below:

Table 8.1 Persons charged with heroin offences and persons attending drug treatment services by the year (1979 - 1981).

Year	Persons charged with heroin offences	Persons with heroin problems attending drug treatment centre
1979	5	55
1980	47	213
1981	177	417

(Dean G. et al 1983)

The number of persons charged with possession of heroin increased from five to 177 in two years, an increase of 35 times. The number attending for treatment at the only drug treatment centre in the country increased from 55 to 417 in the same period, an increase of eight times.

A similar picture was emerging in Edinburgh when the numbers of injecting drug users rose: “*from 50 or so to several hundred by 1979*” and as in Dublin the treatment services were: “*unprepared and overloaded for the sudden demand for support*” (Robertson R. 1990).

In Edinburgh legal sources of injecting equipment had been available through a number of pharmacies, however, in line with recommendations from the Pharmaceutical Association, these outlets ceased to supply drug users - the last supplier closing in 1982 (Robertson R.1994). In Dublin the drug users supply of clean injecting equipment was obtained mainly from break-ins to pharmacies or from the casualty departments. There was no experience of pharmacists selling injecting equipment to drug users prior to the 1980's; however during the early 1980's one or two pharmacies began to sell small amounts of injecting equipment to drug users (Boles J. 1997). In both cities a culture of injecting drug use was growing in the absence of any reliable supply of sterile injecting equipment.

Robertson has documented the Edinburgh experience with drug use problems from a General Practitioner perspective. He practises in one of Edinburgh's deprived working class areas, an area and a community very similar in profile to the one described in this Dublin study. The author has visited Dr Robertson's practice and observed the obvious similarities between the two communities. Robertson's principal contribution was to establish a cohort of 203 drug users attending his practice in 1985 and to follow them since that time, He reported on this study in 1994 (Robertson R. 1994). Other Scottish general practitioners have also published studies on drug users attending their service, Neville et al reported on three general practice's experience in Dundee and Gruer et al have also reported on methadone maintenance in Glasgow (Neville RG.1987, Gruer 1997). Cohen et al described the profile of 150 drug users presenting to a central London general practice and their management between 1988 and 1990 (Cohen 1992). Martin et al in Bedford reported on 192 patient presenting to their practice with drug use problems, the practice having been involved in offering maintenance and general care to drug users since 1986 (Martin E.1998). At the recent world conference hosted by the World Organisation's of National Colleges and Academies of general practice (WONCA) in Dublin (June 1998) there were a total of 17 presentations, from seven different countries, by general practitioners on various aspects of their work with problem drug users (WONCA

1998 abstracts). Further, there were another 11 presentations on aspects of HIV care in general practice, many of these papers referring to HIV infection in drug users, (ibid). Therefore it can be concluded that general practitioners have been offering care to drug users and reporting on this care since it became apparent that there was a growing problem in the late 1970's. Often this care was offered in the absence of adequate statutory services and sometimes GPs were the only doctors offering care. This care was often given against the wishes and advice of other sections of the medical profession and opposed by them. General Practitioners have also been involved in treating people with HIV disease, often before secondary services were instituted, and have recorded their work in the medical journals. This was certainly the case in Ireland (Bury G. 1989, 1991),

“A subject is constituted by its research, and this research in turn determines the boundaries and configurations of the discipline.” (Marinker 1983).

In summary one of the essential components of any academic discipline is that it is capable of sustaining research into its own area of expertise. This research is essential for the critical evaluation of accepted knowledge and practices. General practitioners, by the nature of their work, have a close relationship and frequent contacts with their patients, and are therefore ideally placed to observe the natural history of disease or conditions as they arise in the individual and in the communities they serve. There now exists a substantial international literature of original research from general practice that exploits the opportunity of longitudinal research. Further there is now a growing literature, emanating from general practice, from those who have been involved in all aspects of care of drug users. The results of these studies have challenged what was accepted 'best' practice and accelerated change in the care and our understanding of the nature of problem drug use. The present study is an important addition to the literature, especially in the Irish context, as it is the first community based study in Ireland to address the problem of drug use in a defined community. The study looks to identify a 'hidden population'; that is one not obviously known to or easily accessible to the drug treatment services.

Methodological considerations:

“ history is nothing more than (he thin thread of what is remembered stretched out over a sea of what is forgotten.” (Milan Kundera 1965. The Joke.)

Self-reported drug use: The question of the reliability and validity of interview data obtained from ‘deviant populations’ has exercised the minds of many in the social sciences. Deviant refers to any population whose behaviour is illegal or so different to their peers that the behaviour or activity is covert. Two differing views are advanced: Firstly that “deviant’ groups especially those involved in illegal activities will deny or underreport these activities or behaviours (Becker H. 1963). Secondly that in the appropriate setting, with a skilled interviewer, the respondent will accurately report illegal activities and behaviours (Diskind MH. 1964). Non-medical problem drug use is, by its nature, illegal and therefore those who engage in this activity, and who do not attend a treatment facility, are not available to the usual research methods and instruments. Therefore self-reports are often the only practical means of assessing behaviours (De Irala et al 1996).

Several studies have evaluated the reliability and validity of self-reported drug use (Ball J. 1967, Brown J. 1992& Hyser Y. 1992). Most of these studies agree that drug users can be reliable informants of their own drug use history if interviewed under the right social conditions and that these are ones familiar and agreeable to the interviewee. Further that the interviewer is knowledgeable about problem drug use and acceptable to the interviewee and finally the interviewer should use a structured questionnaire to be consistent and ensure that important questions are asked of all respondents. Ball, writing on this subject, states:

“they could recall events often to twenty years ago with surprising accuracy” and “# appears that the first shot of heroin or the first felony arrest were drastic events in the addicts life” (Ball J. 1967).

In a review article “A digest of memory phenomena for addiction research” Hammersly states:

“It is often impossible to observe substance use over time in its natural setting; even when possible observation may alter behaviour. Available objective indices of use do not provide details of use pattern over time. Furthermore, some addiction issues are not amenable to experimental study. Thus self-reports are likely to remain an essential research tool.” (Hammersly R. 1994).

He points out that self-reported data can produce an over estimate (Skog O. 1993) or an under estimate (Poikoinen K. 1983) of substance use.

However, he recognises: -

“Studies that have attempted to validate self-reported data, have in general found self-reports are reliable and often to be more complete than most objective sources, such as hospital or police records.” This supported by Collins et al study (Collins JJ. 1983). Further he adds that if possible:-

“independent contemporaneous sources should be used for verification”. And importantly *“that research using self-reported data understands the limits of such data.”*

Korf in his published thesis “Dutch Treat” details two cohort studies, one among “Foreign daily opiate uses” in Amsterdam and the second “Heroin Tourists field studies”. He describes in detail the methodology used to establish these cohorts and their subsequent follow-up over time, that is one to two years. Self-reported reliability was tested for “source-demographic variability” and “criminal career” and found to be high in both studies. Further he found that reliability for income and expenditure: *“correspond to each other with sufficient consistence”* (Korf DJ 1995).

However consistency in drug career variables was on the low side, but if a one-year margin is allowed: *“it is enough to satisfy the requirements very well”*.

The reliability of self-report of specific HIV risk drug behaviour has been established in at least two studies (McElrah K. 1994, De Irla J. 1996). However Kokkevi found self-report for drug use behaviour was reliable but that HIV and hepatitis sero-status were reported less reliably than most other studies (Kokkevi A. 1997).

The current study must be measured against the criteria outlined above to determine its validity and reliability. In this study there are fifty pairs of questionnaires available for comparison, completed one decade apart. The questionnaire used in 1995 is based on the 1985 version but with new questions covering additional areas (Appendix 2). However there are 23 key questions which are common to both questionnaires covering such topics as personal characteristics, education, prison record, family, medical and drug use history with special reference to drug use in pregnancy. -

Twenty-seven (54%) of respondents gave an identical set of answers in 1995 to those in 1985, or their answers were consistent with time. The only question where there was a sizeable disagreement in the answers on the two questionnaires was ‘the history

of drug use', with seven (14%) respondents giving a history of 'first drug used' as cannabis in 1985 and as heroin in 1995. This difference could be due to memory lapse, as there would be some difficulty remembering events back as far as twenty years ago. Further cannabis smoking has been regarded as a fairly harmless recreational activity for many years; a drug that causes few if any serious problems and therefore the respondents might not have thought it worthy of note (Bretcher EM. 1972).

Sixteen (32%) other respondents gave their 'age of first heroin use' as being younger in the 1995 replies than in the 1985 ones. This again might be due to difficulty in remembering accurately an event so far removed in time. Alternately that respondents in 1995 may have mistaken the date of their "first illicit drug¹ use (any drug including cannabis) for their "first use of heroin", that is the question could have been interpreted differently by the respondents than intended by the questioner. In 1985 the public perception was that the opiate use problem in Dublin was a recent phenomenon and so possibly the interviewees responded to what they thought the researcher might want to hear - that is 'acquiescence bias' and therefore gave a more recent date of drug use onset. Three (6%) of the respondents who gave different replies in the two interviews were ill at the time of the interview in 1995 all of them had advanced HIV disease, and this might have had an effect on their ability to recall events with accuracy. Each of these three respondents gave two or three answers that were at variance with prior answers. In all other cases there was only one answer that differed in the two questionnaires. The researcher did not bring the first completed questionnaire to the second interview and so was unaware of these discrepancies at the time of the second interview.

The method used in the first part of this study (1985) is similar to other community studies conducted in Dublin, for the Medico Social Research Board, in the early 1980's (Bradshaw J. 1985). It is the first community based study of problem drug use undertaken by a general practitioner in Ireland, The researcher had little difficulty in interviewing respondents once they were located; the interviews took place at a time and place convenient to the respondent, and at a pace and in a manner most likely to put the interviewee at ease. The researcher was initially surprised by the openness and frankness of the replies of the interviewees and their willingness to answer personal questions about themselves and their lives. He was known to nearly half of the group prior to the study, as their family doctor, and was possibly recognised by others as a

local doctor serving members of their extended family. At the end of the interview a number of respondents were asked why they had agreed to be interviewed and it was apparent that they had relative trust in doctors in general, but more particularly with one who worked within the area

Overall there is a high level of consistency between the fifty paired questionnaires taken at a ten-year interval. The figures from this study are similar to those derived from the other studies previously cited, so there is good reason to accept that the replies to these two questionnaires are valid and reliable.

Natural History

In attempting to describe the natural history and consequences of injecting opiate use in this cohort of drug users, it is necessary to recognise certain limitations when attempting to generalise from the study. By its nature this is a study of a select, specific group of drug users identified geographically, demographically and in time. Care was taken to define the group in terms of a known population - that is the study was confined to one district electoral division for which there are population statistics available from the Government Central Statistics Office (CSO 1981).

Eighty-two (80%) out of the identified target group of 103 were interviewed in 1985 and formed this cohort. The number of non-respondents is 21 (20%). There were legitimate concerns that the non-respondents might differ in some important respects from those interviewed; such as in their age range or in their drug career histories. Local community workers, both professional and voluntary, were of the opinion that the respondents and non-respondents were similar in age, family background, social history and drug use history, however, it was felt important that the opinions of these 'key informants' should be supported by an independent source. This independent source was sought through the records of Trinity Court where it was found that 20 of the 21 non-respondents had a record of attendance.

The records of the non-respondents held at Trinity Court support the 'key informants' view that the non-respondents were similar to those interviewed in a number of important respects these being age-range, gender balance address and positive history of heroin use by injection. Therefore it can be taken that the interview group is representative of all the drug users in this community at that time (See page 73). Further the people living in St Teresa's Gardens, despite or because of having many

social and infrastructure problems, formed a tight-knit community with many of its residents being related by blood or through marriage. Three of the key informants who were born in and living within the community had clear insights into all aspects of the community, its people and problems.

It is difficult to be sure that the 103 individuals identified in 1985, who make up the target group, were all the drug users in this community. However local knowledge, derived from key informants of whom the author is one, would support this notion. Further this contention is supported by “Study 2” in which the researcher reviewed a random sample of all the records of people attending the drug services in 1985 in order to identify a comparison cohort of 100 drug users from Dublin, but from outside the Merchants Quay F Ward. Of the 1045 individuals who attended the drug treatment services, in the twelve months of 1985, just under half (n=514) of whom attended in that year with heroin problems. Twenty-six of these 514 patients were from the Merchants Quay F area and were all known to the researcher, that is they were part of the original cohort, so there were no new names identified. Since the time of the first study the researcher has identified only one other person who admitted to heroin use in or before 1985 from his practice records. This person, a female, reported that her drug use in 1985 was only occasional and so she did not come to the attention of the community activists or the treatment services. It is therefore likely that the author identified, with the assistance of other key informants, most if not all the individuals using drugs during the study period.

Heroin Use Prevalence

The 1985 study provides prevalence figures on heroin use within the electoral ward, Merchant’s Quay F, during the period 1979 - 1985. This is based on information from the 82 respondents with a cross analysis using the relevant census of population figures, 1981 (CSO 1981). The study shows the first incidence of heroin use, from within the study group, to have occurred in 1969 and there was a gradual increase in this until 1976 when nine (11%) of the 82 respondents were using heroin. After this time there was a rapid escalation in heroin use amongst the cohort, numbering 66 (80%), by 1981. Thereafter there was a dramatic fall in the numbers of new heroin users, with only four new users in 1982, two in 1983 and none at all in 1984 and 1985.

Therefore by 1979 there was already a very serious heroin use problem in Merchant's Quay F, that is there were 45 regular heroin users in this one electoral ward when the entire case load of opiate users attending the Drugs Advisory and Treatment Centre in that year was 182 (Trinity Court).

Eighty-one of the 82 respondents gave an address in St Theresa's gardens, the only local authority housing in the Merchant's Quay Ward. This is similar to another community-based study conducted in two electoral wards in Dun Laoghaire in 1984 which showed that the majority of drug users in the area either lived in local authority flat complexes or other local authority housing (Power B 1986). Dean et al in their study of attendees at the Drugs Advisory and Treatment Centre between 1979 and 1983, showed that the greatest incidence of "drug abuse" was in the north and south central city area of Dublin. This analysis did not make any distinction between those residents in local authority housing or other, private, housing, however these areas of the city have large numbers of public housing projects which were built in or around the 1950's, to replace the older inadequate tenement buildings (Dean G (i) 1985). The Merchant's Quay F study clearly demonstrates that in Dublin City, the area and type of housing within it, is an important factor in an analysis of heroin use. The social and economic deprivation of inner city communities and the building of large-scale local authority housing estates should inform a significant part of a deeper analysis of Dublin's heroin problem (Joyce & McCashin 1981).

The male to female ratio of 3:1 is similar to that found by Bradshaw's 1985 analysis of attendees at the Drug Advisory and Treatment Centre (Bradshaw J. 1985). However Bradshaw reported a higher prevalence of heroin use amongst females in the age range 15-19 years than in males of the same age in the North Dublin inner-city study. This is not replicated in the Merchant's Quay study for any of the years studied, which shows heroin use in 1979-1981 to be concentrated in the under 25 years age groups. In this study there is a high prevalence in males, aged 15-19 years, in both 1979 and 1981, when the age-specific heroin use prevalence figures were 14.4% and 16.9% respectively. Both these figures are greater than in Bradshaw's study, for the same sex and age groupings, but when the figures for both females and males are combined Bradshaw's age-specific heroin use prevalence figures are greater. This figure is 11.9% whereas then the Merchants Quay F figures are 10.7% and 11.2% for the years 1979 and 1981 respectively.

Significantly, while those under 25 years of age continue to dominate the figures for 'current' heroin users in 1983 and 1985, there is a dramatic decrease in the numbers of persons under the age of 20 years initially using heroin. The age-specific heroin use figure for males, 15-19 years, had fallen to 6.8% in 1983 and to 0.8% in 1985. Clearly after 1981 young people in the 15-19 age group in the Ward did not embrace heroin use to the same extent as their older siblings or neighbours in previous years. There is a clear fall-off in the extent of heroin use within the Ward, which starts sometime between 1981 and 1983. So by the time of the interview in 1985, some 40 (49%) of the respondents claim not to have used heroin during that year and 32 of the 40 had not used heroin for one year or more. The fall-off in the number of first time users begins in 1981 and by 1984 this has fallen to zero. Possibly the researcher failed to identify them but this is not thought to be likely by him or the other informed sources. It is more probable that, by 1983, all the vulnerable youth of the area had already been introduced to heroin; this possibility has been termed "exhaustion of the susceptible", by epidemiologists. (Barry J. 1997) Further the younger siblings of the drug users and their peers could see the damaging effects of drug use and therefore were not attracted to such a life-style. Again it may have been due to a lack of supply of heroin but there is no evidence from police sources of a fall off in supply. (Garda Siochana 1983) Other factors that might have contributed to this fall off in drug use were, firstly that there was a growing awareness in the area of the problems associated with drug use not only for the individual, but also their family and the wider community. Secondly there had been a revival of St Teresa's Gardens Development Committee in 1980, which actively fostered local sporting, recreational and youth development activities. Lastly a government sponsored training course for community/youth leaders was set up in 1982 in order to improve the skills base and the effectiveness of local community leaders.

Alongside the fall in first-time users, between 1981 and 1983, there was also a decline in the numbers who continued to use heroin. This may have occurred for reasons such as change of address, police activities and the raising of public awareness. However, a number of community developments may also have been important in this decline, such as the formation of the 'Concerned Parents Against Drugs' group (1983). This group tried to encourage drug users into treatment but also acted as a vigilante group who targeted those they suspected of drug pushing and expelled them from the

community (Cullen B. 1992). Other developments include the setting up of the Youth Development Project in “The Small Club”, St Teresa’s Gardens in 1983, whose main aim was to offer other local youth alternatives to drug use. Finally there was the establishment of a Drugs Counselling service in St Teresa’s Gardens (1983), by the Eastern Health Board.

There are no specific prevalence figures for The Merchant’s Quay area after 1985 but the researcher is aware that after a fall off in drug use, from around 1983 to 1986, it started to become a significant problem once again. Figures from Trinity Court support this contention and they show a lull and then rise in drug use across the city and in particular in the south inner-city area (Trinity Court).

Changes in the socio-demographic characteristics of the cohort

There are no significant unexpected changes in the socio-demographic characteristics of this group over the decade. More are married, some have separated and others are widowed. There appears to be an increase in the number of the cohort who held employment since the first interview. However most of this increase is probably due to the fact that some of those who died had their status recorded as employed on their death certificates - even though they had not worked at these jobs for any significant length of time or for many years.

Study 1 shows that the cohort has a socio-demographic profile similar to other community studies within Dublin (Dean ‘85 & Power ‘84). The profile is also similar to that reported for attendees at the drug treatment centre in 1983 (Trinity Court). The male to female ratio is 3:1 for this study. The respondents are mostly from large families with concomitant features of material and social deprivation, such as high levels of paternal unemployment, single parent household and high levels of alcohol misuse by one or other parent. There is a history of poor education with only seven remaining in school beyond 15 years of age, and 14 respondents admitting to having poor literacy skills. The employment record is equally poor and this does not change over the decade.

By 1995, 82% of the cohort had been in prison - this was four more than in 1985 with 45% of the cohort having been in prison after 1985. The average length in prison was between three and four years (n=3.4years) for those in prison by 1985. If this is costed

at £42,000 per annum, the cost of one years confinement in 1994 (Dept of Justice) this amounts to a £10 million bill for the State.

The profile of the cohort is very similar to that of Mountjoy prisoners interviewed by O'Mahony in 1986 and again in 1996. O'Mahony points out that:

“the prison population comes from five specific areas of Dublin noted for severe levels of socio-economic and cultural deprivation and for other problems such as drug abuse and chronic unemployment”

One of those areas referred to by O'Mahoney is the south inner city, an area that includes the Merchants Quay wards. He also found that one major difference in the prison populations in 1986 and 1996 was as a result of drug use:

“the great increase in the number of prisoners with severe drug problems” (O'Mahoney 1996).

The similarity of the profile of the Merchants Quay F cohort to that of the Mountjoy prisoners is therefore not surprising as many of the Merchants Quay F cohort were in prison at the time of O'Mahoney's study.

Drug Use

All 82 of the cohort gave a history of opiate use by injection, however 40 (49%) reported that they had stopped using for at least a month when interviewed in 1985. This figure looked promising in 1985, however 63 (77%) of the cohort had used heroin between 1985 and 1994 with 29 (35%) used during 1995. As some of this cohort had died by 1995 this figure of 35%, if measured in terms of those who were interviewed (n=50), would be much higher at 58%. That is 58% of the survivors interviewed were still using some form of opiate in 1995. Twenty-four of the 50 were on a methadone programme and the other five were using 'street' drugs only. These figures support the World Health Organisation's contention that opiate addiction is “*A chronic relapsing condition*” (WHO).

Only 16 (20%) of the cohort were abstinent between 1985 and 1995. Ten of the 40 respondents abstinent in 1985 were still abstinent in 1995, two of these 10 having tested HIV positive, one HIV negative and the other seven had not tested or not returned for test results. All the respondents who had not tested were offered tests by the researcher, at the time of the 1995 interviews, to be done then or at a time convenient to them - all declined. However it is probable that these seven people are

uninfected by the HIV virus as they all had stopped drug use before 1983 when it is thought that the HIV virus was introduced into the drug using community in Dublin (Hillery I 1990).

The picture that emerges from the study is one of long-term opiate addiction in the majority of this cohort, with only 16 of this cohort able to be drug free for the decade between interviews. Further only nine of these 16 give a history of being free of any infections or other physical problem.

Mortality

“The morbidity and mortality associated with illicit heroin use result principally from the chemical and microbiological contamination of injected substances and accidental overdose which is a consequence of the uncertainty of street-drug concentrations.” (Wolk J et al 1990).

Numerous studies from both Europe and America have shown mortality among heroin users to be much higher than amongst their non drug-using peers, by as much as 10 to 30 times (Perucci C. et al 1991, Eskild A. et al 1993). Korf cites papers from Germany, Denmark, Sweden and Netherlands, which confirm these high death rates amongst heroin users (Korf D 1995). Studies of cohorts of drug users seen in general practice vary in the mortality rates. Robertson an Edinburgh general practitioner recruited a cohort of 203 drug users between 1980 and 1985 from within his practice area. This cohort has been followed up since that time and when re-interviewed it was found that there had been 40 (19.7%) deaths in the 10 years from 1982. Fifteen of these deaths were attributed to overdose and 16 due to AIDS related deaths, the other nine deaths are not attributed (Robertson R. 1994). Two other studies from general practice, one in London (Cohen 1992) and one in Bedfordshire (Martin 1998) give death rates of 2% and 3.8% respectively.

The present study, the only one undertaken in Irish general practice, shows the mortality over the 10-year period is 27 (32%). Of interest in the period from 1995 to the end of 1998 a further four of the cohort died that is a total of 31 (38%) of the original cohort of 82 persons. This figure is much higher than other general practice based cohorts. However, there are important differences - the cohorts in the British studies were all practice based. All the patients were recruited from their own practice population and each of the practices offered methadone substitution as a treatment for

the heroin dependent patients. In contrast the Merchants Quay F study is a community based, not practice based, study even though 68 of the cohort at one time had become patients in the researcher's practice. Further general practice based prescribing and community dispensing was not adopted as Health Board policy until 1996. Prior to 1996 and certainly throughout the 1980's the medical profession as a whole, and particularly those doctors working in the drug services, actively discouraged general practitioners from prescribing opiates for maintenance purposes (Kelly M.). As the extent of the HIV infection amongst drug users became apparent and the obvious potential public health risk emerged a more pragmatic approach was adopted. This was some 12 years after the U.K. Advisory Council on The Misuse of Drugs (A.C.M.D.) reported that "the spread of HIV is a greater danger to the individuals and public health than their drug misuse" (ACMD 1988)

In the Merchants Quay F study, 14 (52%) of those who died did so as a result of HIV disease. This compares with 16 (40%) in the Edinburgh cohort. The last report on the Edinburgh cohort was at the end of 1993 so that it is probable the death rate by 1995 had risen and may have moved closer to that found in this study. Table 8,2 compares the mortality in the Edinburgh and Dublin groups, both drawn from general practice.

Table 8.2: Mortality and HIV in the Dublin and Edinburgh GP Based studies

Numbers	Dublin 1985 - 1995	Edinburgh 1982-1992
Cohort numbers	82	203
HIV positive	51 (62%)	98 of 180 (54%)
HIV related deaths	14 (51.9%)	16 (40%)
Deaths from overdose	7 (25.9%)	15 (37.5%)
Other deaths	6 (22.2%)	9 (22.59%)
TOTAL	27 (100%)	40 (100%)

The 'condition' or cause of death on the death certificate states AIDS, HIV or, immuno-suppression in only four (14.8%) of cases; although it is known that 20 of the cases were HIV positive at the time of death. Fourteen of these (20) deaths can be assigned to HIV disease when the 'condition' on the death certificate is read in conjunction with the known HIV sero-status. This anomaly has serious implications for further research, as it is clear that death certification of HIV disease is not

accurately recorded. When the first deaths from HIV disease or AIDS started to occur soon after 1985, family and friends were horrified at the possible stigmatisation and its consequences of this diagnosis being known. A death certificate is a public document and anyone is entitled to access the information on such a document. So individuals and voluntary groups who provided help for persons with HIV infection brought pressure to bear on individual physicians and the statutory health authorities. It was therefore, agreed in consultation with officials from the Department of Health (DOH), that a physician could write some condition related to HIV disease but avoid writing the term AIDS or HIV disease in order to spare relatives and friends the embarrassment of such terms. However the physicians agreed to notify the Assistant Chief Medical Officer (DOH) of the death, the cause of death but with the name of the individual withheld. In this way the Department had accurate figures on deaths from HIV disease but parents and relatives were saved the embarrassment of such labelling (Mulcahy F 1998). This practice has now largely ceased and death certificates, where appropriate, use the appropriate diagnosis. It should be noted that whilst it is the usual practice for relatives to notify the civil authorities of the death of a family member by registering the death, there is no statutory obligation to do so in Ireland, as is the case in Britain.

HIV Infection.

The levels of HIV infection in different cohorts of injecting drug users vary enormously. On a national scale it is low in such countries as the Netherlands, Germany and Britain, and high in southern European countries such as Spain and Italy (EMCDDA1997).

The level of HIV sero-prevalence also varies from city to city being high in Edinburgh, low in Glasgow, low in London but high in New York.

Table 8.3 below shows the percentage of all AIDS cases related to injecting drug use across Europe. As can be seen there is a wide variation from 3.8% in Greece to 65,8% in Spain. The figure for Ireland is 43.8%.

Table 8.3: Percentage of Aids cases related to injecting drug use in EU countries

Country	% all AIDS cases related to injecting drug use
Austria	26.2
Belgium	6.5
Denmark	8.1
Finland	4.0
France	24.0
Germany	14.0
Greece	3.8
Ireland	43.8
Italy	63.5
Luxembourg	15.5
The Netherlands	10.6
Portugal	40.4
Spain	65.8
Sweden	11.6
United Kingdom	6.4

Fifty-one (62%) of the Merchants Quay F cohort have a clinical record or laboratory evidence of HFV infection. This rate is very high and compares with Edinburgh (54%) as one of the highest levels of infection. However this rate does not appear to be representative of the Irish or Dublin figures as the estimate of HIV infection in drug users in Dublin is of the order of 15-30% (Bury G. 1989). There are a number of possible explanations for this discrepancy, the first is that this cohort comes from one small area and within that area is concentrated in one Local Authority housing complex. Secondly many of this cohort, n=63 (77%), are related through marriage or by blood and therefore, are likely to have had more opportunity to share injecting equipment. Thirdly they are one of the oldest cohorts in the city in that they started to use heroin soon after it became available in Dublin. The Dunne family, a well-known criminal family that was widely believed to have started the importation of illegal or 'street' heroin into Ireland, lived in and around the Merchant's Quay area (Flynn S., Yeates P. 1985). Fourthly, from this and other community studies, it is apparent that it was the norm to share injection equipment in the early 1980's as injecting

equipment was not available for purchase through any outlets at that time. Injecting equipment was only available to people, outside of the medical or nursing professions, through theft from hospitals, pharmacies, Health Board clinics or general practice premises. A similar situation arose in Edinburgh with the closure of the only pharmacy in the city dispensing needles and syringes in the early 1980's (Robertson R. 1994).

However if a broader picture is taken the high level of HIV infection in this cohort may not be so unusual. Merchants Quay F, as stated earlier, is part of an area in the South Inner City of Dublin that has the highest number of attendances at the Drug Treatment Services from any one area. This picture has not changed over the years and this area of the city still has high levels of attendance at the drug services (Trinity Court). Further Keogh from the Garda Research Unit reported in 1997 that the South Central A Garda District which "includes the inner city area of the Coombe, Dolphins Barn and Inchicore" has the highest number of known drug users in any one area. There are 623 individuals from this area known to the local police to have a drug problem; this represents 3.81% of the population aged between 15-35 years. This is the second highest rate within the city. The North Central C District with a small population has 237 known drug users with a population of 3,779 persons, aged between 15-35 years. This is a 6.27% rate (Keogh E. 1997).

Dean reported on three community based studies in 1995 and found that there were high levels of HIV infection in all three areas (Dean et al 1992). This would suggest that within Dublin, in certain areas known to have had a long history of drug use problems, there are populations of older drug users with very high levels of HIV infection. Further that these pockets of high infection are lost when the figures available for the whole city are reviewed. Dublin as a whole has low levels of HIV infection compared to many other European cities.

A comparison of the rates of HIV sero-positivity in the MQF cohort at various laboratories or treatment agencies.

The comparison of recorded rates of HIV sero-positivity of the MQF cohort at various laboratories or treatment agencies shows a marked difference ranging from 29 to 51 individuals found to be HIV positive. The Virus Reference Laboratory has records of

29 of the cohort being HIV positive whereas 51 of the same cohort give a verbal history of being HIV positive at interview in 1995 or from clinical records. In the majority of cases clinical records from the drug treatment services or GP records support their histories. It is important to determine how this difference may arise. When HIV testing became available at the end of 1985 the authorities sought to determine the level of infection in the community in order that they might plan services. As there was little to offer in the way of treatment at that time, except support and symptomatic care it was important to encourage individuals, thought to be at risk of infection with the HIV virus (HTLV3 virus as it was known at that time), to come forward for the testing. Individuals were therefore offered anonymity at the various clinics offering such tests in order to encourage their participation. Three main groups were thought to be at most risk at that time, these being men who have sex with men, patient groups being treated with blood products, especially haemophiliacs, and injecting drug users. Many individuals who tested in the early years used false names, initials, different dates of birth or some other code to protect their anonymity. Bury in his thesis "HIV infection and Irish General Practice" details this at length (Bury G. 1991). It is reasonable to assume that some of the cohort described in this thesis gave different names or used some other identifier at the testing agency to protect their anonymity. Therefore the VRL figures cannot be expected to accurately reflect the prevalence of HIV seropositivity in this cohort as information on identifiers used by the cohort when they tested is not available to the laboratory. From clinical records at Trinity Court it is known that 41 of the 78 individuals who attended that service from the MQF cohort are HIV sero positive. However at interview and, or, from clinical records 51 of the cohort were determined to be HIV positive in the main study described here.

On reviewing the questionnaires of the ten individuals identified as HIV positive from the 1995 study, but not recorded as HIV positive in the Trinity Court records, it is found that five of them tested outside of the country and the other five tested with their GPs or the prison service (see results page 103).

In a study executed in 1992 it was reported that:

"After adjusting/or sample differences in gender, race, ethnicity and age group we found a two-fold risk of HIV sero-positivity amongst community recruited IDU's compared with entrants to drug treatment programmes in Chicago. This demonstrates the importance of examining multiple local sources of serological data

from IDU's and suggests the need to extend surveillance efforts to include IDUs outside treatment settings." (Des Jarlais D 1992).

Therefore this thesis demonstrates that the study and follow-up over time, of a community based cohort of drug users shows a higher level of HIV sero-positivity than is apparent from other sources.

Self reported HIV status amongst drug users from a variety of countries and treatment settings show that there is an under-reporting of HIV status amongst drug users (Donoghue MC 1993, Rhodes TJ 1993, Kokkevi A 1997). Injecting drug users, not in contact with treatment centres are more likely not to have tested and to have a higher sero-positivity, when tested, than drug users in contact with treatment agencies. It has also been stated that relying on HIV prevalence studies drawn from samples of drug users in treatment "may be biased" (Donoghue MC 1993).

The study reported in this thesis is observational and non-interventionist. The participants were not asked for blood or saliva to test for HIV status as it was thought to be intrusive and might have adversely influenced the acceptability of the interview process. This is an obvious shortcoming in that the veracity of the verbal reports of the various virus antibody tests is difficult to determine. This shortcoming is compensated by having such a large percentage of supportive clinical evidence for the verbal reports of sero-status, within the clinical notes, that is there is supportive clinical evidence for 80 of the original 82 respondents. Each of the respondents who replied that they had not tested for HIV or Hepatitis C antibodies was offered the opportunity to so test by the researcher. They all declined to do so at the time although one individual did avail of this offer at a later date.

Other Virus Infections

Fifty-seven (70%) of the cohort are Hepatitis B positive, 51 (62%) are HIV positive and 27 (33%) are Hepatitis C positive. The proportion of the cohort who are Hepatitis C positive is probably much higher than is recorded here as testing for Hepatitis C was not initiated until 1992 and by 1995 only a small percentage of the cohort had tested. In other studies the level of Hepatitis C infection in injecting drug users is very high, approximately 80% in Dublin, 56% in a German study and 74% in a Dutch study (Smyth R 1995, Polyuka S.1991, Von de Hock JA. 1990). Twenty-one (25.6%) of the cohort are infected with all three viruses, that is Hepatitis B, C, and HIV and a

further 21 are infected with Hepatitis B and HIV infection. It can be assumed that the known Hepatitis C levels in this cohort are low because of the low level of testing by 1995, that is only 28 had tested and of these 27 were positive. This means that this cohort have a considerable level of viral infections which will pose further medical problems for the individuals, but also with the potential for infecting partners and relatives in the long-term.

It is apparent that this group has a heavy reliance on hospital and other medical services for treatment of both their problem drug use and its medical consequences. All but one of the surviving cohort (98%) had been an in-patient in the ten years between 1985 to 1995 and 24(48%) of them in the previous 12 months. Their use of services is at a much higher rate than their non-drug using peers. This finding is supported by Bury's study on the use of medical services by a group of HIV positive individuals attending a general practice (Bury G, O'Kelly F. 1989).

Risk Behaviours

Many studies have shown that drug users can and do modify their risk behaviour, especially injecting risk behaviour, when offered methadone substitution treatment. However the best results are obtained from well run methadone programmes which offer support, counselling and medical follow-up as an adjunct to methadone stabilisation, maintenance or detoxification (Farrell M et al 1994). The group under study had modified some of their risk behaviours over time. Twenty-four of them were on a methadone programmes and therefore should not have been injecting, however one third of this number admitted to using street drugs while on such a programme. A small but significant group (n=5) continued to use street drugs and did not avail of any treatment programmes. Sharing of injection equipment in 1995 had fallen significantly (n=8) however more admitted to having shared needles in the previous five years (n=18) - this at a time when the dangers of sharing equipment were well known and when needle exchange facilities were increasingly available (Barry J. 1998). Most of this group who served a prison sentence shared needles and other injecting equipment whilst within the Irish prison system (n=14). The easy availability of drugs and the paucity of methadone programmes within the prison systems do nothing to discourage continuing risky injecting behaviour, in fact the sharing of injecting equipment in prisons has been recognised as a public health risk

and it has been proposed that the prison authorities should actively considering making injecting equipment and condoms available to serving prisoners (Task Force 1996,1997).

Although a significant minority of the surviving cohort were not in a sexual relationship at the time of interview (n=20) all but a few had one or more sexual relationships in the previous ten years (n=48). The level of condom use was low in both male and female respondents. Some 60% of the women reported a change in sexual practices to some less risky ones, compared with 43% of the males however there was still a significant level of risky sexual behaviour. This finding is in keeping with other studies, which show that drug users may and do change injecting practices but are much slower to change sexual practices (Cassin S 1998, Hickey A et al. 1994). The difficulties of effecting behavioural changes in sexual practices to less risky ones has received little attention to date in the Irish context, aside from making condoms available to those who attend drug, HIV or Sexually Transmitted Disease services. Certainly it is an area which needs further study in order to find appropriate methods of achieving sexual behaviour change in HIV sero-positive drug users especially now that the newer treatment regimes mean that treated individuals are going to survive with relatively good health for many years to come (RCGP HIV/AIDS Newsletter 1998).

Is the experience of the Merchants Quay F (MQF) cohort representative of that of other Dublin drug users from the same era?

Seventy-eight individuals from the MQF cohort have a clinical record at the Trinity Court Drugs Treatment and Advisory Centre. A review of these 78 medical records reveals that the MQF cohort is slightly older than other drug users whom attended the treatment centre in 1985, but this is not statistically significant. The gender balance is similar as is the socio-demographic background although the Merchants Quay F cohort are less likely to have been in employment and are more likely to have a prison record, this difference is again not statistical significant. The two cohorts have a similar history of age of first illicit drug use although the Merchants Quay F cohort started to use heroin at an earlier age, again this difference is not statistically significant. However more of the MQF cohort had attended the drug treatment centre

by 1984 than other Dublin drug users, that is 86% compared with 50%. This is statistically significant ($\chi^2 = 28.94$, $df = 2$ and $p < 0.0001$). Most of the Merchants Quay F have a recorded history of jaundice, 52.6% compared with 32%, p value = 0.002, which is statistically significant and more have a record of HIV sero positively, 52.6% compared with 20%, p value = 0.0001 which is again statistically significant. The number of deaths by 1995 in both groups is similar, that is 14% of the Trinity Court cohort compared with 18% of the Merchants Quay F cohort. This is of no statistical significance, however, the numbers are small and the missing data for both groups is high.

It can be concluded therefore that the MQF cohort differs from other Dublin drug users attending Trinity Court in just two respects, that is they started using heroin at an earlier age and first attended the Drugs Treatment Centre earlier. More of them, not surprisingly, became infected with HIV virus. However, in all other respects they are similar. The MQF area of the city was one of the first areas to experience heroin use and this cohort exhibit the problems associated with uncontrolled illegal injecting use of opiates. They are simply manifesting at an earlier stage what probably awaits other groups of drug users in different parts of the city, as time unfolds.

It should be noted that many of those in the comparison cohort did not attend the drug treatment services after 1985. They all gave a history of dependant heroin use and there was only one drug treatment service until 1992, so the question must be raised as to what happened to those who did not return. It is unlikely that this number continued to use illicit opiates and not need the attention of the drug services, nor is it likely that this number of users were treated by general practice. General practitioners had actively been discouraged from treating drug users up to 1996 at which time the Irish College of General Practitioners and Department of Health agreed a protocol to involve GPs in the long term care of drug users. This protocol, together with a fee schedule, encouraged a number of general practitioners that had been treating patients with drug problems, privately, in their practices to enter the names of such patients onto the central treatment list that is held in the Drug Treatment Centre. This list is the direct responsibility of the medical director of the Drug Treatment Centre and is a confidential document. It is possible that many of this comparison cohort have died and that their deaths would be unknown to the drug services, however Dublin is a relatively small city, the drug world is smaller still, informal networks exist and word of the death of an individual would be known to other drug users attending the

treatment agencies. It may be that many have “matured” out of drug use and/or emigrated. Further research, which is beyond the scope of this work, should be initiated to see what happened to these non-returnees. This important piece of research would further inform our understanding of the natural history of drug use.

How do this cohort differ from their non-drug using peers?

A second comparison group of non-opiate users was drawn from the researcher’s practice. All the patients living in the same community (MQF Ward) were selected. This numbers 283 people who attended the practice in 1985 and were all within the same age range, that is 15 to 34 years. None had a history of drug use problems in 1985. However, by 1995, eight had started to use heroin by injection, one of who developed HIV infection. One other male developed HIV infection but did not use drugs. His source of infection is likely to have been through the sexual route as he had a history of sex with other men.

Four of this comparison cohort is known to have died by 1995 that is two males and two females. The two females both died as a result of neoplastic disease, one male from acute coronary heart disease and one took his own life.

The majority of the comparison cohort and the index cohort (MQF cohort) all lived within the one local authority housing flat complex and therefore they share certain social and cultural influences. However their experience with drug use, HIV infection and mortality are markedly different. The markedly increased level of HIV infection and mortality in the index cohort (MQF cohort) result from their history of injecting opiate use.

Drug Policy in Ireland

Official drug policy in Ireland has evolved cautiously, slowly and has largely been reactive rather than pro-active. This is in marked contrast to the speed and scale of increasing drug use over a relatively short time period. The policy has also been changed with little public debate and little explanation of any changes. Butler in a paper read at a “Fourth International Conference on the Reduction of Drug Related Harm” in which he outlined official government policy in the area stated:

“the changes were made quietly, almost deviously but they were at least made”.

These changes in drug policy can be broken down into four distinct periods which mirror the evolving policy or Ireland's, more specifically, Dublin's, drug problem. These phases are the first or early one, the second phase covering the time of the 'epidemic of heroin use' and the third phase covers that period when it was realised that a large number of drug users were infected with HIV. Finally the present phase which deals with the current situation and the services now available. This is shown in table form overleaf, table 8.3. The table is a modified and expanded version of Butler's table (Butler S. 1993). The table above outlines the different phases.

In the early phase the first specialist led drug treatment centre was set up, and was similar to other services in the U.K. at that time (1969). The Coolmine Therapeutic Community was also started soon after this time and the Misuse of Drugs Act 1977 was enacted. This was the first Bill enacted by the Dail in relation to anything to do with drugs. The second phase, the "epidemic of heroin use in Dublin" first became apparent to the Authorities in 1979. However, there was no increase in services but legislation was toughened to increase penalties for drug dealing. This was enacted in the Misuse of Drugs Act 1984.

Table 8.3: Chronological development of drug treatment and HIV services in Dublin

	Early Phase 1968 – 1978	Opiate Epidemic 1979 – 1984	HIV Infection 1985 – 1995	Present Phase 1996 →
Type of illicit drug use	Mainly cannabis, LSD, barbiturates, amphetamines, little opiate use, little injecting.	Mainly heroin and other opiates, when heroin not available. Injecting drug use was the normal method of delivery.	Opiates — heroin, morphine sulphate tablets, buprenorphine and methadone. Some cocaine use. Injecting opiates still the normal pattern.	Opiates - especially heroin and physeptone. Physeptone diverted from the clinics onto the streets. Opiate use outside of Dublin first apparent. Injecting still popular but sharing much reduced. Younger users smoke more heroin. All drugs easily available.
Structures and Philosophy of the treatment services	Two treatment centres. One is a medical model, based on “British Clinic System”. The second is a voluntary therapeutic community, like “Day Top” in the U.S. Both had a total abstinence philosophy.	Two centralised services continue to dominate with limited development of community based services. A small number of GPs try to prescribe for limited numbers of addicts - most stop due to problems - no support. Philosophy of total abstinence still dominant.	HTV antibody testing available Oct ‘85. High levels of infection in two main groups: - gay men and injecting drug users. HTV specialist appointed in 1988. GPs give general medical care until services started. Some harm minimisation strategies and services introduced by Health Board services - limited, very slowly and cautiously introduced.	Condoms made legal in 1993. 2 nd fflV Specialist appointed. Significant development of drug services at local, district and city level. Thirty more beds available for detoxification. At district and community level these services are GP led. Over 70 GPS actively treating drug users in their practices. Closer links between GPS statutory and voluntary services. Still further service development needed. Care is still largely reactive, with little preventative care.

Source: adapted and expanded from an earlier version by Butler (Butler S. 1993)

It was the advent of HIV infection and the realisation that a large percentage of Ireland's HIV infection was related to injecting drug use. That prompted a change in the philosophy behind service provision. This change was slow to emerge in comparison with drug services in Britain where the role of the Advisory Council of the Misuse of Drugs (A.C.M.D.) was influential and persuasive in changing policy. The A.C.M.D issued two reports; "Treatment and Rehabilitation 1982" and "Prevention 1984" which each presented a case for drug policies other than those in which abstinence was the sole aim. Both reports were published before the HIV connection was apparent. Two further reports; "AIDS" and "Drug Misuse in 1988 and 1989" developed this argument stating that

" the spread of HIV is a greater danger to the individual and public health than drug misuse".

Butler in his paper "Drug problems and drug policy in Ireland" (1991) gives a detailed account of the development of drug policy by the Irish Government over a 25 year period. He further explains issues in the paper on "Harm Reduction in the Republic of Ireland 1993", in summary he states:

"the particular circumstances of drug policy making in a society (Ireland) where: -

(i) formal policy making on social and economic issues has generally been seen as weaker than certain, (ii) illicit drug use is of relatively recent origin, (iii) imported harm reduction ideas, despite their perceived value in reducing the transmission of Human Immune Deficiency virus (HIV) appear to run contrary to a communitarian ethic -which, more than in other European societies, is firmly rooted in traditional religious values" (Butler S. 1993).

Throughout this period, change in treatment was initiated by the services involved in day to day care of drug users, but only as needs became pressing. An AIDS Resource Centre sited in a community hospital. The Royal Hospital Baggot Street, began to dispense low dose methadone to a number of drug users. Some GPs became involved in methadone maintenance with the tacit support and some limited resource from the statutory treatment agencies. These changes, from the ground up, eventually pushed changes in policy, which were taken cautiously with a wary eye on the reactions of a conservative society; In 1992 Dean et al reported on the known HIV status of three community based cohorts first identified between 1982 and 1984 (Dean et al 1992). Of the 203 opiate users identified 87 (43%) were HIV positive. If this 87 is expressed

in proportion of those known to have had an antibody test, this becomes 86%. Table 8.4 shows the main findings of the study.

Table 8.4; 1991 follow up of Intravenous Heroin Users originally studied in three community studies in Dublin in 1982 - 1984

Area of the City	Number HIV positive	Number HIV negative	Number Sero-status Unknown	Total
North Central Dublin	31 (22m, 9f)	4 (3 m, 1f)	50 (32m, 18f)	85 (57m, 28f)
South Central Dublin	47 (37m, 10f)	9 (4m, 5f)	26 (21m, 5f)	82 (62m, 20f)
Dun Laoghaire	9 (5m, 4f)	1 (0m, 1f)	26 (19m, 7f)	36 (24m, 12f)
Total	87 (64m, 23f)	14 (7m, 7f)	102 (72m, 32f)	203 (143m, 60f)

This paper and the report of the National Aids Strategy Committee (NASC) in 1992 confirmed the importance of injecting drug use as the largest risk group or category in the HIV prevalence in Ireland. By 1992, 1,156 persons were known to be HIV positive and of these 619 (53%) were injecting drug users (NASC 1992). The most recent phase of service development has been the most dramatic with the Eastern Health Board finally appointing a Programme Manager, with proper funding, responsible for the development of drug services. The reasons for the failure to develop the drug services sooner are complex and varied but would include the services being overwhelmed by a sudden emergence of a large number of drug users (1979-1983) with marked addiction and medical problems. The Courts also used me drug service as a reference point for offenders claiming drug problems before the Courts. This sudden explosion in work, a policy of complete abstinence as the treatment goal and a conservative management team, including its two medical directors meant that the service was slow to adapt to the changing nature of the drug problem. All these factors taking place within a rapidly changing society are some of the reasons why the Health Board had to step in and put in alternative services. The Irish College of General Practitioners and the Eastern Health Board agreed a policy for the inclusion of general practice in the care and maintenance of drug users in primary care. This involves GPs maintaining stabilised drug users on methadone within their practice to an agreed protocol. GPs undertake specific training run jointly by the I.C.G.P. and the Eastern Health Board. The GPs who are thus trained are

allowed to care for 10 and 15 patients under the protocol and are remunerated by the Health Board for doing so. Other GPs who wish to treat up to 30 drug users undergo a special level of training prior to them being incorporated in the drug services (ICGP 1997). Drug treatment now takes place within many GPs surgeries across the city and within satellite clinics, which are small community drug treatment centres. These satellite clinics treat up to a maximum of 50 clients and are usually staffed by GPs and other ancillary staff. One of their policy aims is a close working relationship with local GPs. Community groups are represented on the monitoring committees and are actively involved in supporting these clinics. Above this there are addiction centres and these centres have a larger catchment area than the satellite clinics and cater for large numbers of clients. They are also staffed by GPs, supported by one of the Psychiatrists specialising in drug addiction problems. As well as psychiatric support there is a team of addiction counsellors, HIV counsellors, outreach workers, nurses, community welfare officers and other assistance. There is also onsite dispensing by a full-time pharmacist. These centres are a resource for the satellite clinics as clients can be referred from the satellite clinic to the addiction centre and vice-versa. Further there are three central clinics which are each staffed by a Psychiatrist, specialising in substance abuse, and complemented by junior staff, which act as primary care as well as tertiary care centres. In all there are now about 3,600 drug users in treatment and yet there is still a waiting list of anything up to six months before new clients can be assessed by these services.

The role of the General Practitioner and the management of opiate users is now central to the Eastern Health Board's and Government strategy. They are supported in this by the various clinics listed above and by an array of ancillary healthcare workers. This strategy and policy have developed within the broad terms first outlined by the I.C.G.P. policy statement of 1991 (ICGP 1991). The conditions and supports are now in place which allow general practitioners to involve themselves in caring for drug afflicted individuals in a professional way with adequate specialist support and encouragement. The author's practice have now amended their practice policy to include prescribing methadone to such patients under the agreed protocol.

These service developments have had an impact on the incidence of HIV infection. Between January 1997 and June 1998 a total of 181 new cases of HIV infection were confirmed by the Virus Reference Laboratory. Of these, 125 were male, 55 female

and one case of unknown gender. The male to female ratio is 2.3:1. The incidence rates for the various categories were as follows, see table 8.5: -

Table 8.5: New cases of HIV infection by risk category (January '97to June '98).

Risk Category	Number (%)
Heterosexual	61 (33.7%)
Homosexual	57 (31.5%)
IV Drug Users	29 (16%)
Other	34 (18.8%)
Total	181 (100%)

These figures show that the transmission patterns have now changed with heterosexual spread being the most common route and followed by homosexual spread and then in third place IV drug use. A report detailing these findings, from the Department of Health, for the National AIDS Strategy Committee says:

“the declining incidence amongst drug users maybe in part due to a huge expansion of drug treatment services particularly in the Eastern Health Board area where the majority of drug users reside. The figures would also indicate that the Board’s strategy of needle exchange/methadone maintenance is proving effective in reducing the incidence of HIV in IV drug use risk category”. (NASC 1999).

The cumulative figures for HIV infection still shows that IV drug use is the largest risk group. The numbers of new cases of HIV infection appears to be falling and the profile of the risk groups is changing probably due to the relative success of the drug treatment services. However, the realisation that the drug treatment services need to be financed on a regular recurring basis and will probably require further new funding has yet to be fully realised by the public at large.

Alex Wodak, Director of Alcohol and Drug Service in St Vincent’s Hospital (Sydney) sums up the complex problems associated with HIV infection in drug users thus:

“Illicit drug use is associated with a multitude of serious adverse health, social and economic consequences. Consideration of the health sequelae of illicit drug use requires some thought about social and economic complications of drug use, as they considerably influence health costs and are also considerably influenced by them.

Health complications of injecting drug use threaten individual drug users, their partners and families. In the case of HIV, complications of injecting drug use also threaten the general community.” (Wodak A. 1998).

A recent disturbing footnote to the seemingly improving situation, in the level of HIV infection in drug users in Dublin, is the emergence of a cohort of second generation drug users, that is children of the older first cohort of drug users. Whilst there are no figures to date from the drug treatment services, there are figures available from within the author’s practice and from one of the adjacent general practices. Both these practices provide services for approximately the same area which includes the Merchants Quay F area. There are seven individuals, known to these practices, to be injecting drug users all of who have one or more parents that has been or still is a drug user. This seven consists of four females and three males all born between the years 1976 and 1980. Two, of this group, are known to be HIV positive and also Hepatitis C positive; one of them has Hepatitis B positive. The viral status of three of the group is as yet unknown, one of these three having refused any blood test. The seventh individual is known to have tested HIV negative. Hepatitis B and C negative also. These seven individuals have originated from just five families. Further, two of those families are related. There are two sets of siblings within the group of seven.

Table 8.6: HIV infection and other virus infections in 2nd Generation Drug Users

Number	Virus Infections
2	HIV Pos. & Hepatitis C Pos.
1	Hepatitis B Pos.
1	HIV Neg. & Hepatitis B Neg. & Hepatitis C Neg.
3	Virus Status Unknown
Total 7	

Out of the ten parents, seven of these parents are known to be drug users and all seven are HIV positive.

These small but disturbing figures could be the start of a second wave of HIV infection amongst injecting drug users.

Chapter 9

Main Conclusions and Commentary

The main conclusions of the study are that:

- The cohort studied (MQF cohort) is similar to other Dublin drug users, their peers, of the mid 1980's. They started to use heroin by injection at an earlier date than others and therefore became exposed earlier to the medical consequences of such "risky" behaviour.
- Injecting drug use as a life style is very hazardous and results in a high mortality (32% mortality in a ten-year period).
- There is a high level of chronic disease, chiefly secondary to three viral infections, HIV, Hepatitis B and C.
- The study confirms that opiate drug use is a chronic relapsing condition. There is a high level of continuing opiate dependence ten years later.
- There is a continuing high level of "risky" behaviour within the cohort, although needle and other injection equipment sharing has fallen. Risky sexual behaviour remains worryingly high.
- The profile of this cohort is similar to other identified cohorts in Dublin in that it emanates from a poor marginalised area of the city.
- Problem drug use is costly to both the individual and to society in general. For the individual it is costly in physical and social terms and for society in the provision of ongoing medical and prison costs. It is also costly in economic terms, in that there are a large number of individuals who are lost to the work force and who are largely dependent on state subsidies.
- The cohort shares many of the same characteristics of the comparison cohort of non-drug users drawn from the Merchants Quay F Ward. There are no obvious distinguishing features that would help determine why the study group were more likely to embrace risky drug use than their peers were.
- It demonstrates the feasibility of conducting research on a 'hidden' population, over time from a general practice base.

The study details high levels of morbidity and mortality associated with injecting drug use over a ten-year period in one cohort of drug users. These high levels of mortality and morbidity are closely associated with, but not exclusive to, HIV infection, which was probably introduced into this cohort around 1983. This group was unaware of the

potential dangers of drug use when they first started injecting heroin making them different to other later cohorts of drug users in the city who have started their drug using careers in more recent times. This is shown in the relatively low levels of HIV infection in these newer drug users, however it is worrying to note the high levels of Hepatitis C infection in these same groups.

The MQF cohort of drug users is little different to their Dublin peers of the 1980's, except that they were one of the earliest cohorts to embrace street heroin when it was first introduced into Dublin. It is almost certain that there are numerous other small pockets of drug users, scattered across the city, with equally high levels of HIV infection and Hepatitis C infection. This view is supported by Dean's follow up report on the three community based studies undertaken in the 1980's. (Dean et al 1992). These pockets are most likely to be concentrated in the North Inner City, the South Inner City and in other densely populated deprived communities across the city and so the potential public health risk from the spread of these virus infections is obvious. These areas are well known to all who work with drug users and so it is a cause of continuing concern that more is not being done to target them for more focused social, educational and health services.

Problem drug use in Dublin was and still is to be found in the most marginalised and deprived areas of the city. As Butler states:

“It should also be clarified that epidemiological studies have consistently revealed that, within Dublin, drug problems are not the prerogative of hedonistic students, nor are they randomly distributed; instead they are associated with poverty, unemployment and general social disadvantage, and are largely located in a handful of identifiable ‘problem neighbourhoods’ in the inner city and in some out suburban areas” (Butler S. 1993).

The Health Board is now, at last, fully committed to developing a comprehensive treatment service for problem drug users, however they have not dealt with, nor can they be expected to deal with, the fundamental root cause of the drug use problem in Dublin, which is poverty. Problem drug use is a *social* problem with *medical* sequelae. Until now society has treated the ‘drugs problem’ as a medical or legal one, that is putting in to place treatment services for those who need and want to seek care and prison sentences for those who continue to break the law to feed their habit. Even then it still took the medical authorities twenty years to develop anything approaching

adequate treatment services. In those intervening twenty years drug users had to rely on an over-stretched drug treatment unit and a small number of general practitioners for any type of care. The paucity of care and the largely indifferent attitude of those who should have been responsible for care during this time greatly added to the burden of those individuals caught up in drug use. As a society we need to face up to social inequity and tackle some of the worst aspects of inequality at local and national level. Sir Douglas Black, former Chief Medical Officer in the Department of Health (United Kingdom) and author of “The Black Report”, a seminal work which clearly linked social inequality to ill-health and premature death, in the 1980’s wrote:

“But to study a problem is not the same as trying to solve it. My own approach to a solution is likely to be challenged as simplistic but here it is:

Social problems call for social solutions. So far as they manifest themselves in ill-health they can to some extent be palliated by health services; but they cannot be abolished” (Black D. 1993).

Ideally to tackle the worst aspects of the drug use problem in Dublin would mean improving the physical infrastructure, providing suitable sporting and other recreational facilities, attracting sustainable employment opportunities and improving the skills base of the already identified vulnerable communities. In the absence of the commitment and political will to do this, much could be done, relatively inexpensively by targeting the educational services, such as providing pre-school facilities, remedial teaching services and in lowering class sizes in these areas of obvious deprivation.

In 1990 the Irish College of General Practitioners adopted and issued a “policy statement on illicit drug use and problems of drug addiction” which stated:

“The origins and effects of illicit drug use are primarily social problems which have medical consequences. To ignore the social milieu in which these problems are found, and to concentrate remedial efforts on the medical aspects, is a blinkered approach which is doomed to fail” (ICGP 1990).

At the present time there is little evidence to suggest that the statutory authorities are paying more than lip service to the idea of seriously trying to address the issues of inequity in our society.

Dublin is a small city that is growing at a fast pace and which, in recent years, has become increasingly wealthy. There have been many gains associated with this relative and sudden affluence such as an increasingly confident workforce, high

employment rates and more disposable income. There have also been some problems such as increasing house prices and worsening traffic problems. The country has been informed by its political leaders that

“For the first time in our history -we are able to decide -what we -want and go out tomorrow and get it.” (An Taoiseach, Bertie Ahern 1999)

However despite this new found confidence and wealth there are still areas of Dublin city which are largely unchanged, that is they continue to be as deprived as they were throughout the 1970’s, ‘80’s and ‘90’s. These areas of deprivation within the city are well known and visible to all that have open eyes. It should not be beyond the wit and capabilities of our civic and political leaders to address and moderate the worst aspects of this relative deprivation and in doing so address the major root cause of Dublin’s continuing drug problem.

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SOCIAL HISTORY

Appendix 1

1. No.
2. D.O.B. AGE: SEX: M F
3. Marital Status, M. S W. Sptd.
4. With whom do you live?
 (a) Parents (b) Spouse (c) b/g friend (d) other
5. Number of children. AGES:
6. Children living (a) with you, (b) with spouse/partner (c) grand parents, (d) in care.
7. Ago on leaving school.
8. Did you attend regularly?
9. R./W. poor fair good
10. Type of school last in (a) Primary (b)-Vocational (c) Secondary Any exams.
11. Employment status, now (a) unemployed (b) employed
12. Longest period in employment
13. Months since last employment
14. Father's (a) occupation (b) health/psychiatric
15. Mother's (a) occupation (b) Health/psychiatric
16. Parents - Do they get on well?
17. If rather/Mother dead - your age at death
18. Police record Yes/No. Convictions Yes/No (a) before drug use (b) after drug use
19. Prison record Yea/No
20. Total time in prison (a) before drug use (b) after drug use
21. Family size and ages. M. F.
22. Where do you come in the family?

SOCIAL HISTORY CONTINUED

23. Any hobbies? Belong to any clubs?

24. How many friends have you?

DRUGS HISTORY

Do you smoke? How many /day? less 5, 5-10, 10-20, 20+

How old at first cig.?

Do you drink? How many drinks/Session? 1, 1-3, 3-5, 5+

How old when first drank?

Does your father drink?

Does your mother drink?

Drink ever a problem for either of your parents?

Do either of your parents take medication on a regular basis?

If yes, what medication?

Type of drugs you have used:

Amo. Bar Mor Pet Phy Dic Pal Can Coc Alc DF118

(a) Once (b) Occ. (c) Reg.

What is your drug of choice?

Have you ever used heroin?

Age that you first took heroin?

Preferred route: Oral, I.V. I.M. Snorting?

How often do you use heroin?: Once weekly, 1-5 per week. daily, more

When was the last time you used heroin?

Have you ever stopped using heroin? Yes/No

How long for?

How many times have you stopped?

If stopped using heroin, Why?

DRUGS HISTORY CONTINUED

Did you take cannabis one. other drugs (a) prior to using heroin

(b) after stopping heroin

Was it due to(a) sickness, (b) parents, (c) J.S.H./Coolmine (d) Local Dr.

(e) local counsellor, (f) concerned parents (g) lack of supply,

(h) community support (i) prison

Are you using any drugs at present?

How do you think the local community has reacted to the drug problem?

Are drugs available locally?

Sibling drug use

How do you feel about the future?

Do you think drugs are causing you any problem?

Why do you take drugs?

Why?

Would you support the concerned parents group?

MEDICAL HISTORY

Ever been to J.S.H. drug treatment Centre?

Ever in Hospital? When? Why?

Ever detoxified (a) inpatient (b) outpatient?

Number of times 1, 1-5, 5-10, 10+

Medical problems:

- (a) Hepatitis (b) Abscesses (c) Epilepsy
- (d) Endocarditis (e) Resp. arrest (f) STD
- (g) Psych, problems (h) Asthma (i) Other

Pregnancies/Deliveries - Number

Pregnant when on heroin/ or other opiates (Phy Dic Pal)

Dates and Hospitals

Any medical problems with any of children?

Medical problems predating heroin use?

Ever on any long term medication?

If so what?

Ward Questionnaire

Appendix 2

Demographic Data

1.1	Date of Interview:	dd	mm	yy
		<input type="text"/>	<input type="text"/>	<input type="text"/>
1.2	Identity Number:	<input type="text"/>		
1.3	How long have you been at your present address:			
	1. less than 1 year			
	2. 1 -2 years			
	3. 2+ -5 years			
	4. 5+ -10 years.	<input type="text"/>	<input type="text"/>	
1.4	How many times have you moved in the last 10 years:	<input type="text"/>	<input type="text"/>	
1.5	Have you lived outside of Dublin in the last 10 years?	<input type="checkbox"/>		
1.6	If yes was it in			
	1. Ireland (1=yes 2=no)	<input type="checkbox"/>		
	2. UK	<input type="checkbox"/>		
	3. US	<input type="checkbox"/>		
	4. Japan	<input type="checkbox"/>		
	5. Australia	<input type="checkbox"/>		
	6. Other	<input type="checkbox"/>		
1.7	If yes for how long? (months)	<input type="text"/>	<input type="text"/>	<input type="text"/>
1.8	Date of Birth:	dd	mm	yy
		<input type="text"/>	<input type="text"/>	<input type="text"/>
1.9	Age:	<input type="text"/>	<input type="text"/>	
1.10	Sex (1= Male 2=Female):	<input type="checkbox"/>		

1.11 Are you?
 1. *single* 2. *married* 3. *cohabiting*
 4. *separated* 5. *divorced* 6. *widowed* 7. *other ...*

1.12 Has your marital status changed in the last 10 years?

1.13 Are you living with?:
 1. *spouse* 2. *b/g friend* 3. *parents*
 4. *alone* 5. *other*

1.14 Do you have children?
 1. *Yes* 2. *No* 3. *DK*
 4. *WS* 5. *NA*
 (if no go to 2.1)

1.15 If yes, how many?

child 1 M/F *age*

child 2 M/F *age*

child 3 M/F *age*

child 4 M/F *age*

child 5 M/F *age*

1.16 Do they live with you?

1.17 If no, who do they live with?:
 1. *other parent* 2. *grandparents*
 3. *other relative* 4. *foster family*
 5. *adoptive parents* 6. *in care*
 7. *other* 9. *N/A*

Education:

**I would now like to ask you a few questions
about your education:**

2.1 At what age did you leave school?

2.2 Can you read and understand a letter or newspaper;
1. *easily* 2. *with difficulty* 3. *not at all*
4. *no response*

2.3 Did you do any exams?

2.4 If yes:
1. *10 Cert* 2. *Group Cert* 3. *Inter Cert*
4. *Leaving Cert* 5. *Diploma* 6. *Degree*
7. *None* 8. *don't know* 9. *won't say*

Work History:

I would now like to ask you about your work experience.

3.1 Are you presently employed?

3.2 If **no**, when did you last work:
1. *within the last year* 2. *within last 5 yrs*
3. *within last 10 yrs* 4. *over 10 yrs age*
5. *never* 6. *DK*
8. *won't say* 9. *NA*

3.3 What is the longest period in work (in months)?

Family

I would now like to ask you about your family:

- 4.1 What was/is your father's occupation?:
1. labourer 2. skilled worker 3. clerical 4. nil
5. DK 6. won't say
- 4.2 What was/is your mother's occupation?:
1. housewife 2. cleaner 3. skilled 4. clerical
5. nil 6. DK 7. won't say
- 4.3 Did you live with both parents all the time as a child?
(if yes go to 4.6)
- 4.4 If **no**, who did you live with?:
1. one parent only 2. other relatives
3. in a childrens home 4. foster parents
5. other 9. NA
- 4.5 If **1** was it
1. father 2. mother 9. NA
- 4.6 Is your mother alive?
- 4.7 If **no**, what age were you at mother's death?
- 4.8 Is your father alive?
- 4.9 If **no**, what age were you at father's death?
- 4.10 Do you have brothers?
- 4.11 If **yes** how many?
- 4.12 Do you have sisters?
- 4.13 If **yes** how many?
- 4.14 Would you describe your childhood as being happy?

Prison

- 5.1 Have you ever been to prison?
(if no go to Medical History)
- 5.2 If yes, when was the last time?
- 5.3 What is the total time spent in prison:
1. nil 2. less than 1 yr 3. more than 1 year
- 5.4 If 3, time in months
- 5.5 If you have been in prison in the last 10 years
did you use drugs in prison?
- 5.6 If yes did you share needles in prison?:
1. always 2. frequently
3. sometimes 4. never

Medical History:

If female:

- 6.1 Have you ever been pregnant?
- 6.2 If yes, how many times?
- 6.3 Were you ever pregnant when on drugs?

All

- 7.1 Have you ever been in hospital as a patient?
- 7.2 If yes, how many times in the past 12 months?
- 7.3 If yes, how many times in total?
- 7.4 How many detox's in the last 10 years?
- 7.5 Are you getting any medical treatment at the moment?

7.6 If yes, is that treatment for:

- 1. *drug related problem*
- 2. *other physical problem*
- 3. *mental illness*
- 4. *other*
- 9. *NA*

7.7 Do you have any medical problems?

- 7.8 *Problem 1.*
- Problem 2.*
- Problem 3.*
- Problem 4.*

7.9 Have you ever had jaundice?

7.10 If yes, have you ever tested for Hepatitis B?

7.11 Is the result

1. *positive* 2. *negative* 3. *DK* 4. *WS*

7.12 If yes, have you ever tested for Hepatitis C?

7.13 Is the result

1. *positive* 2. *negative* 3. *DK* 4. *WS*

HIV Infection

8.1 Have you ever been tested for the HIV virus?
(if no go to 8.10)

8.2 Where did you take the first test?:

1. *GP* 2. *Hosp/clinic* 3. *Drug R Centre*
4. *prison* 5. *other*

8.3 When did you test? (what year)

8.4 Did you have counselling before the test?

8.5 Why did you test?

 1. was asked to test by clinic/doctor

 2. I thought I should for my family

 3. I was ill and thought it best

 4. I was worried about HIV

 5. I was made to test

 6. don't know

 7. won't say

 8. other

8.6 If 8 please specify _____

8.7 If yes to 8.1 when was your last test?

 1. <3 months ago 2. 3-6 months ago

 3. 6-12 months 4. between 1 & 5 yr s

 5. between 5 & 10yrs

 6. more than 10 years 9 NA

8.8 What is the number of times you have tested?

8.9 Do you know the result of your last test?

8.10 If yes, was it

 1. positive 2. negative? 3. WS

8.11 If you haven't tested, would you like to test?

8.12 If no, is it because

 1. don't want to 2. was never at risk

 3. can't be bothered 4. afraid

 5. afraid for the family 6. insurance

 7. other

8.13 If 7 please specify _____

- 8.14 Have any of your family been affected by HIV?
 (if no go to 9.1)
- 8.15 If yes, is it
 1. spouse 2. brother 3. sister 4. cousin
 5. child 6. other
- 8.16 no. of brothers infected HIV
- 8.17 no. of sisters infected HIV
- 8.18 no. of cousins infected HIV
- 8.19 no. of children infected HIV
- 8.20 no. of others infected HIV

Past Drug History

- 9.1 What was the first drug you used (exc. alcohol)
 1. heroin 2. cocaine 3. hash
 4. acid 5. other opiates 6. other
- 9.2 At what age did you first take heroin?

Current Drug History

- 10.1 What is the longest period you were drug free?
 1. <4 weeks 2. more than four weeks
- 10.2 If 2, time in months
- 10.3 Are you presently attending any drug service?

10.4 If yes, is it

- 1. *Trinity Court*
- 2. *Satellite Clinic*
- 3. *MQP*
- 4. *Ana Liffey*
- 5. *prescribing GP*
- 6. *small club*
- 7. *St. Andrew's*
- 8. *other*

10.5 Are you on a methadone programme?

10.6 Are you currently using street drugs

10.7 If yes what drugs are you using?

- 1. *heroin*
- 2. *cocaine*
- 3. *crack*
- 4. *ecstasy*
- 5. *LSD (acid)*
- 6. *hash*
- 7. *methadone*

	drug	route
1. heroin	<input type="checkbox"/>	<input type="checkbox"/>
2. cocaine	<input type="checkbox"/>	<input type="checkbox"/>
3. crack	<input type="checkbox"/>	<input type="checkbox"/>
4. ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
5. LSD (acid)	<input type="checkbox"/>	<input type="checkbox"/>
6. hash	<input type="checkbox"/>	<input type="checkbox"/>
7. methadone	<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.8 How long is it since you used drugs?

- 1. *today* 2. *this week* 3. *one month*
- 4. *one year* 5. *one to five yrs* 6. *five to ten yrs*
- 7. *more than ten yrs*

10.9 If you are still using what is your drug of choice?	<input type="checkbox"/>
1. heroin	<input type="checkbox"/>
2. cocaine	<input type="checkbox"/>
3. crack	<input type="checkbox"/>
4. ecstasy	<input type="checkbox"/>
5. LSD (acid)	<input type="checkbox"/>
6. hash	<input type="checkbox"/>
10.10 Do you share needles?	<input type="checkbox"/>
1. always 2. sometimes 3. never	<input type="checkbox"/>
10.11 Have you shared needles in the last 5 years?	<input type="checkbox"/>
10.12 Do you use a needle exchange?	<input type="checkbox"/>
1. always 2. sometimes 3. never	<input type="checkbox"/>
10.13 Do you clean your works?	<input type="checkbox"/>
1.always 2. sometimes 3. never	<input type="checkbox"/>
10.14 How much does your habit cost per day in £s?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10.15 To fund your habit do you need to steal?	<input type="checkbox"/>
10.16 Do you take any prescribed drugs other than methadone from your GP/Hosp/clinic?	<input type="checkbox"/>
10.17 If yes how many (past and present)?	<input type="checkbox"/>
10.18 If yes	<input type="checkbox"/>
Benzodiazepines (tranquilizers)?	<input type="checkbox"/>
Anti-depressants?	<input type="checkbox"/>
other (specify)	<input type="checkbox"/>
10.19 Do any of your family use drugs?	<input type="checkbox"/>
(if no goto 11.1)	

10.20 brother 1 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD(acid).
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.21 brother 2 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD (acid)
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.22 brother 3 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD (acid).
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.23 sister 1 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD (acid)
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.24 sister 2 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD (acid)
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

10.19 sister 3 type & main route:-

- 1. heroin
- 2. cocaine
- 3. crack
- 4. ecstasy
- 5. LSD (acid)
- 6. hash
- 7. methadone

drug	route
<input type="checkbox"/>	<input type="checkbox"/>

(Route key: 1. intravenously 2. smoking 3. snorting 4. skin popping 5. orally 6. other)

Sexual History:

11.1 Are you currently having a sexual relationship?

11.2 If yes

1. with one person 2. with more than 1 person

11.3 How many sexual partners have you had
in the last 6 months?

11.4 How many sexual partners in the last 10 years

11.5 Do you know if any have tested for the HIV virus?

11.6 If yes was the result

1. positive 2. negative 3. Don't know

11.7 Do you use any form of contraception?

11.8 If yes Is it?

1. barrier (condom, cap)

2. pill (ocp)

3. coil (iucd)

4. i njection (Depo-provera)

11.9 If you use condoms how often do you use them?

1. always 2. sometimes 3. never

11.10 If you use condoms only **sometimes** or **never** why?

1. Don't like them,

2. no risk to me

3. partner won't use them

4. want to have a baby

5. no point

11.11 Have you changed your sexual practices since HIV?

11.12 How changed?

1. *less partners*

2. *become abstinent*

3. *use a condom*

11.13 Are you happy?

11.14 What does the future hold for you?

TRINITY COURT COHORT

Appendix 3

Demographic Data

1.1 Chart No.

1.2 Address 1985 _____

Postal Code '85
(Dublin district no. or '99' for Co. Dublin)

1.3 Address last known _____

Postal Code last known
(Dublin district no. or '99' for Co. Dublin)

1.4 Date of Birth:

1.5 Age:

1.6 Sex (1=Male2=Female):

1.7 Marital status

- 1. single 2. married 3. cohabitin
4. separated 5. divorced 6. widowed 7. other

1.8 Do you have children?

- 1. Yes 2. No 3. DK
4. NR 5. NA.....

1.9 If yes, how many?

Work History

2.1 Presently employed ? (1=Yes.2=No)

2.2 If **no**, last in work

- 1. within the last year 2. within last 5 yrs
3. within last 10 yrs 4. over 10 yrs ago
5. never 6. DK
8. NR 9. NA.....

Prison

3.1 Has record (*yes/no/DK/not recorded*)

Medical History

4.1 Ever had jaundice?

4.2 If **yes**, ever tested for Hepatitis B?

4.3 Result

1. *positive* 2. *negative* 3. *DK* 4. *NR*

4.4 If **yes**, ever tested for Hepatitis C?

4.5 Result

1. *positive* 2. *negative* 3. *NR*

4.6 Ever been tested for the HIV virus?

4.7 Result

1. *positive* 2. *negative* 3. *NR*

4.8 1st recorded attendance

dd	mm	yy
<input type="text"/>	<input type="text"/>	<input type="text"/>

4.9 Last recorded attendance

<input type="text"/>	<input type="text"/>	<input type="text"/>
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4.10 Total number of attendances

4.11 RIP (*yes/no/DK/NR*):-

Females only:

4.12 No. of children 1985

4.13 History of drug use in pregnancies (*yes/no/DK*)

Drug History

5.1 First used drugs

yy
<input type="text"/>

5.2 Age first used heroin

<input type="text"/>

29.10.'81

To Whom It May Concern:-

Three years ago there was no serious local drug abuse problem. During this period and especially the last eighteen months there has developed a widespreak and very serious drug problem.

The drugs abused are 'hard' drugs - especially heroin and cocaine.

The drug abusers are between 12 years and 25 years old.

This practice has seen approximately sixteen cases of serum hepatitis secondary to drug abuse. These have been reported to Prof. O'Donnell (Chief Medical Officer - Dublin City) and are a matter of record.

This practice has direct knowledge of thirty serious drug abusers. They include:-

- 1) 12 yr. old boy - serum hepatitis - 2yr history of heroin abuse
- 2) 14 yr. old boy - still abusing
- 3) 15 yr. old girl - serum hepatitis - still abusing
- 4) 15 yr. old boy -
- 5) 16 yr. old girl - serum hepatitis - habitual abuser.

The others range in age from 17 yrs. to 25 yrs. Five females fifteen males. Done of them are in employment.

Amongst this group are three family units; within these unite are children who are 'at risk'.

- (1) Mother of two small children. Husband in prison for three years Mother is abusing drugs for the last six months - allows her flat to be used for this purpose. Now apparently dealing in heroin. Has broken off contact with this practice and the Public Health Nurse.
- (2) Young couple with a 5 year old child - both abusing drugs. The child has witnessed the parents injecting themselves. This child would be in serious neglect if not for her grandmother and aunt who supply her basic needs. Both parents unemployed probably survive by 'dealing' in drugs.
- (3) Young couple - unmarried. 18 year old girl was using heroin when pregnant - agreed to detoxification before delivery. Baby was born 'irritable' and was kept under observation for a couple of weeks. Mother back on heroin. Baby at present in St. Ultans Hospital - parents slow to take the child home. The baby has been hospitalised for nearly four out of the five months of life. Both parents abuse heroin and probably 'deal' in it.

Most of the people we have detailed come from one flat complex the rest from neighbouring flat complexes.

Dear Dr. Crawley,

(1981)

We recently learned of a local project concerned with curbing drug abuse in a local flat complex (St. Theresa's Gardens, Dublin 8.)

This group was set up by residents in St. Theresa's who were concerned with the increasing drug abuse in the area. Their chief concern is that the young teenagers do not experiment with these stimulants and eventually end up with some, or all, the drug related problems.

We were pleased to learn of this innovation, as we have been in contact with some of these drug abusers in the course of our work.

This organisation came to our notice from parents who were involved in this group. They appear to be well organised and have contacted various authoritative bodies i.e. Jervis Street drug centre, the "Drug Squad", Coolmine etc.. We had separately advised different involved personnel to contact the H.E.B. as we felt that your organisation would be able to support this group, practically and financially in their aim. It was, therefore with dismay that we learned from Terry Kearney (Social worker and co-ordinator to the project) that she had contacted your organisation and had received little practical encouragement.

Your recent H.E.B. diary states the function of the bureau. We would like to draw your attention to sections d, e, and f. This seems to us to imply a statutory obligation, on the part of the H.E.B. to actively support projects such as this one.

We would see this, as an obligation, to provide a structured programme, and educational aids necessary to sustain this group in their efforts.

This well-intentioned (non-professional) organisation is about to founder for lack of direction and resource. We would see this as an opportunity for the H.E.B. to actively support the group, who aim to prevent the further spread of drug abuse among their children and local community.

If “co-operation with local area Health Board” is necessary we would see that it is the responsibility of the H.E.B. to evaluate the scheme and recommend to the Health Board that it is deserving of full and active support.

In writing to you, we are assured of the support of local General Practitioners who serve this area.

Yours sincerely,

Fergus D. O’Kelly,
LRCP + SI D. Obs. D.C.H.

Kevin O’Doherty,
LRCP + SI D. Obs. D.C.H.

CURRICULUM VITAE

Appendix 6

Name: Fergus Desmond O'Kelly
Date of Birth: 24/01/1948
Medical Education: Royal College of Surgeons in Ireland. (1968-1974)
Pre-Registration year: St. Laurence's Hospital, Dublin 7 (1974-1975).
Postgraduate Training: Dublin Regional Vocational Training Scheme (1975-1978)
Assistant in General Practice, Dolphin's Barn, Dublin 8 (1978-1979).
Principal in General Practice, Dolphin's Barn, Dublin 8 (1979-to date).

Positions of relevance held:

1. Member of St. Teresa's Gardens Youth Development.
2. Co-ordinator of primary care HIV Research Project
3. Chairman of HIV/AIDS subcommittee Irish College of General Practice
4. Government appointment to (a) National AIDS Strategy Committee, (b) Expert Group on Methadone Prescription, (c) Board of the National Drugs Advisory and Treatment Centre, Trinity Court.
5. Lecturer (part-time) Department of Community Health/General Practice, Dublin University.
6. Director of the Dublin Regional Vocational Training Scheme.

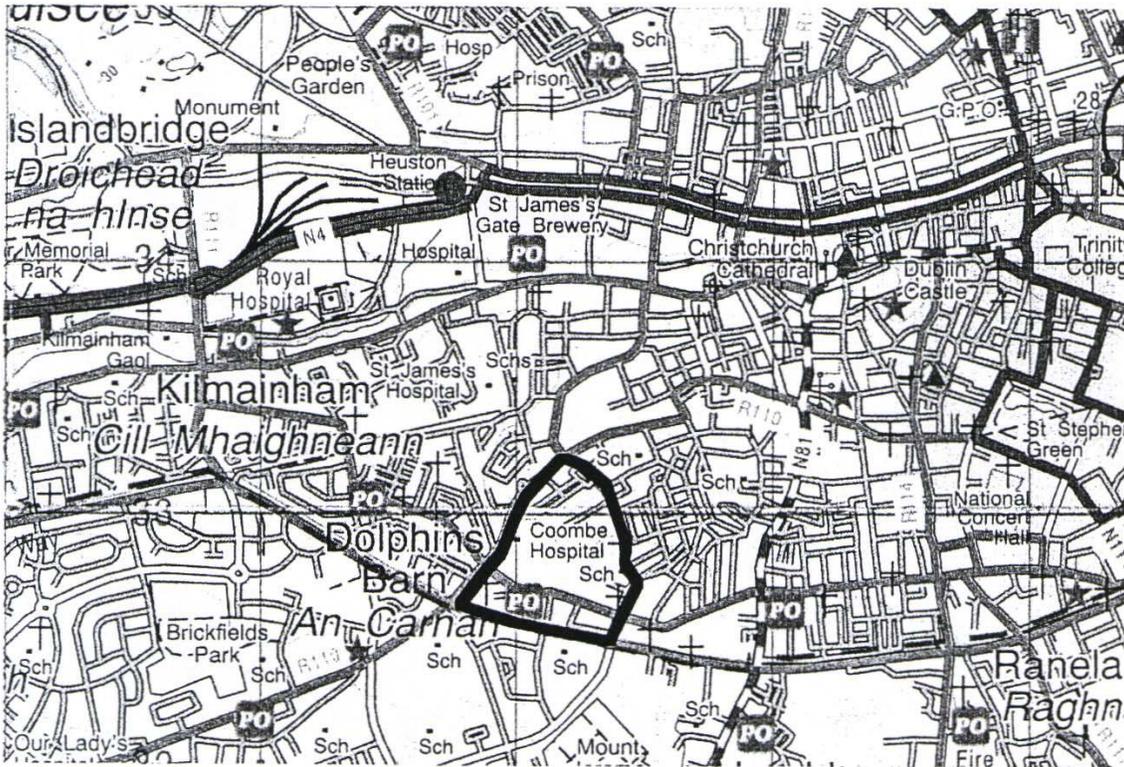
Relevant publications:

1. O'Kelly F, O'Doherty K, Bury G, O'Callaghan E. Heroin use in an Inner City Practice. *IMJ* 1986; 79: 85-87.
2. O'Kelly F, Bury G, Cullen B, Dean G. The Rise and Fall of Heroin Use in an Inner City Area of Dublin. *IMJSc* 1988; 157: 35-38.
3. Bury G, O'Kelly FD. HIV Infection in a Dublin General Practice. *JRCGP*. 1989;37:101-103.
4. O'Kelly FD. HIV infection and the role of the GP. *Forum (Journal of ICGP)* 1990;6:49-50.
5. Dean G, Lavelle P, O'Kelly F, Power B. Follow up of a Cohort of Intravenous Heroin users in North and South Central Dublin and in Dun Laoghaire. *IMJ* 1992;85:9-10.
6. O'Kelly F, Bury G. An Analysis of the Effects of HIV Infection in a Cohort of Intravenous Drug Users. *IMJ* 1996; 89: 112-114.

MAP 1



Dublin DEDs with Merchants Quay F DED shown in black



Dublin's inner city showing location of Merchant's Quay F DED in black

MAP 3

