REPORT OF
WORKING PARTY ON
DRUG ABUSE

1971

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MEMBERS OF THE WORKING PARTY

Dr. Karl Mullen	Chairman
Mr. A. P. Bourke	President, Students' Representative Council, Dublin University, (Resigned owing to pressure of work in January, 1969 and was replaced by Mr. Chard).
Dr. W. E. Boles	Practising pharmacist in Dublin; member of the Council of the Pharmaceutical Society of Ireland.
Mr. A.C.R. Chard	A member of the Students' Representative Council, Dublin University. (Resigned in June 1969 to take up a post in Northern Ireland).
Dr. F. Campbell	Assistant Inspector of Mental Hospitals, Department of Health.
Mr. S. Hensey	Principal Officer, Department of Health.
Dr. P. A. Jennings	Deputy Chief Medical Officer, Department of Health.
Dr. P.C. Jennings	General medical practitioner and a District Medical Officer in Dublin.
Miss N. Kearney	Psychiatric Social Worker, Dublin Health Authority.
Dr. M.P.G. Lawler	Senior Psychiatrist, Longford/Meath/West-meath Mental Health Board.
Mrs. M. Whelan (nee) McEvaddy)	Department of Social Science, University College, Dublin.
Dr. P.I. Melia	Psychiatrist, Student Health Service, Trinity College and St. Patrick's Hospital, Dublin.
Dr. P.I. Mullins	Detective Sergeant, Gárda Siochána.
Mr. B. O'Callaghan	Vice-President, Students' Representative Council, University College, Dublin. (Resigned in October, 1969 to take up a teaching post).
Mr. E. O'Dea	Detective Inspector, Gárda Siochána.
Mr. A.O. Gormain	Senior Psychologist, Department of Education.
Dr. R.D. Stevenson (Appointed August 1969)	Senior Psychiatrist, Dublin Health Authority.

Mr. C. Keogh, Higher Executive Officer, Department of Health, acted as Secretary to the Working Party.

CHAPTER I

Introductory

1.1 *Terms of Reference*

We were established by the Minister for Health in December, 1968 with the following terms of reference:

> **"To examine the extent of drug abuse in Ireland at present; to advise the Minister on the steps which might be taken to deal with the problem, including measures to discourage young persons from starting the use of drugs (e.g. publicity, education, example, etc.); to advise on the action to be taken to assist in the rehabilitation of persons who have acquired the drug habit."**

1.2 *Meetings*

We held our first meeting on 14th January, 1969 and were addressed by Mr. Sean Flanagan, T.D., Minister for Health. A copy of the Minister's address is contained in Appendix A. At a later date, the present Tánaiste and Minister for Health, Mr. Erskine Childers, T.D. met the Working Party and addressed the members. A copy of Mr. Childers' address is contained in Appendix B.

We have held 43 meetings in all since our establishment. In addition a number of sub-committees which were formed to deal with particular aspects of our terms of reference met on several occasions. Details of these sub-committees are given at Appendix C.

1.3 *Interim Report*[*]

We submitted an interim report to the Minister for Health on 2nd September, 1969. In the introduction to that report, we indicated that the task which the working party had been given raised some issues which would take time to consider adequately; consequently, we had decided to submit interim recommendations at that stage regarding certain matters on which we felt action should not and need not be delayed pending the submission of our final report. We are happy to record that the recommendations which we made, having been accepted in principle by the Minister, were acted upon promptly by the Department of Health to the fullest extent possible. We hope that the measures taken have been of some help in retarding the growth of drug abuse in this country.

[*] A summary of the interim report was contained in a press statement published on behalf of the Minister for Health in 1969. The statement in question is reproduced at the end of this report (see page 75).

CHAPTER II

Extent of Drug Abuse in Ireland

2.1 *Source of Information*

There is no practical method of measuring precisely the prevalence of drug abuse in a community. We referred to this matter in Chapter II of our interim report but pointed out that it was not of paramount importance to our consideration of the problem to know the exact number of persons involved and that a general assessment of its size should suffice for consideration of the measures necessary to combat drug abuse. We indicated that we had two existing sources of information and we outlined the steps we had taken to obtain additional information from a number of other sources.

Few of these sources yielded worthwhile information. A summary of the results of our enquiries is contained in paragraph 2.3 Chapter II of our interim report and the following is supplementary information in relation to a number of the headings contained in that paragraph:–

2.2 *Post-Primary Schools*

(i) *Report of Medico-Social Research Board*

A survey in connection with the study of cigarette smoking among Dublin post-primary schoolchildren was carried out in the Spring of 1970 under the joint auspices of the Irish Cancer Society and the College of General Practitioners. The questionnaire used in this survey, which was designed and processed by the Social Survey Unit of the Economic and Social Research Institute, included a number of questions on drug abuse. The results of the survey, in so far as they related to these questions, we were made available to the Medico-Social Research Board. The Board prepared a report, summarising these results, which they submitted to the working party.

The survey was based on a random sample of 14 Dublin post-primary schools and covered a total of 5,483 pupils. Of this number 126 pupils or 2.3 per cent claimed to have taken drugs. A breakdown of ages shows that of those aged 16 years and over 4.9 per cent (73 out of 1,481) stated they had taken drugs, while in the under 16 age group, the percentage was 1.3 per cent (52 out of 3,991). Out of a total of 103 pupils who named the drugs they had taken, 85 stated they had taken only one drug while 18 had tried two or three drugs. Cannabis was the drug specified by the greatest number, 77.7 per cent (80 out of 103) claiming to have

taken it. There was no significant difference in the proportion of boys and of girls amongst those who claimed to have taken cannabis.

A further analysis showed that 410 pupils or 7.5 per cent of the total in the sample, claimed to have been offered drugs at one time or another. The drug most often referred to was cannabis (132) but 196 pupils did not give the name of the drug offered. In this group of 410 the number of boys was significantly greater than the number of girls (274 compared with 136) as was also the percentage of pupils aged 16 and over (13.2 per cent) compared with those under 16 years (5.4 per cent).

Information was also obtained which showed that 421 pupils, i.e.7.7 per cent of the total "at risk", claimed to have attended a party at which drugs could be obtained. In this case the figures indicated that there was a fairly even distribution as between boys and girls of all ages among those in the group.

In interpreting the results summarised above, regard must be had to the fact that the survey was limited in scope, the data having been obtained as part of a wider study which had no direct relevance to drug abuse.

(ii) *Professor C. W. M. Wilson's Survey*

Professor C.W.M. Wilson, Department of Pharmacology, Trinity College, Dublin submitted the results of a survey which he had carried out during 1969 in 16 secondary schools in Ireland, covering a total of 3,344 pupils. All of the schools with one exception were located in Dublin. The objects of the study were stated to be to obtain information about the drug taking habits of the pupils and their attitudes towards drug abuse. The survey was based on the replies to a questionnaire completed by the pupils themselves. Professor Wilson's analysis showed that 2.8 per cent of the pupils in the sample admitted having taken drugs at one time or another. He points out that a larger proportion of boys than of girls had been involved in drug taking but that since the sample consisted predominantly of boys (82.5 per cent) the incidence of drug taking revealed in the survey was unduly biased by the higher incidence in the male element.

Professor Wilson's report also revealed that about 14 per cent of those surveyed indicated that they would have liked to try drugs; over one-fifth claimed that they knew someone who had taken drugs and one-third that they knew where to obtain drugs. About 85 per cent considered that there was a drug problem in Ireland whilst 95 per cent felt that they should be taught something about the effects of drugs of addiction.

2.3 *Universities*

As in the interim report the information on the incidence of drug abuse in Universities is based on reports submitted to the working party by the psychiatrists to the Student Health Services in the two Universities in Dublin. The information on drug-taking was gathered during the examination of cases attending the student health clinics for the investigation and treatment of various psychiatric disorders.

The reports on the incidence of drug taking amongst student patients were widely divergent and our efforts to form a reliable estimate proved inconclusive.

In the academic years 1967-68 and 1968-69 the proportion of student patients who admitted to having taken drugs appeared to remain approximately constant, but recently this proportion has increased. However, in most of these cases the drug-taking consisted of the occasional and often single incident of taking cannabis. Nevertheless, there has been an increase in those who admit to taking cannabis habitually, and also in those who take LSD occasionally. Before the introduction of regulations restricting the distribution of amphetamines instances of amphetamine abuse were encountered, again usually on an occasional basis. No student patient admitted to taking an opiate (e.g. heroin or morphine) or any other "hard" drug while at University. Some who reported that they had taken cannabis frequently in the past had become disillusioned about the habit and had either abandoned it altogether or drastically reduced their intake.

In the majority of cases there were no observed or reported ill effects amongst the student patients who admitted to the occasional moderate use of cannabis. However, in the minority who took cannabis frequently there was often a diminution in study performance. This may, or may not, have been due to the drug.

In recent months there has been a small but increasing number of patients who have sought treatment due to persistent anxiety or depression following LSD "trips" and in one case following the taking of cannabis; there has been one case of a psychosis following LSD which required hospital treatment.

Some patients expressed the view that cannabis and LSD are "relatively safe" but all who were questioned were emphatic in the opinion that heroin and morphine were dangerous and they stated that they would not take the latter drugs.

Since it is accepted that drug abuse is associated with personality disorders and the students who are the subject of the reports were suffering from psychiatric disorders it is likely that the incidence of drug abuse in the clinic patients is higher than that in the general student population. Consequently we consider that there is a need to study the incidence of drug abuse among the general body of university students.

2.4 *Other Sources*

With regard to the information contained in paragraph 2.4 of our interim report the following is the up-to-date position:–

(i) *Figures supplied by the Gardai*

The following were the numbers of person charged etc. in connection with drug offences in each year from 1965 to 1970:

Year	Number of persons charged, etc.	Number of Convictions	Drug(s) involved
1965	2	2	Cannabis
1966	1	1	Cannabis
1967	Nil	-	–
1968	24	25	14 Tranquillisers, barbiturates, am-

			phetamines, etc. 5 Morphine and/or pethidine 1 Heroin and morphine 4 Cannabis
1969	59	68	20 Morphine and/or pethidine and/or cocaine 13 Cannabis 3 Tranquillisers, barbiturates, amphetamines 3 Heroin and Cocaine 2 Morphine and amphetamines 1 Heroin and methadone 1 Heroin 1 Methadone 15 Unspecified drugs
1970	71	88	42 Cannabis 7 Morphine and/or pethidine 5 LSD[1] 5 Dipipanone 3 Cannabis/LSD[1] 3 Heroin and morphine 6 Unspecified drugs

Details of these cases will be found in Appendix D.

Of the 59 persons charged in 1969, 23 were involved in larcenies of drugs from Dublin Health Authority dispensaries. As indicated in our interim report the numbers of such larcenies have dropped dramatically since the security measures recommended by the Working Party were implemented. In this connection, it will be noted that of the 71 persons charged in 1970 only 2 persons were involved in larcenies from dispensaries.

(ii) *Returns from Psychiatrists*

Under a system of voluntary notification initiated by the Department of Health information relating to persons receiving treatment in connection with drug dependence or abuse is furnished to the Department by psychiatrists attached to hospitals and in private practice.

A summary of the information obtained from such notifications sent to the Department in respect of the year ended 31st December, 1970 is contained in Appendix E. Questionnaire forms were sent to 37 hospitals and 40 psychiatrists and notifications were obtained from 11 hospitals and 3 psychiatrists, the majority of the cases notified being in the Dublin area.

It will be noted that a total of 159 persons (106 males and 50 females, 3 not specified) were the subject of such notifications of whom 107 were cases dealt with by the Drug Advisory and Treatment Centre, Jervis Street Hospital, Dublin. 104 of the total were un-

[1]The unauthorised possession of LSD was made a punishable offence as from 18 May, 1970, under the Health (Possession of Controlled Substances) Regulations, 1970.

der the age of 25. 124 were single and a large proportion (78 of the 125 cases in which this information was supplied) were unemployed.

Analysis of the general pattern of drug-taking amongst the 104 persons in the under 25 age group showed that 58 were persons who abused drugs sporadically while 41 were persons who were either "unable to maintain normal living" or "required drugs to maintain normal living". The drugs most commonly abused in this age group (taken either alone or in combination with other drugs) were LSD (36), cannabis (22), barbiturates (14) and narcotics (14).

Although the figures, for which we are indebted to the Department of Health, provided interesting material for study we would stress the dangers of drawing firm conclusions from analysis of so small a number of cases, particularly since two-thirds of the total were cases reported by the Advisory and Treatment Centre, Jervis Street Hospital.

2.5 *Summary of the present position regarding the extent of drug abuse*

In September, 1969 there were approximately 350 persons involved in the abuse of drugs in the Dublin area whose names were known to the Gardai. By December, 1970, this figure had grown to about 940. Whilst the efforts of the Gardai have been intensified following the strengthening of the Drug Squad (see Chapter III) we do not feel that this factory fully accounts for the increase in numbers. We are satisfied that there has in fact been a real increase in the number of persons involved in drug abuse. Whilst it can be assumed that the actual number of persons involved is greater than the figure of 940 it is obviously impossible to make an accurate assessment of what the number may be. However, if a factor based on the experience of the Gardai is applied to the figure of 940 the resultant total may be estimated to be in the region of two thousand to two thousand five hundred.

There has also been a change in the pattern of abuse, as disclosed by the Gardai. Whereas originally there was a variety of drugs involved including amphetamines, barbiturates and tranquillisers, the drugs now most commonly abused are cannabis and lysergic acid diethylamide (LSD).

There is evidence that the peddling of drugs in Dublin (mainly cannabis and LSD) has increased significantly in the last 12 months. We are satisfied, however, that drug pushing is not as yet occurring generally as a large-scale commercial operation. However, in two instances in the last few months, commercial drug pushers have come to the notice of the Gardai.

There is no evidence of any significant use of heroin, but having regard to the fact that illicit supplies are at present difficult to obtain in this country, the position should not be viewed with complacency lest such supplies become available.

There has been increased evidence of drug abuse in some of the larger provincial towns. Although we are satisfied that it is not at present a significant problem numerically in these areas, it is imperative that the position be kept under close surveillance.

There can be little doubt, however, that the problem has steadily increased in size in the Dublin area.

CHAPTER III

Prevention of Illicit Supply of Drugs

3.1 *Statutory Controls*

In Chapter III of our interim report we referred to the need for statutory controls and systems of security against thefts as an elementary precaution to prevent drugs liable to abuse from getting into the wrong hands. Our experience of the problem in the meantime strengthens this view and serves to show that there is a direct correlation between the availability of drugs and the prevalence of abuse. Since we submitted our interim report some further controls have been implemented and a summary of the present position is set out below:

(i) *The Poisons (Ireland) Act,* 1870

This Act applies control to the sale of scheduled poisons. These include opium, morphine, cocaine, heroin and preparations containing these drugs. Since 1870 several substances have been added to the schedule, including the barbiturates and certain of the amphetamines. This Act imposes labelling and recording requirements and provides that certain of the scheduled substances may only be sold to a person known to the seller. The sale of the scheduled substances is confined to authorised persons (i.e. registered pharmaceutical chemists etc.) by virtue of the operation of the Pharmacy Act (Ireland) 1875 (as amended). The Pharmaceutical Society of Ireland institutes proceedings for breaches of the 1870 Act.

(ii) *The Dangerous Drugs Act,* 1934

This Act, which is based on international law, controls very strictly the import, export, distribution, sale and possession of specified narcotic drugs, some of which are also subject to control under the Poisons (Ireland) Act, 1870. Detailed requirements regarding the issue and dispensing of prescriptions, and the records to be kept by pharmacists and medical practitioners are laid down. The Act originally applied only to the narcotic drugs derived from natural sources e.g. opium (including morphine and heroin), cocaine, Indian hemp (cannabis) etc. In 1946 the synthetic drug pethidine was added and in August, 1969 a large number of other synthetic drugs which produce similar effects. Powers of inspection at manufacturing, wholesale and

retail levels are provided. It will be noted that unauthorised possession of any of these drugs is an offence. This Act is administered by the Department of Health and is enforced by the Gardai, and, where appropriate, by Officers of Customs and Excise. A person found guilty of an offence under the Act is liable, on summary conviction, to a fine not exceeding fifty pounds or to imprisonment for a term not exceeding six months, or both or, on conviction on indictment, to a fine not exceeding five hundred pounds or to imprisonment for a period not exceeding five years, or both.

(iii) *The Medical Preparations (Control of Sale) Regulations,* 1966

These regulations, which were made under Section 65 of the Health Act, 1947 (as amended), prohibit the sale to the general public, except on prescription, of certain scheduled substances. These include the amphetamines, barbiturates, tranquillisers and various other classes of drugs. The regulations also lay down requirements regarding the number of occasions on which prescriptions may be dispensed and require pharmacists to retain prescriptions for inspection for a period of two years, when fully dispensed. These regulations only apply to retail sales. At present each of the 27 health authorities is empowered to enforce and execute these regulations, and to prosecute offences under the regulations, in its own area. This power will be automatically assumed by the health boards established under the Health Act, 1970. The penalty for contravening the regulations is a fine not exceeding five hundred pounds, on summary conviction.

(iv) *Medication Preparations (Control of Amphetamine) Regulations,* 1969,
Medical Preparations (Control of Amphetamine) Amendment) Regulations, 1970

Under these regulations also made under Section 65 of the Health Act, 1947 (as amended), the manufacture, sale and distribution of amphetamines, certain of their derivatives, and preparations containing such substances are prohibited. The regulations contain a provision enabling the Minister for Health to grant a licence permitting the manufacture, distribution or sale of the substances or preparations covered by the regulations, subject to certain conditions.

Under arrangements made by the Department of Health arising out of the regulations, the amphetamines were withdrawn from ordinary channels of distribution and authorised supplies are now available at a single designated centre. The position regarding enforcement etc. by health authorities and the penalty for contravention are the same as apply in the case of the Medical Preparations (Control of Sale) Regulations, 1966. We fully endorse the action taken by the Minister in introducing

these controls the effect of which has been to reduce considerably the possibility of thefts etc. and abuse.

In this connection we were interested to note the findings in a survey carried out by Professor C.W.M. Wilson which he submitted to the working party. His survey showed that the presence of amphetamine in the urine of boys in custodial establishments in Ireland had fallen from 11.4 per cent to 0.6 per cent in the period between October, 1969 and April, 1970.

(v) *Health (Possession of Controlled Substances) Regulations,* 1970
These regulations, which were made under Section 78 of the Health Act, 1970, make it an offence for a person to be in possession of certain scheduled substances except in circumstances specified in the regulations e.g. a doctor, dentist or pharmacist requiring them for the purpose of his profession, or where a person obtains the substance on prescription for medical or dental treatment. The substances covered by the regulations include barbiturates, amphetamines and hallucinogenic substances such as lysergic acid diethylamide (LSD). The penalties for contravening these regulations, which are enforced by the Gardai, are the same as those applicable under the Dangerous Drugs Act, 1934, with the exception that the maximum fine on summary conviction is one hundred pounds.
We welcome these additional controls which will enable the Gardai to deal more effectively with the unauthorised possession of a wide range of substances which were outside the scope of the Dangerous Drugs Act, 1934.

3.2 *Proposed further controls*

The Minister for Health has indicated that the controls provided for in Section 78 of the Health Act, 1970, are intended as an interim measure pending the introduction of legislation containing more comprehensive measures for the control of drug abuse.

In addition to providing for the control of possession of the classes of drugs covered by the interim provision in the Health Act, 1970, the proposed legislation would give more flexible powers to the Gardai for dealing with drug offences generally, particularly in relation to powers of search and arrest. The Gardai have represented that under existing legislation they have difficulty in obtaining and executing warrants for search of premises in connection with drug offences since such warrants can only be obtained on the information of a Chief Superintendent and executed by a Garda of not lesser rank than Superintendent. The Gardai consider that such warrants should be obtained and executed by Gardai of lesser rank. They also consider that specific provision for search of person on suspicion, on the lines provided for in the British Dangerous Drugs Act, 1967, is necessary.

The proposed legislation would also enable the Minister to exercise certain additional controls in relation to such matters as the safe custody of drugs, the keeping of records, and the availability of

certain drugs liable to abuse. In addition, provision is being made for dealing with offences involving the use of forged prescriptions.

We consider that these further controls are necessary and, in view of the increase in the abuse of cannabis and LSD, they should be enacted as soon as possible. However, we consider that there should be no undue interference with the freedom of the individual as far as any changes in procedures relating to search and arrest are contemplated.

3.3 *Penalties for drug offences*

Under the Dangerous Drugs Act, 1934, and Section 78 of the Health Act, 1970, there is no differentiation, in either case, between the substances covered as regards the maximum penalties for offences involving unauthorised possession. We recommend that there should be a system of "scaled" penalties i.e. that the unauthorised possession of such drugs as cannabis, amphetamines, barbiturates, etc., should merit a lower maximum penalty than narcotics such as heroin, morphine, etc.

We recommend, in particular, however, that, irrespective of the classification of the drug involved, there should be provision in legislation making a clear distinction between offences involving unauthorised possession of drugs intended for one's own personal use and those involving possession intended for illicit supply to others.

We have also made recommendations in Chapter V regarding further legislative measures relating to prescribing etc., which we consider necessary for dealing with drug abuse.

3.4 *Cannabis*

Cannabis has long been the subject of controversy. Those advocating the relaxation of its control claim that it is relative harmless and certainly less harmful than alcohol or tobacco which are freely and legally available in Western Society.

In view of current interest in the matter, we consider it desirable to set down certain arguments which have been made for and against the "legalisation" of cannabis.

(a) It has been claimed that cannabis is relatively harmless that it has not been demonstrated that it has produced physical dependence.

While authoritative reports e.g. the report on cannabis by the British Home Office Advisory Committee on Drug Dependence (the "Wootton" Report) 1968, do not conclude that there are grave dangers in the use of cannabis, there is a dearth of adequate modern studies on the physical, psychological and social effects of the long-term use of cannabis. Much research is needed before it can be stated that cannabis is harmless. Furthermore, cannabis is an intoxicant and although the relationship between cannabis and psychosis or crime is disputed, there is evidence which suggests that it may lead to loss of ambition and apathy.

(b) It is claimed that "legislation" of cannabis might ensure that the drug would not be adulterated by harmful additives (e.g. opium) and the strength and purity of the cannabis available could be monitored.
This might be so, but until the use of cannabis has been proved "safe" it is not entirely an effective argument.

(c) It is claimed that repression encourages rebellion and has been ineffective in the past and that by relaxing control, animosity between young persons and authority might be reduced with beneficial social results. The failure of the prohibition of alcohol in the U.S.A. is quoted as an illustration of this. It is also argued that relaxation of control would put cannabis pushers out of business and that they would thus cease to encourage cannabis users towards progression to "hard" drugs.

Against this, however, the situation could easily arise where former pushers of cannabis would concentrate on pushing "hard" drugs. Furthermore, it may be argued that relaxation of control in this country alone might result in an influx of drug takers and attendant criminals from abroad. Freedom of supply could also lead to widespread experiment, including abuse by juveniles. Against the experience of prohibition of alcohol in the U.S.A. must be set the effectiveness of the Harrison Laws in reducing opiate addiction, especially in the Southern States of the U.S.A.[1] It should also be pointed out that cannabis is controlled under the U.N. international conventions for the control of narcotics and that its "de-control" could hardly be effected unilaterally by any individual state subscribing to these conventions.

We would draw attention to the following extract from 16th Report of the WHO Expert Committee on Drug Dependence published in 1969:–

> "As pointed out by previous WHO Expert Committees concerned with drug dependence, medical need for cannabis as such no longer exists. However, the non-medical use of this substance persists and has been increasing in a number of countries. In some countries, there are considerable differences of opinion about questions of dependence liability, the acute and chronic effects on the individual user and the community, and the type and nature of the controls to be applied. This Committee strongly reaffirms the opinion expressed in previous reports that cannabis is a drug of dependence, producing public health and social problems, and that its control must be contained. It was generally recognised that more basic data on the acute and

[1]Razor, R.W. (1968) "Narcotic Addiction in young people in the United States" in "The Pharmacological and Epidemiological aspects of Adolescent Drug Dependence", Ed. C.W.M. Wilson (Oxford).

chronic effects of cannabis on the individual and society are needed to permit accurate assessment of the degree of hazard to public health."

Our Conclusions

Having examined the position we consider that:–

(a) In the light of present knowledge it cannot be said that cannabis is harmless, especially in regard to long-term and frequent use. Therefore, it should remain subject to control. However, the legal and medical status of cannabis should be kept under review in the light of experience and research;

(b) Possession of a small amount of cannabis otherwise than for peddling or pushing should not normally be regarded as a crime to be punished by imprisonment.

3.5 *Lysergic Acid Diethylamide (LSD) and other hallucinogenic agents*

The evidence available to the working party indicates that there has been a significant increase in the abuse of LSD particularly during the past 12 months or so and, as already indicated in paragraph 2.5, LSD, together with cannabis, are the drugs most commonly abused in Dublin at the present time.

LSD and other hallucinogenic drugs such as mescaline and psilocybin, have only a limited use in psychiatry as an adjunct to psychotherapy. The Report of the British Home Office Advisory Committee on Drug Dependence entitled "The Amphetamines and Lysergic Acid Diethlamide (LSD)"[2] which deals extensively with the pharmacology and the clinical and illicit uses of the drug states in paragraph 108 that a review of the world clinical literature on LSD up to 1967 and papers since published show that there is no conclusive evidence that LSD therapy is superior to any of the other treatments currently used and sums up the position in the statement that the efficacy of LSD in clinical use is non-proven but that a number of responsible clinicians believe it to have a real though limited value. The Committee conclude (paragraph 111) that "there is no proof that LSD is an effective agent in psychiatry".

On the other hand the dangers inherent in the illicit use of LSD cannot be ignored. This is brought out clearly in the following extracts from paragraphs 113 and 114 of the Committee's report:

"113. ……..……..... …… It appears, therefore, that the use of LSD otherwise than under responsible medical supervision, is a hazardous venture. For the uninitiated, uninformed, the incautious or mentally unstable experimenter the positive dangers are manifest and we did not have to search far

[2]HMSO 1970.

for evidence of disappointment, distress and often disaster resulting from a "bad trip" on LSD ……"

"114. Instances of suicide, paranoia, persistent psychosis, and even homicide, as well as spontaneous recurrences of effect resulting directly from taking LSD are well documented[3]……"

For these reasons we were perturbed to note the view expressed by some university students as recorded in Chapter II paragraph 2.3 that LSD was "relatively safe". Persons "at risk" so far as the abuse of LSD is concerned should be left in no doubt as to the grave dangers involved even in a single experience of misusing the drug.

Legitimate supplies of LSD were discontinued in this country following the withdrawal of the drug by the manufacturers in 1966 and such supplies as are now in the hands of persons abusing the drug can only be from illicit sources (e.g. smuggling or illicit manufacture). In order to assess the position regarding illicit manufacture of LSD we sought advice on the methods of preparing the substance. We are greatly indebted to Professor R.F. Timoney, Dean of Studies, College of the Pharmaceutical Society of Ireland, for the information in the matter which he furnished to us. We are making this information available to the Minister and it should be of assistance in any investigation into the possibility of illicit manufacture of LSD in this country.

3.6 *Drug thefts*

The position regarding thefts of drugs from dispensaries and hospitals etc., and the measures taken to counteract such thefts were outlined in Chapter III of our interim report. We were gratified to note that, in the intervening period, there have been no further thefts of any significance from dispensaries and that apart from a few petty thefts arising from time to time from other sources the problem generally appears not to be significant at present. Nevertheless, we consider that the position should be kept constantly under review. In this connection, we would recommend that there should be a system of regular inspection of the premises and records of wholesalers and other dealers in bulk quantities of drugs.

3.7 *Other sources of supply for illicit use*

(a) *Smuggling*

As mentioned in paragraph 2.5 cannabis and lysergic acid diethylamide (LSD) are the drugs most commonly abused. The Gardai have indicated that the source of these drugs is smuggling which has shown a tendency to increase.

Following the recommendations made in our interim report,

[3]An example would be "A Classification of LSD Complications" (Paper read at XI Annual Conference of the V.A. Cooperative Studies in Psychiatry, New Orleans, March, 1966 by Dr. Sidney Cohen, MD, Chief, Psychiatry Service, Wadsworth V.A. Hospital, Los Angeles, California 90073).

we were informed that there have been joint discussions regarding the measures to be taken to deal with the problem between representatives of the Department of Health and the following Departments;

Revenue Commissioners,
Department of Posts and Telegraphs,
Department of Justice (Garda Siochana).

We realise that the detection and prevention of drug smuggling, particularly in the case of small quantities, present a difficult problem. We consider, however, that there should be continued close liaison between the authorities concerned and we recommend that the Government Departments referred to should explore every means at their disposal for dealing with the situation. In this connection, we would recommend that special consideration be given to the following measures:–

(a) the use of special techniques (e.g. ultra-violet ray, dogs etc.) for detecting concealed drugs;

(b) a more extensive check on incoming letters and parcels;

(c) a more flexible application of customs procedures so as to achieve closer liaison with the Gardai in suspected cases of drug smuggling;

(d) greater use of deterrents in the form of

  (i) search of suspected persons at customs posts;

  (ii) provision for harsher penalties for smuggling offences under the Customs Acts.

Consultation and liaison with the authorities of other countries would be essential in applying many of these measures effectively.

(b) *Hypodermic syringes*
Availability of hypodermic syringes can be an important factor in the existence of drug abuse. We are fortunate in this country that heroin and other drugs normally administered intravenously are not abused to any significant extent. However, it is important that the position regarding the ready availability of syringes be examined and any safeguards or precautions necessary to prevent them from falling into the wrong hands be implemented.

(c) *Forged prescriptions*
Apart from the evidence furnished regarding the existence of a general problem (see Chapter V paragraph 5.1), information supplied by the Gardai indicated that for a period in the earlier part of 1970 there had been a substantial increase in the number of forged prescriptions presented for dispensing in the Dublin

area, particularly for certain specific preparations controlled under the Dangerous Drugs Act, 1934. Arising out of this report the Department of Health, on our advice, issued a special notice through the Pharmaceutical Society to all retail pharmacists in Dublin alerting them to the position and suggesting the steps which might be taken in all cases where prescriptions were suspected to be forged. Arrangements were also made to alert doctors through their medical journals to the danger of forged prescriptions and to the need for safeguarding stocks of headed notepaper and prescription pads.

The changing pattern of drug taking and the apparent ease with which such forgeries can be attempted make it imperative that the position be closely watched and necessary action taken. The use of special cards for recording the dispensing of medicines suggested for consideration in paragraph 5.5 Chapter V, could provide an effective method of dealing with the problem.

3.8 *Strengthening and training of body of Gardai dealing with drug abuse*

We were glad to learn that following the recommendation made in our interim report three additional Gardai, including one Ban Garda, have been assigned to the Drug Squad.

We would reiterate our recommendation that arrangements should be made for the special training of the Gardai concerned. In this connection, we also recommend that arrangements be made as soon as possible to enable Gardai in the provinces (at least one member of the force in each large urban area) to receive the necessary training in connection with drug abuse. The provision of any necessary equipment for the assistance of the Gardai should also be provided without delay.

The strength of the Garda Drug Squad should be kept under review and additional appointments made as the need arises.

3.9 *Compulsory licensing of discotheques, clubs, etc.*

Under existing legislation clubs etc. selling intoxicating liquor and public dance halls are required to be licensed annually. This facilitates supervision and control of these establishments by the appropriate authorities. However, in the case of other private clubs (e.g. discotheques, "beat" clubs etc.) a number of which have recently been established in Dublin and other large towns, and which are normally frequented by young persons in the age-groups with which drug abuse is associated, there are no such licensing requirements. It is considered desirable that these clubs should be subject to some form of control by way of annual registration or licence.

CHAPTER IV

Study and Research in Relation to Drug Abuse

4.1 *Survey of drug abuse*

In paragraph 2.3 (f) of our interim report we indicated the desirability of carrying out detailed research to ascertain the social, environmental and other factors involved in the existence of and growth in drug abuse amongst young persons. Following further consideration of the matter, arrangements were made, on our recommendation, for the carrying out of a survey of persons involved in drug abuse in Dublin, with the co-operation of the Dublin Health Authority. A social research worker was appointed to assist in the preparation of the survey and to undertake the field work, under the supervision of Dr. R.D. Stevenson, Senior Psychiatrist, St. Brendan's Hospital, Dublin. The aim of the survey is to obtain data on the socio-economic and medical characteristics of those known to have abused drugs and on their experience with drugs, and to investigate the role of socio-cultural factors in influencing the individual towards drug-abuse. Using an administered questionnaire, the research worker is interviewing as many as possible of those living in Dublin who have received in-patient psychiatric care, have attended out-patient clinics for treatment, or who are known to have come to the attention of the Gardai for drug offences, over a 30-month period from January, 1968. The survey which commenced some time ago, will take several moths to complete and the results will not therefore be available in time for inclusion in this report. These results will undoubtedly provide information which will be extremely valuable for working out details of any proposed programme for dealing with the problem of drug abuse.

4.2 *Analysis of 50 cases of drug dependence*

Pending the completion of survey referred to in the preceding paragraph we had at our disposal the results obtained from an analysis of 50 cases of drug dependence dealt with by the Dublin Health Authority psychiatric service in the period November, 1968 to April, 1970. A summary of these results, for which we are indebted to Dr. R.D. Stevenson and his colleagues, is given below. The cases in question were persons who attended St. Brendan's Hospital, Dublin, both as in-patients and out-patients in that period.

As it will be appreciated that this was, of necessity, a limited study, interpretation of the data obtained is subject to qualification in

several respects and it would be inadvisable to use the information as a basis for definitive conclusions pending the completion of the more detailed survey now in progress.

(i) *Summary of results*

General

A large majority of the cases (82 per cent) were persons who had either been charged with offences or who attended for treatment on the advice of the Gardai.

Age, Marital status, etc.

Ages of patients ranged from 14 to 22, the average age being 17.

78 per cent were males.
96 per cent were single.
90 per cent were Irish nationals.
86 per cent came from urban areas.

Education

Primary … … … …	42 per cent
Intermediate Certificate standard …	36 per cent
Leaving Certificate standard …	14 per cent
Vocational School … … …	8 per cent

The earliest indication of deviant behaviour amongst those in the sample was truancy; 36 per cent were absent for more than half the time during their last year at school.

Employment Record

On leaving school and prior to drug taking, few had a stable work record, 72 per cent having had from 5-20 different jobs. The usual reason for change of job was "boredom". Only 8 per cent changed to obtain a better job; only 4 per cent were dismissed. In 62 per cent of cases the longest period of continuous employment was less than one year, out of an average period of possible employment of three years. 30 per cent had periods of unemployment exceeding one year. Delinquent behaviour prior to drug-taking was common; 30 per cent had either appeared in Court or had been involved with the Juvenile Liaison Officer.

Family History:

Social class[1]*:*

Professional … … … …	4 per cent
Intermediate … … … …	4 per cent
Skilled … … … …	42 per cent
Party skilled … … … …	22 per cent
Unskilled … … … …	28 per cent

[1]The classifications used are those contained in "Classification of Occupations". British General Register Office (HMSO 1960)

Father

Average age … … … … … 47
Average age at birth of first child … … 25

Work record of fathers

96 per cent were in continual employment;
40 per cent had been in one job;
30 per cent had changed jobs once;
26 per cent had changed jobs twice or three times;
20 per cent were either absent from the home or had died (of whom 2 had committed suicide) prior to the survey;
15 per cent had a history of problem drinking.

Mother

Average age: 47
30 per cent were themselves on "nerve tablets".

Siblings

Average number in family: 5

Only child … … … …	10 per cent
1 Sibling … … … …	14 per cent
2 Siblings … … … …	14 per cent
3 "… … … … …	10 per cent
4 "… … … … …	12 per cent
5 "… … … … …	14 per cent
6 "… … … … …	24 per cent
11-13 "… … … … …	2 per cent

Patient's birth order in the family

1st-2nd Child … … … …	42 per cent
3rd-4th " … … … …	18 per cent
5th-6th " … … … …	22 per cent
7th + … … … … …	18 per cent

64 per cent of patients were living with parent or parents at the time of interview.

Pattern of drug-taking:

Drugs first taken

Drugs classified as narcotics (other than cannabis) … …	10 per cent
Cannabis … … … …	20 per cent
Amphetamines … … …	20 per cent
LSD … … … … …	10 per cent
Barbiturates … … … …	4 per cent
Other substances[2] … … …	36 per cent

[2]These include a variety of substances such as nutmeg, cleaning fluid, etc.

The majority of the "first" drugs were either obtained from friends or purchased illegally. In 90 per cent of cases the drugs were administered orally. 60 per cent took their first drug in Ireland as against 30 per cent in England.

Most recent drugs taken[3]

Heroin … … … …	40 per cent
Morphine … … … …	18 per cent
Other drugs classified as narcotics (excluding cannabis) … …	68 per cent
Cannabis… … … … …	80 per cent
Amphetamines… … … …	30 per cent
Barbiturates… … … …	28 per cent
LSD … … … … …	40 per cent
Other Substances[4] … …	32 per cent

In most cases the drugs were either obtained from friends or were illegally purchased or stolen. 46 per cent had been taking drugs for less than 12 months whilst 38 per cent were "on" drugs for periods from one to three years.

In contrast to the taking of "first" drugs, the most common method of administration was by the intravenous route (70 per cent); this applied mainly to narcotics (e.g. morphine) and amphetamines.

(ii) *Comment*

A noteworthy feature of these statistics is the wide variety of substances abused and the extent to which the person involved abused a number of drugs simultaneously. (See footnote). As indicated in Chapter II para. 2.5 this pattern has altered and the drugs now most commonly abused are cannabis and LSD. It is also significant that the abuse of amphetamines, a prominent feature in the foregoing statistics, has ceased following the making of the Medical Preparation (Control and Amphetamine) Regulation, 1969.

We feel it necessary to comment that the person involved in this study were a selected group in the sense that they had come to the attention of the Gardai, and had received treatment in a psychiatric hospital during the period November, 1968 to April, 1970. The information regarding the drugs taken by this group, especially in relation to heroin and other similar drugs could not therefore by regarded as a true refection of the position in the drug-taking population as a whole at this point in time. In this connection we have also had regard to the fact that there is no method of determining scientifically (e.g. by laboratory investigation) whether a person has taken heroin as distinct from other opium derivatives.

[3]Many drug abusers took a number of drugs simultaneously.

[4]These include a variety of substances such as nutmeg, cleaning fluid etc.

CHAPTER V

Prescribing, Administering and Supplying by Doctors of Drugs Liable to Abuse

5.1 *Overprescribing etc.*

Information furnished to the working party indicated that there were several instances of drugs liable to abuse being made available in excessive quantities through overprescribing, persons attending several doctors simultaneously and the use of forged prescriptions.

We also had evidence that a small number of doctors were supplying maintenance doses to person dependent on drugs.

A meeting was held between representatives of the Irish Medical Association, the Pharmaceutical Society of Ireland and members of the working party to consider the position. We were satisfied that a certain problem of "overprescribing" does exist. One view expressed was that the best method of dealing with the problem was for the medical profession to discipline its own members. It was realised that this would present certain difficulties. It would appear, for instance, that the Medical Registration Council has not at present sufficient powers to enable it to exercise adequate control of prescribing by doctors; accordingly, any disciplinary procedures adopted would have to be accepted on a voluntary basis and would not have the force of law.

We feel that the Minister should consult with the Medical Registration Council in the matter and if no satisfactory and watertight solution emerges the matter might than be approached on the basis that special provision be made in legislation for the control of irresponsible prescribing of certain specified drugs.

In the case of drugs to which the Dangerous Drugs Act, 1934, applies the Minister is at present empowered where he suspects that a doctor or dentist is prescribing or supplying drugs "otherwise than is properly required" for medical or dental treatment, to refer the matter for investigation to a tribunal and, if the tribunal so recommends, to withdraw the authority of the practitioner involved.

5.2 *Provision for dealing with irresponsible prescribing*

We consider that any new legislation to curtail irresponsible prescribing of specified drugs liable to abuse should include provision for the following:

(a) keeping of records by doctors, dentists and pharmacists relating to such drugs,

(b) inspection of such records by authorised officers of the Minister or of a health board,

(c) where, following such inspection or otherwise, the Minister considers that there is *prima facie* case of irresponsible prescribing, provision for:–

(i) referring the matter to a specially constituted medical tribunal;

(ii) enabling the Minister, if the tribunal so recommends, to withdraw the authority of the doctor concerned to administer, prescribe or supply the drugs concerned or other of the specified drugs if the tribunal considers it necessary;

(iii) giving the doctor concerned the right to present his case to the tribunal before it reaches a decision:

(iv) providing for incorporation in the scheme of a procedure to enable cases to be dealt with speedily by the tribunal should the necessity arise.

5.3 *Maintenance medication of persons dependent on certain drugs*

The administration and supply of certain specified drugs to persons dependent on such drugs should be subject to special controls to be provided for in legislation. We recommend, in particular, that these controls should include provision for the following:

(a) subject to (b) below, where a specified drug is to be used primarily for the treatment of dependence, either on a continuing basis (maintenance) or in reducing doses (withdrawal) such use should be confined to doctors attached to specially designated centres:

(b) a doctor not attached to a specially designated centre may administer such drug in a single emergency (in cases of withdrawal symptoms) on the strict understanding that he will then refer the patient for further treatment to one of the special centres, and notify the centre of the referral:

(c) any drugs supplied in accordance with the procedure outlined at (a) and (b) should be administered at the time of the patient's attendance: such drugs should not be supplied on a "take home" basis in any circumstances.

The drugs covered by the recommendation in para. 5.3 are generally those to which the Dangerous Drugs Act, 1934, applies and other substances, at the Minister's discretion, which would warrant inclusion because of the manner in which they are abused or in view of their inherent properties.

5.4 *Registration of persons dependent on drugs*

The establishment of a system of registration of persons dependent on drugs was recommended in our interim report (Chapter IV). Having considered the matter further we are of the opinion that such registers should be compiled and kept by the special centres referred to in para. 5.3 above.

5.5 *Record card for dispensing of drugs liable to abuse*

The question of having a "drugs and medicines" card for each person in the country should be examined. The use of such a card could be considered in relation to specified drugs liable to abuse or to all drugs and medicines which are obtainable only on prescription. The latter arrangement, however, would pose many practical difficulties and, consequently, as a practical measure for the prevention of drug abuse we recommend that the issue of such cards should be considered only in relation to drugs of abuse. The proposal, in general, envisages that such drugs and medicines issued by a medical practitioner or dispensed by a pharmacist would be recorded on a card which would have to be produced on each occasion on which such drugs etc. were being obtained by the holder. In order to prevent abuses (e.g. multiplicity of cards) it would be necessary to have a system whereby cards would be issued from a single source to persons within a specified area (e.g. the functional area of a health board).

CHAPTER VI

The Drug Taking Sub-Culture

6.1 *Definition*

Children are progressively introduced into the customs, values, beliefs and patterns of behaviour of the society in which they are growing up. This is often referred to as the "socialisation" process and it is carried out through the family, friendship groups, environment, educational, religious and other institutions of society. For some, this process of socialisation is within the context of a group whose beliefs, values and patterns of behaviour differ from those of the wider society. This constitutes a sub-culture within the larger culture and, in some instances, the patterns of behaviour of this group differ from those of the wider society in such a way that they are classified as "delinquent" or "deviant" as well as "different". Thus a person can be either born or introduced into a sub-culture whose "normal" patterns of behaviour would be classified as "deviant" by the wider society. For him, "normal" development is adjustment to behaviour which is regarded as deviant by the wider society and group pressures on him are towards non-conformity to the expectations of that society.

6.2 *General characteristics*

In some countries it would be true to say that a person is born into a drug-taking sub-culture, i.e., a group where what would be considered as abuse of drugs by the wider society is an activity which is accepted and approved as normal. In Ireland, where drug abuse as a group phenomenon has existed only over a limited period, it is more accurate to say that a drug abuser may become involved in the drug-taking sub-culture at a critical time in his development, i.e., teenage and early adolescence. The tendency to form closely-knit distinctive groups with their own patterns of behaviour and group relationship is general in society. Its importance is probably strongest in adolescence and is closely related to the physical maturation process and the movement towards independence and away from adult protection which occurs at this time. The young person experiences a sense of security in identification with young people of his own age. For some, this sense of security is found in a group which, for a variety of reasons, adopts values contrary to those which seemed absolute at an earlier age, values which some of them reject as middle-class and irrelevant. In their common rejection of the "establishment", the members of the group develop a cohesion and

solidarity of their own and, frequently, a commitment to values which are opposite to those of the wider society.

6.3 *Historical background*

The origins of the present drug cult can be traced back to the post-war beatniks of California. The characteristics and ideals of these beatniks are vividly described in Kerouak's "On the Road" and Lipton's "Holy Barbarians". These groups, which were at first small, expressed disillusionment with American establishment society and its values, and, ceasing to engage in work appropriate to their education and training, they "dropped out" of American establishment culture. They rejected values characteristic of Occidental culture, such as materialism and competitiveness, and instead turned to Oriental philosophies, with their accent on mysticism and contemplation. In their rejection of the establishment they were also critical of the establishment's acceptance of alcohol. They tended to identify with under-privileged groups and were particularly close to the Negro jazz musicians, whose music they adopted. As cannabis smoking was already common among American Negroes, it was soon adopted by the beatniks. The mental states induced by cannabis intoxication were readily associated with their new enthusiasms, mysticism and contemplation, and its use took on an almost religious air. Cannabis was joined by LSD with its reputation as an aid to transcendental understanding. This cult has, since its beginnings in the late 1940's and early 1950's spread in a much attenuated form to a large section of educated American middle-class youths, so that the use of cannabis, which is believed by its users to be relatively safe, is now extremely widespread.

In the United Stated the use of heroin is principally seen in the under-privileged youths in big cities. (e.g. the Negroes and Puerto Ricans in New York) (Razor, 1968),[1] and there is evidence that its use is very extensive. The addiction may be seen as a reaction to frustration in a group who are denied opportunity in a land of plenty. There are, however, indications that within the last four to five years middle and upper-class hippies have also progressed to heroin.

The beatnik sub-culture and that of its successor, the hippy cult, has attracted many youths of unstable personality, as the group philosophy provides emotional support to those who drop out of the establishment culture due to their inability to cope adequately with it.

The beatnik/hippy cult spread to Britain in the 1960's, where it became a minority cult, largely in Universities and among the "arty" fringe. Its attitudes, which included approval of the use of drugs, were reflected in the newspaper "International Times". Essentially comprised of middle-class educated youths, the sub-culture in turn influenced the "pop" culture of mass media and in particular "pop" music, and in this way its ideals became disseminated among the general adolescent population and, at present, young persons of all social classes are involved.

[1] See Appendix F.

6.4 *The "drug scene" in Dublin*

The evidence we have of drug abuse in Dublin suggests:

(a) A drug-taking sub-culture does exist which takes the form of closely-knit groups of young people many of whom see themselves as a distinctive "elite" within the wider society. They describe themselves as being "turned on", "liberated", "having insight". There is a strong sense of group solidarity and "brotherhood" among the group members and they tend to supply one another with drugs on a friendly and informal basis. This was described by one person who works on the "drug scene" as somewhat like the Irish custom of "round drinking"—"I'll 'turn you on' today and I know that if you have them, you'll 'turn me on' tomorrow" is implicit in the sharing approach. Apart from "pushing" which does not yet seem to exist on a large scale commercial basis in Dublin (although there is recent evidence that pushing is increasing), selling of drugs among members of the friendship group does not appear to aim at making a profit but more with "putting a value on the drug" as one person put it. The young people who belong to the drug sub-culture frequent the same parts of the city and there are establishments well known to them where they can go to meet their friends. Within the wider group there are small friendship groups of perhaps four or five people who are constantly in touch and see a great deal of one another. Some of them have mentioned that one of the things they like most about drug-taking is that it helps them to make friends and get to know people they wouldn't have met other wise.

(b) Among the young people who belong to the drug-taking sub-culture in Dublin there is widespread rejection of what they consider to be the values of the larger society. Many of them express discontent and disillusionment with their own parents' approach to living – especially their concern with making money and possessing material things. They question the value of work and "getting a job" is frequently associated with something "dull, monotonous and pointless, anyway". When they are helped to get a job, they have great difficulty in coping with the demands which it makes upon them, e.g., being at work regularly and on time. Some of them are attracted by occupations which they consider to be "creative" and capable of being carried out in one's own time (e.g. writing). For many of them, leaving school is associated with being "fed up", "couldn't stick it any more". The analysis of 50 cases of drug dependence dealt with by the Dublin Health Authority psychiatric service

revealed that 36 per cent were absent more than half the time in their final year at school (see Chapter IV). It would appear that the vast majority of these young people no longer practise, and many of them totally reject, the religious faith in which they were brought up.

(c) Cannabis and LSD are currently the drugs most widely abused by the young drug-taking population in Dublin (see Chapter II). There is no doubt that being "turned on" by these drugs confers status on the members within the group and that there is a high degree of support and approval by the group for continuation of a pattern of drug-taking. Very few young people are alone when they take their first drug. In the vast majority of cases, they are "with friends" at the time and those of them who habitually abuse drugs belong to a closely-knit group who accept and approve of drug-taking as a normal and desirable pattern of behaviour, i.e. a sub-culture.

(d) At present, it is not possible to accurately assess all the characteristics of Dublin's young drug-taking population. It is hoped that the survey now being carried out (see para. 4.1 Chapter IV) will produce accurate information in this area which will help us to understand how young people become abusers of drugs, thereby highlighting some of the problems facing programmes of treatment and rehabilitation as well as possibly suggesting methods of prevention. At present, however, we do know that a drug-taking sub-culture exists in Dublin and that understanding the part it plays in the continuation of drug abuse is vital to working with the young people who belong to it. An approach to each person on an individual basis is not enough where drug abuse is part of the whole context of a person's life and social relationships with related usual patterns of behaviour. Even through a programme might be devised which would provide help for each individual separately there appear to be those whose drug abusing problem would not be catered for by such a programme. In fact, we believe that, as well as physical and psychological dependence on drugs there also exists what might be called "sociological" dependence, i.e., dependence which is reinforced or even produced by the whole social context or "sub-culture" to which the young drug abuser belongs. People can be treated on an individual level for physical and psychological dependence, but a treatment programme must be carried beyond the individual and into the community to be effective in dealing with a problem which has sociological dimension. We believe that the implications of the existence of this element among the factors related to drug abuse are considerable for any programme of treatment, rehabilitation and continuing support in the community.

CHAPTER VII

Education and Publicity

7.1 *Introduction*

Many recent reports and publications dealing with the abuse of drugs by young people, especially those dealing with the social aspects of such abuse, have mentioned the need for education of the young. Persons in this country, concerned by the prospect of a possible vast increase in the abuse of drugs by children and teenagers, have asked that some type of programme of education be introduced as soon as possible.

It is evident that different individuals mean different things when they say that drugs are a problem for education. Some may mean that all the media of communications and the resources of the schools should be used to provide information and advice for all age-groups. Others may mean providing information for particular age-groups, while there are those who may have in mind changing a particular education system in some way or other so that it may take more account of the needs of young people.

We deal with the question of communicating information about drugs to young person in para 7.3 below. However, we consider that as a first priority information and advice should be provided for adults on the lines recommended in para. 7.2 following.

7.2 *Information and advice for adults*

(a) We consider that information and advice in relation to drugs should be provided as a matter of urgency for those who come into regular contact with young people – parents, teachers, doctors, clergy, youth leaders and other persons engaged in voluntary social work. The aims of such an approach might be:–

(i) to help those people towards a better understanding of the young;

(ii) to alleviate their anxieties relating to drug abuse, and indeed other activities of young people, to help to correct common misconceptions and to attempt to ensure a balanced approach to the problem;

(iii) to provide them with sufficient factual information and a proper understanding so that they may know what to do or say to an individual who has taken drugs and to help them in talking to those who are concerned about the matter.

(b) We consider that this approach could for a start take the form of seminars and courses for the classes of persons specified at (a) above. Ideally various professional and other bodies, representative of such persons, should cooperate both by participating in and running these courses and seminars.

The following recommendations are made in regard to the holding of the courses and seminars:–

(i) they should be organised on a sound professional basis;

(ii) lecturers, leaders and organisers should be persons who are thoroughly acquainted with the subject of drug abuse and care should be taken to present a balanced approach; for example, it may not be entirely desirable to leave either the organising or lectures solely in the hands of those who have close and regular contact with drug abusers;

(iii) in all cases aims and objectives should be defined and efforts made to check the extent to which these are attained. This in itself should mean that the number of participants be kept small.

We consider that the Department of Health and Education should cooperate in initiating such courses and seminars; they should also assist those groups anxious to hold them and should provide some machinery for assessing the results of these or any other educational measures adopted.

We consider that as a result of such courses and seminars a certain amount of expertise would be built up over a period so that individual children and their parents could be offered some informed advice.

7.3 *Communication of information to young persons*

We have considered the question of providing information regarding the use and abuse of drugs to school children and other young people as a preventive measure and have sought the opinions of educationists and other interested persons. There would appear to be agreement that some work may be done directly with young people in schools and in other settings. However, it is evident too that there is not general agreement about the means to be used and there is a notable lack of research evidence which would support firm recommendations.

For instance, much more would need to be known about what the content and tone of any proposed programme should be; about who should conduct it and communicate the information; about the effectiveness of the various means and media that might be used; about the age groups of the pupils or young people to be involved and the conditions and settings that would be most appropriate.

From our examination of the position in other countries it would appear that, in general, in countries which have just "discovered" some young people abusing drugs the initial reaction has been one of horror among the adult sections of the population, who feel that "something" must be done. This "something" usually means anything, e.g. public talks to groups of parents and to young persons; lectures on the effects of drug misuse in school; films giving information on drugs, how they are used and the social and physical ill-effects of regular abuse. Research workers and others have now begun to take a closer look at the methods and to question some of the assumptions on which this approach is based. Information from other related areas seems to suggest that attempting to communicate with the young in order to try to influence their habits is, to say the least of it, a complex matter, the outcome of which can be uncertain. For instance a report[1] of a study carried out for the Ministry of Health in Britain points out that school smoking policy and health education have had little effect on young people. On the other hand, evidence from some recent surveys on drug education suggests that direct communication to young people of information about drugs, even though aimed at alerting them to dangers, is likely to cause experimentation.[2]

Certain other problems also arise. Many young people will know about various kinds of drugs, their use and possible effects. They will know, for example, that cannabis use is widespread in the U.S.A. and elsewhere and that infrequent use has not so far been shown to be harmful in itself. Therefore, it would be of little use bluntly telling these children that all abuse of drugs is likely to cause them irreparable harm. On the other hand, since there is much more involved in drug information than indicating the immediate physical or psychological effects of various substances, frank discussion on the subject would involve one in explaining a very complex situation to young persons of all ability levels. Another factor to be taken into account is that many of the young people who use drugs are likely to be resistant to a drug education programme in normal educational settings.

In these circumstances we consider that the recommendations we have made relating to the holding of courses and seminars for teachers, youth leaders and others should be implemented without delay. We do not think that at this point in time there should be any "crash" programme for schools or youth clubs or that there should be any general use of the mass media in an educational campaign.

Accordingly we recommend that:

(a) Special provision should be made for young people who have been identified as having abused drugs or who associate with those who are so involved. In the case of those who are being treated for any dependence we think that

[1] "Adults' and Adolescents' Smoking Habits and Attitudes" (A.C. McKennall and R.K. Thomas, London, H.M.S.O.).

[2] "Drugs and School Children" (R.S.R. Wiener, Ph.D., London; Longman, 1970).

education should take the form of personal development and rehabilitation (see Chapter IX). For those not undergoing treatment, who have simply come to the notice of the Gardai or other authorities, education could best take the form of interpersonal communication either in the places where these young persons normally meet or in youth centres, clubs, their own homes, treatment centres or in Garda stations. Ideally, professionally trained counsellors and social workers should be available to carry out this work but, in their absence, medical personnel, members of the Garda Siochana and other suitable persons should be given some training in the special techniques required.

(b) Children at risk, i.e. those who are likely to be vulnerable, should be identified as early as possible. Measures for informing parents, teachers, etc. as recommended in para. 7.2 above should help to bring to light many cases that might otherwise be overlooked. Other sources of discovery of such children would be the School Health Examination Service and the School Guidance Service. Early indicators of the difficulties of children, such as poor school attendance, ought not to be disregarded and should be investigated and followed up to the fullest extent.

(c) Notwithstanding the views expressed above some school authorities may feel strongly about the need to provide their pupils with information regarding drugs. We think that where such information is given it should form part of religious education or of health or civics programmes. For instance, the subject of drug abuse could well be included as part of a general discussion of social issues by senior pupils who are about to leave school. Only persons with an adequate knowledge of the subject of drug abuse should be involved in disseminating information.

(d) A group representing the Department of Health and Education, the schools, the university departments, and professional bodies concerned should investigate the general question of communicating information on drugs to young persons, should provide guidance for school authorities and indicate areas where research is needed. This group should include specialists who would advise on medical, psychological and social aspects.

7.4 *Counselling and youth guidance*

It is necessary to mention that drug abuse among young persons is really an indication of the difficulties they have in coping with the demands of living. A few take drugs, others do not. There is a need to attempt to understand the factors that cause those few to take drugs and others to adopt various deviant methods of coping with life. There is a great need for much more research and investigation of the various human problems of young people.

The importance of personal and vocational guidance in schools should not be overlooked. For example, concern for the pupil's personal adjustment to life should go hand in hand with concern for scholastic attainment. Another pertinent consideration is that with the increase in numbers attending university and other centres of third level education there is a danger that the needs of the individual student may be ignored. Efforts should be made to provide more counselling services in these institutions.

Education of young people should be viewed in a much wider context than that of learning at schools. There should be much greater and more varied provision for meeting the out-of-school needs of children. What we have in mind are the availability of trained youth leaders, encouragement of youth organisations, provision of playground facilities and opportunities for healthy leisure time activities.

We feel, in particular, that there is a group of young people who for one reason or another tend to be "missed out" by existing youth organisations, clubs, etc. The type of person we have in mind is the chronic delinquent and generally those who tend to "opt out" of society. Some thought should be given to ways and means of giving special help to these groups, e.g. by providing youth clubs run on non-traditional lines.

7.5 *Publicity*

We note that practically all of the presentation material that might be used for lectures or courses at present is of American or British origin – this applies to films, pamphlets and indeed professional articles. Material more appropriate to Irish circumstances should be selected and provided. We feel strongly that there should be no indiscriminate production of such material which should be carried out with defined aims and with a view to measuring its effectiveness. Drug advisory and treatment centres should be developed as resource centres for this and other educational purposes.

We realise that the subject of drugs has considerable news potential and provides gripping material for many people. We wish to warn against the tendency to treat the subject in a sensational manner while not in any sense deprecating delicate documentary coverage. All too frequently news articles, public talks and lectures would seem to be concerned with disseminating sensational material or providing entertainment rather than helpful information. One effect of this indiscriminate approach to the subject would appear to be to raise the anxiety of parents, teachers and others concerned with young people to a level where some of them tend to demand panic action. There is also the danger that this type of publicity will arouse the curiosity of young persons and lead them to experiment with drugs.

Chapter VIII

Treatment and Advice for Drug Abusers

8.1 *Present position*

In Chapter IV of our interim report we referred to the fact that at the time of our establishment there were no organised facilities for the special care of persons becoming involved in drug abuse. We referred to the establishment at Jervis Street Hospital, Dublin of an out-patient advisory and treatment service and we recommended that this service should be backed by an in-patient special care unit in a psychiatric hospital. A special unit for the treatment of drug abusers and alcoholics was subsequently established at St. Brendan's Hospital, Dublin, but this joint arrangement did not prove successful and the operation of this unit was discontinued for drug cases.

Experience of the treatment facilities provided for persons dependent on drugs through the psychiatric service of the Dublin Health Authority has highlighted the many problems associated with such treatment and with the rehabilitation services for the drug abusers. The experiment of the Courts in dealing with drug offenders also brought to light certain difficulties arising out of the general question of custodial treatment.

8.2 *Mental Treatment Acts*

Under the provisions of the Mental Treatment Acts, persons who are dependent on drugs may be admitted to psychiatric hospitals as "voluntary patients" or "temporary patients". Under the general definitions contained in the Acts, "voluntary patients" may be admitted for treatment on completion of a simple written application except for persons under 16 years, for whom application must be made by the parent or guardian and accompanied by a medical recommendation. "Temporary patients" may be admitted and detained on a compulsory basis. Application for admission is made by the husband or wife, a parent or other near relative, the Assistance Officer, or in certain circumstances any interested person and the application must be accompanied by medical certification. A temporary patient may not be detained for longer than six months but this period may be extended to twelve months in the case of an addict.

These provisions have certain limitations as far as the requirements of drug abusers are concerned. One of the main difficulties encountered in this connection is in relation to patients for whom

compulsory residential care is desirable in their own interest. In such cases relatives (usually parents) are frequently unco-operative either by refusing to make the necessary application for admission or by seeking the discharge of the patients against medical advice after they are admitted. This lack of co-operation can often be attributed to pressure being exerted by the patients by way of threats or pleading. We feel that given suitable treatment facilities and with a greater understanding of the benefits to be derived therefrom, parents could be more readily persuaded to co-operate in securing admissions and in seeing that patients remained for the full duration of any necessary treatment.

8.3 *Drug abusers and the Courts*

We understand that there is no provision in existing legislation under which persons convicted of criminal offences can be sentenced by the Courts to an institution other than a prison or place of detention. We consider that it would be of great assistance in dealing with drug abusers coming before the Courts if Justices had power to commit them, subject to expert medical advice, to a suitable institution, other than prison, which would have special treatment facilities,

8.4 *Treatment requirements of various categories of drug abusers*

In considering the facilities required to meet the various needs and circumstances of drug abusers it is necessary to have regard primarily to the types of person and the nature and degree of abuse involved. The requirements thus appear to us to fall into four main categories, as set out at (a) to (d) below.

We would like to make it clear that that recommendations which follow relate solely to persons in need of medical treatment arising out of their abuse of drugs. They do not, therefore, apply to persons who engage in the commercial peddling of drugs ("pushers") but who are not, themselves, dependent on drugs. These later persons, in our view, should be dealt with by the law (see Chapter III, para. 3.3 for comment in relation to differential treatment of offences involving unauthorised possession).

(a) *Young persons who have been experimenting with drug or abusing them occasionally (e.g. at week-ends)*. These persons seldom require in-patient treatment and can be dealt with at out-patient centres. However, should they require hospital treatment for some underlying psychiatric condition they should preferably be treated in the type of adolescent unit referred to in para. 101 of the Report of the Commission on Metal Illness. It is understood, however, that no such unit is at present available. Whether treatment for such persons is provided on an in-patient or out-patient basis care should be taken to ensure that they do not come in contact with "established" drug abusers.

(b) *Persons dependent on drugs who are strongly motivated to recover and are willing to accept treatment* may be treated in an "open unit" (i.e., a unit where patients are not compulsorily detained). These persons would include "therapeutic addicts" (i.e. cases of drug dependence developing out of the prolonged use of certain drugs under medical supervision).

(c) *Persons dependent on drugs who are convicted of crimes associated with their abuse of drugs, e.g. theft of drugs or money to obtain drugs, peddling (as distinct from commercial pushing of drugs referred to above).* In all such cases the court, in imposing a sentence, should be empowered to stipulate (following expert medical advice) that the convicted person will first be committed to a controlled therapeutic unit (a "closed unit") for short-term treatment, including medical complications of his drug dependence. On completion of such treatment he would be committed to prison (for the crime of which he was originally convicted). He should serve only a portion of his sentence in prison and should be put on long-term probation of, say, three years with the stipulation that, should he break his probation by resuming drug taking or committing further crime, he would be required to serve a further portion of the sentence. He should not, however, be released on probation unless he is being placed under rehabilitation for some time or in employment. The overall aim should be that such persons should be kept in a drug free environment for at least six months.

(d) *Other persons dependent on drugs*. Some of these persons would come before the Courts for offences involving unauthorised possession. We would envisage that such persons would be committed (following expert medical advice) to a controlled therapeutic unit (a "closed unit") for appropriate treatment. Their discharge would be followed by a period of probation on the lines indicated in the case of (c) above.

Persons in category (d) not coming before the Courts could be dealt with through the "closed unit" service, being admitted either on a voluntary basis or as "temporary" patients, but preferably the latter. There should be arrangements for the discharge of these patients on a trial basis and for compulsory readmission of patients who relapse.

8.5 "*Closed" units*

Our recommendations in sub-paragraphs (c) and (d) above envisage the availability of special controlled therapeutic units. An important factor in the provision of such a unit is its public image which should be one of temporary compulsory treatment with the object of helping young persons to overcome the drug habit and take their place in society. Parents, employers and other in the community will be

involved in the programme of such a unit which would appropriately be a centre in itself and which may or may not be associated with existing treatment services.

We recognise, however, that for a small proportion of the persons involved, such a unit may not be appropriate (e.g. repeated attempts at treating them there may have proved ineffective). For these, compulsory treatment, at least temporarily, in a maximum security institution may be necessary. The facilities outlined below should be provided in such an institution. We note that the Dublin Health Authority has already announced its intention to provide treatment along these lines at the Central Mental Hospital, Dundrum.

We consider that the accommodation and facilities to be provided in a typical "closed unit" might be as follows:–

Accommodation

The unit should be self-contained and should be structurally divided in such a way that the patient can progress through various divisions, depending on his clinical improvement. These divisions should conform as closely as possible to the following pattern. [A unit of 50 beds has been taken merely for the purpose of illustrating the proportion of beds that might be provided in the various departments of the unit. In practice the size of any unit to be provided would, of course, depend on the number of persons requiring treatment for drug dependence]:–

(a) a 5-bed detoxification ward

(b) a 20-bed unit with facilities for industrial therapy, education, leisure time activity, etc.

(c) a small 5-bed ward for those patients who have been disruptive and whose behaviour can be "shaped".

(d) a 20-bed ward for patients who go to outside employment or to places of training from the unit.

Facilities and staff

The unit should contain facilities for basic education and general rehabilitation, including a placement and guidance service. We have dealt more fully with the question of rehabilitation in Chapter IX of the report.

(a) Adequate medical staff should be available to the unit.

(b) There should be a high nurse/patient ratio. Nursing staff should be adequately trained.

(c) The staff available to the unit should include persons with adequate training and experience in social work, placement, recreation therapy and research.

(d) Occupational therapists should be available to the unit.

(e) There should be a close liaison between the unit and the Probation Service.

8.6 *Use of treatment facilities*

One of the practical difficulties arising in connection with treatment for drug abusers is the reluctance of some of the persons involved to come forward for advice or treatment. The Garda Drug Squad have been doing invaluable work in persuading some such persons to seek proper medical attention. We consider, however, that much more could be achieved in this direction through the services of social workers in the field. This matter is dealt with more fully in Chapter IX under the heading "Integration of Services".

Chapter IX

The Rehabilitation of Drug Abusers

9.1 *General objectives*

"The aim of rehabilitation must be to re-educate the individual to live without drugs and to assume or resume a normal social life."[1] Rehabilitation begins when a person who is abusing drugs first comes into contact with any of the service provided for him. While research into the characteristics of drug abusers and their particular needs is being undertaken, the initial development of services must go ahead. Existing services can be further developed or new ones set up in the light of research findings, or, indeed, the development of basic services will encourage further research in a field where, at present, there is much speculation and a shortage of factual information. With this in mind, the following proposals are made with regard to the rehabilitation of drug abusers.

9.2 *A proposed programme*

Living a drug-free life ultimately must be based on each individual's decision not to use drugs because they are incompatible with personal goals. Characteristics of many of the known drug abusers indicate that the personal goals of this group are limited to living from day to day and consequently drugs do not interfere, but actually enhance and excite, their style of life. In order to help these individuals to live a drug-free existence, worthwhile personally meaningful goals must be developed so that the individual can make a choice.

Evidence available at present points to the following factors as being some of the characteristics of the drug-abusing population:–

(i) lack of motivation towards alternative styles of life;

(ii) an employment history of multiple short-term jobs;

(iii) a pattern of education and training prematurely terminated, relative to ability and opportunity;

(iv) a general negative attitude towards the types of jobs for which they are qualified and which are open to them;

(v) inability to function at an adequate social level;

(vi) a poor self-concept and inability to cope with frustration and problems.

[1] "The rehabilitation of Drug Addicts", Report of the Advisory Committee on Drug Dependence, London, 1968. (HMSO).

A total and comprehensive programme is needed with the object of providing meaningful goals and integrating the individual into the mainstream of community life. Initially, such services could be seen as supportive and preventive for young persons who are abusing drugs but could be gradually expanded. This programme should include the following features:–

(a) An assessment and guidance service.

(b) Arrangements for accommodation.

(c) Education for self-development.

(d) Personal involvement in planning.

(e) A system for integration of the service of the Departments of Health, Justice, Social Welfare, Education, Labour and of the local statutory and voluntary bodies concerned.

These are considered in detail in paragraphs 9.3 to 9.7 below. The services, advice and expertise of the National Rehabilitation Board and An Comhairle Oiliúna and the National Manpower Service should be utilised as far as possible in the implementation of the programme. However, in order that the programme be an integrated one, all the services should, as far as possible, be administered and staffed by one team. While this discussion is confined to services for the drug-abusing population, this programme could be seen as a service to all youth "at risk". This would be its preventive aspect. If it were to be provided for all youth "at risk" it would be desirable that the unit housing such a programme be located in a community-centred facility and not in a facility that would particularly identify it with the drug treatment services.

9.3 *Assessment and guidance*

(a) *Assessment*

In order to help the participants in the programme it is necessary first to assess their abilities, skills and personality structure for appropriate planning. It is also essential for the individual to develop some objective concept of himself and his abilities.

The purpose of assessment would be:–

(i) to assess the participants by means of psychological and other tests and through periods of observation in actual educational or vocational settings;

(ii) to provide a personal relationship between a staff member and each participant. The lack of motivation towards work, and apprehensiveness about work ability, necessitates that the participants have an opportunity for dialogue and discussion and to receive support and supervision during assessment and while in placement after assessment;

(iii) to work in conjunction with the staff of the treatment centre which referred the individual for assessment.

(b) *Vocational guidance and counselling*

The purpose of this service would be:

(i) to co-ordinate opportunities for employment, education and training in the community. This would allow for alterative approaches:

Full-time training in a job.
Part-time work with part-time technical training.
Full-time education or full-time training, e.g. education for obtaining Leaving Certificate, participation in programmes such as those offered by An Comhairle Oiliúna and the National Rehabilitation Board.

(ii) to interest employers in providing such opportunities and to work in conjunction with employers when participants are placed;

(iii) to co-ordinate the service with existing services such as those of An Comhairle Oiliúna;

(iv) to provide monetary allowances for participants in the programme.

This service would be staffed by a team consisting of a psychologist (with special knowledge in career guidance) and two social workers, with the services of a consultant psychiatrist. The service would be available to all drug treatment centres (in-patient and out-patient). In this connection, it would be particularly important to note the psychology service attached to the National Rehabilitation Board.

9.4 *Arrangements for accommodation*

It is understood that one of the problems which is constantly coming to the attention of Drug Advisory and Treatment Centre at Jervis Street is that of accommodation. Some of the young people who are abusing drugs have nowhere suitable to stay. Others who live with their families need a different environment, at least for a period. Consideration should be given to the problem of accommodation on two levels:–

(a) Efforts could be made by the social workers in this programme to establish a small pool of "foster homes", i.e. families (or individuals) who would be prepared to accept young drug abusers into their homes on a long-term or short-term basis and thereby co-operate with the professional team in their rehabilitation. People willing to co-operate in this way would be screened by the social workers and carefully briefed with regard to some of the problems they might encounter. They would also need ongoing support from the social workers and the question of monetary allowances for them would have to be considered.

(b) There is a need for two residential hostels (one for boys and one for girls) for young people who have overcome the drug habit and need to live in a sheltered environment, at least for a period. No active drug abusers would be accepted into these hostels. Ideally, they would be staffed by house parents who have had some training in understanding the special problems faced by ex-drug abusers.

9.5 *Education for self-development*

As was pointed out in Chapter VI, people are progressively introduced into the customs and values and patterns of behaviour of the society in which they live and for some persons this "socialisation" process takes place within a group (i.e. a sub-culture) whose beliefs and patterns of behaviour differ from those of the wider society. Many of the people who belong to a disadvantaged sub-culture express disillusionment and frustration with life as they see it in the wider society although many of them lack the self-confidence to know how they can come to terms with it or change it. Some turn to drugs as an aid to coping with life's problems and to get a "kick" out of living which thy feel cannot be obtained in any other way.

Rehabilitation programmes for young people in this group will need to concentrate on finding out how to help them to cope with life without euphoriants and escapants. They need opportunities for decision-making, learning to evaluate, development of self-awareness and awareness of their ability to contribute to society.

With such development as a goal, the media through which it is to be accomplished could be varied. A full-time day centre would be necessary as the focal point for development of the various aspects of this part of the programme which would include the following:–

(a) Courses or seminars for those interested in art, drama, music, literature and poetry.

(b) Development of opportunities in sports, both on an individual and team basis.

(c) Outlets for leisure-time activities.

(d) Sessions dealing with mental health values, interpersonal relationships, physical health, community living and community services.

Consideration should be given to the establishment of a body to guide the programme. Such a body should include voluntary groups who would be interested in creating such programmes where they are not in existence. The bulk of the personnel provided through such a body should include an occupational therapist and a full-time rehabilitation officer (probably a qualified youth leader) who would have knowledge of community resources. This would ensure co-ordination of established programmes in clubs, youth groups and voluntary agencies and would facilitate liaison between the programmes and the participants.

The Rehabilitation Officer attached to the Centre would:–

(i) provide direction and incentive to groups who would be interested in new programmes;

(ii) co-ordinate programmes so as to make maximum use of community resources;

(iii) establish those programmes that would not be of interest to the voluntary groups.

He would also be part of the team in the Assessment and Guidance Service. The initiation of the pilot scheme might help to provide guidelines in the development of a day centre on these lines.

Government and local authority involvement in this aspect of the programme would be providing incentives in the form of grants to interested groups, making available resources, e.g, premises, and in contributing personnel for consultation, arranging courses or conducting seminars. As well as the local authorities, the Departments of Health, Education, Social Welfare and Labour would also be involved.

A joint study-group on social problems set up by the Irish Council of Churches and the Catholic Church is currently concerning itself with the area of drug abuse. Comhairle le Leas-Oige has also expressed concern and interest as have many voluntary organisations and community groups. The active participation of groups such as these would be of considerable value in planning and carrying out those aspects of the programme outlined above.

9.6 *Personal involvement of participants in planning*

This aspect of the programme is more a policy than a programme. The policy is that all personnel in this programme would regard the involvement of the participants in the planning of the programme as an educational experience in itself. Through involvement in planning their own programme and working as a group, the participants will have opportunities for learning the process of evaluating, decision-making, developing self-awareness, accepting responsibility, experiencing a sense of being part of a working team and of helping others as well as oneself.

9.7 *Integration of services*

In working out a programme of rehabilitation for drug abusers, the services of a number of Government Departments as well local authorities, voluntary organisations and interested individuals are involved. The co-ordination and integration of these services is vitally important and should be a central concern in the rehabilitation programme.

If we keep all our services “institution-based”, there is a danger that we will never reach those young drug abusers who mistrust this kind of service and will never come to the attention of a recognised treatment facility. We believe that a percentage of these young people have such an attitude to any service set up by “the authorities”.

Therefore, an "unattached worker" would be appropriately involved in this kind of work, i.e. a trained social worker whose special responsibility would be to get to know these young people in the places they frequent and to offer information, guidance and help where this is requested by the people concerned. The observations made and knowledge gained by a worker of this kind would be of great value in helping to an understanding of the "drug-taking sub-culture" and in planning services appropriate to their needs.

CHAPTER X

General

10.1 *Drug abuse more than a health problem*

We were asked by the Minister for Health to examine the problem of drug abuse but it will be clear from the wide field covered by our recommendations that the problem is far more than a "health" matter. Thus responsibility for dealing with the problem and for implementing the various measures referred to in our report rests with a number of Government Departments, other public bodies and interested groups. For example, whilst the Department of Health is essentially concerned with problems relating to treatment and epidemiological aspects of drug abuse as well as with certain aspects of the statutory controls over the availability and distribution of drugs, the Department of Justice has direct responsibility for the enforcement of these controls and for the criminal law. The department is also concerned with the broader issue of delinquency which has often been linked with drug abuse. The Department of Education is vitally concerned in the matters covered in our Chapter on Education and Publicity and on certain aspects of the rehabilitation of drug abusers. The Revenue Commissioners and the Department of Posts and Telegraph have responsibility in relation to the smuggling of drugs which is one of the main sources of the two substances at present being abused – cannabis and LSD.

10.2 *Liaison between Government Departments*

We recommend that there be close and continuing liaison between these Departments for exchange of relevant information to ensure that the problem of drug abuse is being dealt with effectively.

10.3 *Permanent Advisory Body*

Our experience has been that the drug scene changes rapidly making for difficulties in recommending permanent remedies in relation to the various aspects of the problem. Consequently, apart from the liaison between the Government Departments recommended in the preceding paragraph, we recommend that consideration be given to the establishment of a permanent advisory body, to keep the position regarding drug abuse under review and furnish advice to the appropriate Ministers. The membership of such a body could be on lines similar to that of the working party with, perhaps, a somewhat broader representation.

10.4 *Need for prompt action*

The abuse of drugs has grown steadily in Dublin during the last three years and there is evidence to suggest that it exists in other

parts of the country also. As indicated in Chapter I (para. 1.3) we were glad to note that the recommendations made in our interim report were acted upon promptly by the Department of Health. We believe that the further recommendations which we now make would be effective in preventing the spread of drug abuse as well as helping those persons who have become dependent on drugs. The evidence available of the rapid growth of drug abuse in countries where corrective and preventive measures were not taken at an early stage compels us once again to stress the importance of taking prompt action on our recommendations.

CHAPTER XI

Acknowledgements

11.1 *Persons and bodies who made submission etc.*

We are grateful to the several bodies and persons who made submission or gave oral evidence to the working party and who otherwise assisted us in our task. We owe a special debt of gratitude to the Dublin Health Authority and the Committee of Management of Jervis Street Hospital, Dublin (for information furnished in relation to the operation of the advisory and treatment centre for drug abuse and in relation to the carrying out of a survey of persons involved in drug abuse); the Social Science Department of University College, Dublin (for advice and assistance in connection with the carrying out of a survey of drug abuse of Dublin); Dr. G. Dean, Director, Medico-Social Research Board (for the report of a study in relation to drug abuse amongst Dublin post-primary school children); Professor C.W.M. Wilson, Department of Pharmacology, Trinity College, Dublin (for information supplied by him on his investigation of drug taking etc. among secondary school pupils and the presence of amphetamine in human urine); W.N. Houghton, Esq., Inner London Education Authority (for advice and information on certain aspects of the problem of education in relation to drug abuse), Dr. T.M. Gregg, Medical Director, National Rehabilitation Board (for his very helpful and informative advice in connection with our recommendations on rehabilitation); Professor R.F. Timoney, Dean of Studies, College of Pharmaceutical Society of Ireland (for information on methods of preparing LSD); District Justice Cathal O Floinn, President of the District Court, for advice and assistance particularly in relation to the position of the Courts in dealing with drug abusers.

12.1 O*ther persons who gave special assistance*

We also wish to thank especially those persons who were co-opted to various sub-committees and who gave valuable advice and assistance in relation to specific aspects of the work of those committees.

11.3 *Acknowledgment to Secretary and his assistants*

We wish to record our warm appreciation of the very valuable services rendered by our Secretary, Mr. C. Keogh and his assistants in the Department of Health.

Mr. Keogh's enthusiasm and efficiency in dealing with our work simplified our task appreciably. He took great pains in collecting and sifting the statistics and information required by the working party and the part he played in drafting and producing the Report are a measure of his competence and ability.

We are very much indebted to him.

Chapter XII

Summary of Recommendations

Statutory controls

(a) Enforcement, penalties, etc.

(i) There should be no undue infringement of freedom of individuals in the exercise of police powers of arrest, etc. (para. 3.2).

(ii) There should be a system of scaled penalties for drug offences, depending on the type of drug involved (para. 3.3).

(iii) There should be a clear distinction in law between "simple" possession of drugs and possession for the purpose of illicit supply to others (para. 3.3).

(b) *Cannabis*

(i) Existing controls over cannabis should be maintained but its position should be kept under review in the light of experience and research (para.3.4).

(ii) Possession of a small quantity of cannabis for one's own use should not normally be regarded as crime to be punished by imprisonment (para. 3.4).

(c) LSD

(i) The grave dangers involved in the abuse of LSD should be made known to persons "at risk" as far as this drug is concerned (para. 3.5).

(ii) The possibility of local illicit manufacture of LSD should be kept under investigation (para. 3.5).

Thefts, smuggling etc.

(i) There should be regular inspection of wholesalers and other dealers in bulk in drugs (para. 3.6).

(ii) There should be continued liaison between the appropriate Departments and with other authorities abroad with a view to preventing the smuggling of drugs and the use of special techniques should be considered for dealing with the problem (para. 3.7 (a)).

Other preventive measures

(i) The position regarding ready availability of hypodermic syringes should be examined (para. 3.7 (b)).

(ii) The position regarding forged prescriptions should be closely watched (para. 3.7 (c)).

(iii) Members of An Garda Siochana should be given special training in connection with drug abuse and the strength of the Garda Drug Squad should be kept under review (para. 3.9).

(iv) In view of increased evidence of drug abuse in some of the larger towns outside Dublin the position in these areas should be kept under close surveillance (para. 2.5) and Gardai should be trained for the purpose (para. 3.8).

(v) Discotheques and other such clubs should be subject to some form of control by way of annual registration or licence (para. 3.9).

Prescribing, etc. of drugs

(i) Action should be taken to deal with the problem of "over-prescribing" of drugs liable to abuse, if necessary by legislation (paras. 5.1 and 5.2).

(ii) The administration and supply of certain specified drugs to persons dependent on such drugs should be subject to special controls to be provided for in legislation (para. 5.3).

Keeping of records in relation to drug dependence

(i) The registration of persons dependent on drugs should be carried out at special centres (para. 5.4).

(ii) The question of having a "drugs and medicines" card for recording the dispensing of certain classes of drugs should be examined (para. 5.5).

Education and Publicity

(i) Information and advice in connection with drug abuse should be provided as a matter of urgency for parents, teachers and others who come in contact with young persons (para. 7.2).

(ii) Special provision should be made for young persons who have been involved in drug abuse or who associate with those so involved (para. 7.3 (a)).

(iii) Children at risk should be identified as early as possible. e.g. through the School Health Examination and School Guidance Services (para. 7.3 (b)).

(iv) School authorities who feel strongly about the need to provide their pupils with information regarding drugs should ensure that information is given by persons with an adequate knowledge of the subject and them only as part of religious education or of health or civics programmes (para. 7.3 (c)).

(v) Efforts should be made to provide more counselling services for those attending universities and other centres of third level education (para. 7.4).

(vi) There should be greater and more varied provision for meeting the out-of-school needs of children (para. 7.4).

(vii) Publicity material (e.g. pamphlets, films), appropriate to Irish circumstances should be selected and provided; the production of such material should be carried out with defined aims and with a view to measuring its effectiveness (para. 7.5).

(viii) The question of communicating information to young persons on drugs should be examined by a group representative of the Departments of Health and Education as well as other bodies concerned (para. 7.3(d)).

Treatment of drug abusers

(i) The Courts should have power to commit drug abusers to an institution with special treatment facilities, other than a prison (para. 8.3).

(ii) Special accommodation and treatment facilities should be provided to meet the varying needs of different categories of drug abusers (paras. 8.4 and 8.5).

Rehabilitation

A comprehensive programme for the rehabilitation of drug abusers should be provided incorporating an assessment and vocational guidance service, the provision of residential accommodation, opportunities for education and self-development, and continuity and integration with other services (para. 9.2 to 9.8).

General

(i) There should be close and continuing liaison between the Government Departments concerned with different aspects of drug abuse (para. 10.2).

(ii) Consideration should be given to the establishment of a permanent advisory body to keep the position under review and furnish advice to the appropriate Ministers (para.10.3).

Signed

Karl Mullen (Chairman)	M. P. Lawler
W.E. Boles	P. I. Melia
F. Campbell	Denis Mullins
S. Hensey	Ed. J. O'Dea
P. A. Jennings	Tomás A. O Gormáin
P. C. Jennings	R. D. Stevenson
Noreen Kearney	Mary Whelan

C. Keogh (Secretary) 1 February, 1971.

APPENDIX A

ADDRESS BY MR. SEAN FLANAGAN, T.D., MINISTER FOR HEALTH, AT THE FIRST MEETING OF THE WORKING PARTY ON DRUG ABUSE – CUSTOM HOUSE, DUBLIN, 14TH JANUARY, 1969, AT 3.30 P.M.

Mr. Chairman, Lady and Gentlemen,

It gives me great pleasure to meet you to-day and to have the opportunity of again thanking you for agreeing to act on the Working Party. I appreciate that I have given you a difficult task but you are all interested in the subject of drug abuse and I am confident that you will carry out your work efficiently and expeditiously under the leadership of your Chairman who, no doubt, will crack the big whip from time to time and keep you hard at work. A Social Worker remains to be appointed to your group and I think I should add at this point that your membership will also be increased by the addition of a pharmacist.

As you are aware, in this country, we have statutory controls over drugs and I am seeking further powers with a view to preventing the abuse of drugs. But other countries have found that laws are not in themselves the answer to the problem. For example, the United States of America has a most comprehensive legal code dealing with the control of drugs but they still have a very big drug problem. Human and social elementals are most important factors and that is why I have laid such stress in the terms of reference of the Working Party on the examination of measures aimed at discouraging young persons from starting the use of drugs and on the rehabilitation of persons who have acquired the drug habit.

There has been a tendency to regard the drug taker as a social outcast and in some respects as a criminal type; but I do not think that this is a realistic approach to the problem.

For example, many of the people taking drug are young persons, with no evil intent, taking them occasionally "for kicks" or to be "with it" who would, I should think, have nothing to do with drugs if they were properly advised and informed of the harmful consequences of continuing to take them.

Again, while persons who have become dependent on drugs my have been culpable in bringing about their own downfall. I think that many of them are more to be pitied than punished, and should be regarded as sick people in need of medical care to be treated with sympathy and understanding and be helped in every way possible to overcome their dependency on drugs.

I am not, of course, referring to the drug peddlers, trafficking in drugs for gain, these deserve no sympathy and should be punished to the full extent permitted by law.

I think that you are starting your work at a very appropriate time– before the problem of drug abuse in this country has become extensive.

Your chairman has already been informed that I and my Department will be only too pleased to facilitate and assist you in any way possible in your work.

Having said these few words I think I should now leave you to get on with your work.

APPENDIX B

ADDRESS BY ERSKINE CHILDERS, ESQ., T.D., MINISTER FOR HEALTH TO THE MEMBERS OF OHE WORKING PARTY ON DRUG ABUSE AT THEIR MEETING HELD IN THE CONFERENCE ROOM, CUSTOM HOUSE, ON MONDAY 2ND MARCH, 1970.

Mr. Chairman, Ladies and Gentlemen,

Although a certain amount of time has elapsed since you submitted your interim recommendations to me it has always been my intention to meet the members of the Working Party so that I could thank you personally not only for the report itself but also for your dedicated services, undertaken against a background of press publicity. Because of other inescapable commitments, particularly in connection with the passage of the Health Bill through the Dail and Seanad, it is unfortunate that this intention could not be realised until now.

I am therefore very glad to be here today and to have this opportunity of meeting you individually in an informal atmosphere. I understand that the Working Party have been meeting regularly twice a month over the past year or so of its existence and that you have also been coming together in various sub-committees between one meeting and the next. Such a heavy schedule imposes a considerable strain on your time and energy and I must express to you my deep appreciation of the fact that you are doing this work, for the benefit of the community as a whole, on top of your normal duties which in themselves impose a heavy burden.

Although, like many other lay people, the subject of drugs was quite new to me when I became Minister for Health, I had, for various reasons, taken a personal interest in the problem of drug abuse long before that. I found your interim report both interesting and constructive and I think that your decision to issue interim recommendations on matters which could be dealt with in advance of your final report was fully justified.

The officers of my Department who are on the Working Party have, I am sure, kept you fully informed of the steps taken to implement these recommendations. There are a few matters, however, to which I would like to refer.

Section 76 of the Health Bill. 1969

I was very gratified with the ready acceptance by the Oireachtas of my amendment to the Health Bill which will enable me to make the unauthorised possession of certain drugs which are liable to abuse, a punishable offence. I think that this acceptance can be regarded as the measure of concern felt by the community as a whole regarding the problem of drug abuse.

I am at present consulting various interested bodies regarding regulations which would give effect to the new provisions and I expect to be in a position to make these regulations at an early date. I understand that the Working Party will be considering a memorandum in the matter at their meeting today.

The provisions in Section 76 of the Bill are, however, only an interim measure pending the more comprehensive provisions in the proposed Drugs and Poisons Bill for dealing with drug abuse. I understand that a memorandum outlining these proposals has been considered by the Working Party.

Amphetamines

In your interim recommendations you endorsed the action which my Department had taken with a view to obtaining the agreement of the medical profession to voluntary restriction in the use of amphetamines.

However, things have moved rather swiftly in this sphere since then and at my meeting with representatives of the medical profession in October last, at which your Chairman was present, it was unanimously agreed that statutory measures should be taken to restrict the availability of amphetamines and related compounds. The Medical Preparation (Control of Amphetamine) Regulations, 1969, were the outcome of that meeting. As you know these Regulations impose rigid controls over the manufacture, importation and sale of the substances in question. It is, of course, too early yet to attempt to assess the overall effect of the new controls. However, one immediate good which the new arrangements have produced is that stocks of amphetamines held by retail chemists, hospitals and Health Authorities throughout the country have been removed from their ordinary channels of distribution and are now kept in one centre for safekeeping and further disposal. I must congratulate all those who have been concerned in this operation and to thank them for their co-operation in bringing it to a successful conclusion.

Drug Squad

In my view the Drug Squad have performed wonders with the limited number of personnel available to it. I understand, arising out of your recommendation, that extra men (and a woman), have been allocated to these duties and that arrangements have been made for members of the Squad to attend a British Police Course on drugs to be held in the near future.

I sincerely hope that the Gardai will continue their humane approach to these unfortunate young people who have become involved in drugs. It is important that these youngsters as well as their parents and guardians should be able to approach the members of the Drug Squad in the confident expectation that they will obtain advice and assistance whenever possible thus avoiding the less desirable remedies which the law provides at the other extreme.

Advice and Treatment Centre

The provision of residential treatment facilities for persons who become dependent on drugs in St. Dymphna's Unit, which I was

privileged to open formally in December last, completed the establishment of special treatment facilities for drug abusers following the opening earlier last year of the out-patient centre at Jervis Street Hospital. I understand that both units are now functioning on the lines generally recommended by the Working Party. The facilities which are now available through this combined service fulfil a long felt need. Since the service is an entirely new venture difficulties are bound to arise in the early stages but I am confident that these will be overcome in time and I will do my utmost to ensure that any additional requirements which are shown to be necessary in the light of experience will be provided.

Other Measures

Nothing but good can come from the steps which you have wisely recommended and which have been implemented so far. There are other matters, however, of considerable importance on which you have not completed your examination, notably in the fields of education, treatment and rehabilitation. I can readily appreciate that these are matters which give rise to many complex issues which may take some time to clarify but if your achievements to date can be taken as an indication of your future progress I know that I can look forward to receiving your recommendations in the near future.

APPENDIX C

LIST OF SUB-COMMITTEES

(1) *Submission and oral evidence*
Dr. F. Campbell
Mr. Alan Chard
Dr. M. P. G. Lawler
Dr. P. I. Melia
Mrs. M. Whelan

(2) *Education andPpublicity*
Mr. A. O Gormain
Mr. S. Hensey
Miss N. Kearnery
Dr. M. P. G. Lawler

(3) *Drug-taking Sub-culture*
Dr. F. Campbell
Mr. A. Chard
Miss N. Kearney
Dr. M. P. G. Lawler
Dr. P. I. Melia
Mr. B. O'Callaghan
Mrs. M. Whelan

(4) *Special survey of drug abuse*
Mr. I. Fischer*
Mr. S. Hensey
Dr. A. Kearney*
Miss J. Porter$^{\Psi}$
Dr. R. D. Stevenson
Mrs. M. Whelan
Mr. D. O'Donovan*

(5) *Rehabilitation of drug abusers*
Mrs. M. Whelan
Miss. N. Kearney
Miss J. Porter$^{\Psi}$
Miss. M. Munnelly$^{\Psi}$
Miss. J. Glynn$^{\Psi}$

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*Dublin Health Authority

$^{\Psi}$Drug advisory and Treatment Centre, Jervis Street Hospital, Dublin.

APPENDIX D

PERSONS CHARGED ETC. IN CONNECTION WITH DRUG OFFENCES
1665-1970

Year	Age	Occupation	Offence
1965:			
January	33	– (Foreign-National)	Unauthorised possession of Indian hemp
August	28	Business-man	Unauthorised possession of Indian hemp
1966:			
April	18	Student	Unauthorised possession of cannabis
1967:	–	–	–
1968:			
February	22	Student	Unauthorised possession of cannabis
February	19	Unemployed	Unauthorised possession of morphine
April	19	Unemployed	Unauthorised possession of morphine and pethidine
(1) August	19	Storeman	(1) Unauthorised possession of morphine and pethidine. Larceny of drugs from dispensary.
(2) December			(2) Supplying morphine–4 cases
September	18	Factory hand	Larceny of morphine and pethidine from dispensary
October	16	Dispatch clerk	Larceny of morphine and pethidine
November	19	– (Foreign-National)	Unauthorised possession of cannabis
November		Chef	Unauthorised possession of cannabis
November	18	Clerk (female)	Larceny of drugs from wholesale chemist
November	18	Clerk (female)	Larceny of drugs from wholesale chemist
November	18	Docker	Forgery of prescriptions–4 cases
December	30	Journalist	Illicit importation of heroin.
	19		Unauthorised possession of heroin and morphine. Supplying morphine.
December	19	Unemployed	Larceny of drugs from wholesale chemist
December	18	Packer	Larceny of drugs from chemist
December	18	Packer	Larceny of drugs from chemist
December	19	Dentist's Receptionist (female)	Larceny of drugs
December	19	Unemployed	Larceny of drugs from dispensary
December	20	Apprentice	Larceny of drugs from dispensary
December	22	Unemployed	Larceny of drugs from hospital
December	20	Self-employed	Unauthorised possession of cannabis
December	19	Storeman	Larceny of drugs
December	19	Soldier	Receiving stolen drugs
December	19	Unemployed	Receiving stolen drugs
	21	Part-time musician	Receiving stolen drugs
1969:			
January	21	Photographer	Unauthorised possession of cannabis
January	18	Post-office clerk	Unauthorised possession of morphine
January	18	Student	Unauthorised possession of morphine
January	18	– (Foreign-National)-female	Unauthorised possession of morphine

APPENDIX D–*continued*

Year	Age	Occupation	Offence
1969(*contd.*)			
January	18	–(Foreign-National)–female	Unauthorised possession of morphine
January	18	–(Foreign-National)	Unemployed possession of cannabis
(1) January (2)March	18	Unemployed	(1) Receiving stolen drugs (2) Unauthorised possession of morphine and cocaine, Larceny of drugs from dispensary–2 cases.
January	33	Packer	Larceny of drugs
(1) February (2) March	16½	Unemployed	(1) Unauthorised possession of pethidine. Larceny of morphine from dispensary. (2) Larceny of drugs from dispensary.
February	17	Unemployed	Unauthorised possession of pethidine. Receiving stolen drugs.
(1) February (2) February (3) March (4) April	19	Unemployed	(1) Larceny of morphine from dispensary. (2) Unauthorised possession of morphine and cocaine. Larceny of drugs from chemist's shops (3) Unauthorised possession of morphine. Larceny of drugs from 4 dispensaries. (4) Larceny of drugs from dispensaries–4 cases.
February	19	Scientist	Unauthorised possession of morphine and cocaine. Larceny of drugs from chemist.
February	19	Clerk	Unauthorised possession of morphine and cocaine. Larceny of drugs from chemist.
February	16	Dispatch clerk	Unauthorised possession of morphine and cocaine. Larceny of drugs from chemist.
March	19	Unemployed	Larceny of drugs from hospital–2 cases. Unauthorised possession of morphine.
(1) March (2) June	16	Unemployed	(1) Unauthorised possession of morphine. Larceny of drugs from dispensary. (2) Larceny of drugs from hospitals and chemists' shops.
March	19	Storeman	Unauthorised possession of morphine. Larceny of drugs from dispensary.
(1) March (2) April (3) October	16	Student	(1) Unauthorised possession of morphine and cocaine. Larceny of drugs from dispensary. (2) Larceny of drugs from dispensary. (3) Larceny of drugs from manufacturing chemist.
(1) March (2) April	19	Lorry helper	(1) Unauthorised possession of morphine. Larceny of drugs from dispensaries. (2) Larceny of drugs from dispensaries.
March	19	Unemployed	Larceny of drugs from the person.
April	19	Unemployed	Larceny of drugs from dispensary.
April	18	Unemployed	Unauthorised possession of heroin. Larceny of amphetamines.
April	19	Unemployed	Unauthorised possession of heroin and cocaine. Larceny of drugs from dispensary and chemists' shops.
April	21	Apprentice	Unauthorised possession of heroin and cocaine. Larceny of drugs from chemists' shops.
April	18	Unemployed	Unauthorised possession of heroin and cocaine. Larceny of drugs from chemists' shops.

APPENDIX D–*continued*

Year	Age	Occupation	Offence
1969(*contd*.)			
April	17	Unemployed	Unauthorised possession of pethidine. Larceny of drugs from dispensary.
April	18	Unemployed	Unauthorised possession of morphine and pethidine. Larceny of drug from dispensary.
April	18	Unemployed	Unauthorised possession of morphine and pethidine. Larceny of drug from dispensary.
April	16½	Lorry Helper	Larceny of drugs from hospital.
May	16	Unemployed (female)	Larceny of drugs from dispensary
May	18	Unemployed	Unauthorised possession of morphine. Larceny of drugs from hospital.
May	18	Jeweller	Unauthorised possession of morphine and pethidine. Larceny of drugs from dispensary.
May	18	Student	Breaking and entering dispensary
May	19	Unemployed	Larceny of drugs from dispensary
June	18	Unemployed	Attempted larceny of drugs from hospital
June	19	Photographer	Unauthorised possession of morphine
June	19	Unemployed	Unauthorised possession of morphine
June	16½	Apprentice	Larceny of drugs from dispensary
June	16½	Shop Assistant	Larceny of drugs form dispensary
July	18	Unemployed	Larceny of drugs from hospital
July	18	Unemployed	Larceny of drugs from hospital
July	22	Student	Unauthorised possession of cannabis
July	21	Student	Unauthorised possession of cannabis
August	16½	Unemployed	Larceny of syringes from hospital
September	18	Unemployed	Larceny of drugs from doctor's car
September	23	Driver	Unauthorised possession of cannabis
September	22	Company Director	Unauthorised possession and supply of cannabis
September	22	Unemployed	Unauthorised possession of heroin; procuring methadone
September	18	Packer	Larceny of methadone from wholesale chemist and supplying methadone
October	19	Unemployed (female)	Unauthorised possession of cannabis
October	22	Unemployed	Unauthorised possession of cannabis
October	17	Unemployed	Larceny of drugs from dispensary
October	19	Unemployed	Larceny of drugs from dispensary
October	19	Unemployed	Larceny of drugs from dispensary
October	18	Unemployed	Larceny of drugs from dispensary
October	21	Carpenter	Larceny of drugs from manufacturing chemist
November	19	Jeweller	Unauthorised possession of cannabis
November	21	Clerk (female)	Unauthorised possession of cannabis
November	22	Typist (female)	Unauthorised possession of cannabis
December	22	Labourer	Unauthorised possession of cannabis
December	22	Ship's Engineer (foreign national)	Unauthorised possession of cannabis
1970:			
January	24	Labourer	Unauthorised possession of cannabis
January	22	Unemployed	Unauthorised possession of morphine and pethidine. Larceny of drugs from chemist's shop.
January	18	Unemployed	Larceny of drugs from dispensary.
(1) January	18	Unemployed	(1) Unauthorised possession of morphine and pethidine. Larceny of drugs form hospital.
(2) March			(2) Larceny of drugs from chemist's shop.
(3) April			(3) Attempting to procure drugs.

APPENDIX D–*continued*

Year	Age	Occupation	Offence
1970(*contd*.)			
(4) December			(4) Attempting to procure or procuring dipipanone on forged prescriptions (7 charges).
(5) December			(5) Unauthorised possession of dipipanone
(6) December			(6) Attempted larceny of drugs from chemist.
(1) January	19	Unemployed	(1) Unauthorised possession of morphine and pethidine Larceny of drugs from hospital
(2) February			(2) Larceny of drugs from health centre
(1) February	19	Unemployed	(1) Unauthorised possession of heroin and morphine
(2) February			(2) Larceny of drugs from doctor's surgery
(1) February	38	Unemployed (Foreign National)	(1) Unauthorised possession of cannabis
(2) April			(2) Unauthorised possession of cannabis
(1) February	22	Unemployed	(1) Unauthorised possession of heroin, morphine, cocaine, cannabis, pethidine, etc.
(2) March			(2) Attempting to procure drugs
(3) May			(3) Larceny of drugs from doctor's surgery
(4) October			(4) Larceny of drugs from chemists
(5) November			(5) Larceny of drugs from doctors' surgery Larceny of drugs from chemist Unauthorised possession of morphine and pethidine
(1) February	18	Unemployed (female)	(1) Unauthorised possession of heroin, morphine, pethidine, etc
(2) March			(2) Attempting to procure drugs
(3) May			(3) Larceny of drugs from doctor's surgery
February	21	Unemployed (female)	Unauthorised possession of cannabis
March	19	Unemployed	Larceny of drugs from dispensary
(1) March	19	Unemployed	(1) Unauthorised distribution of drugs (2) Unauthorised possession of cannabis
(2) April	17	Unemployed	Larceny of drugs from nursing home
April	22	Musician	Unauthorised possession of cannabis
April	20	Advertiser	Unauthorised possession of cannabis
April	18	Musician	Unauthorised possession of cannabis
April	15	Unemployed (female)	Unauthorised possession of cannabis
April	18	Unemployed	Unauthorised possession of cannabis
April	24	Unemployed	Unauthorised possession of cannabis
April	22	Unemployed	Unauthorised possession of cannabis
April	19	Unemployed	Unauthorised possession of cannabis
April	25	Unemployed	Unauthorised possession of cannabis
April	22	Unemployed (Foreign National)	Unauthorised possession of cannabis
April	19	Student (Foreign National) Female	Unauthorised possession of cannabis
April	16½	Student (Female)	Unauthorised possession of cannabis
(1) April	21	Student	(1) Unauthorised possession of cannabis
(2) September			(2) Unauthorised possession of cannabis
April	19	Packer	Attempting to procure dipipanone
May	18	Clerk (Foreign National!)	Unauthorised possession of cannabis
May	20	Unemployed (Foreign National)	Unauthorised possession of cannabis

APPENDIX D–*continued*

Year	Age	Occupation	Offence
1970(*contd*.)			
May	16½	Unemployed	Attempting to procure dipipanone
May	18	Unemployed	Unauthorised possession of pethidine
May	19	Unemployed	Attempting to procure dipipanone
June	20	Unemployed	Larceny of drugs from hospital
June	20	Unemployed	Larceny of drugs from hospital
July	24	Unemployed (Foreign National)	Unauthorised possession of cannabis and amphetamine
July	22	Unemployed (Foreign National)	Unauthorised possession of cannabis
July	22	Student	Unauthorised possession of cannabis
July	19	Unemployed (Foreign National)	Unauthorised possession of cannabis
July	25	Unemployed (Foreign National)	Unauthorised possession of cannabis
July	19	Warehouse Worker	Unauthorised possession of cannabis
July	16	Designer	Unauthorised possession of cannabis
(1) August	16½	Shop Assistant	(1) Unauthorised possession of cannabis and LSD
(2) September			(2) Unauthorised possession of cannabis and LSD
August	22	Musician	Unauthorised possession of cannabis
August	32	Driver	Unauthorised possession of amphetamines
August	28	Unemployed	Unauthorised possession of pethidine
August	28	Nurse (female)	Unauthorised possession of pethidine
August	30	Unemployed	Unauthorised possession of cannabis
August	26	Unemployed	Unauthorised possession of cannabis
August	22	Unemployed	Unauthorised possession of cannabis
August	23	Unemployed	Unauthorised possession of cannabis
August	22	Unemployed	Unauthorised possession of cannabis
August	19	Unemployed	Unauthorised possession of cannabis
August	21	Unemployed	Unauthorised possession of cannabis
August	20	Unemployed	Unauthorised possession of cannabis
August	20	Unemployed	Unauthorised possession of cannabis
August	22	Unemployed	Unauthorised possession of cannabis
September	19	Unemployed	Unauthorised possession of cannabis
September	18	Unemployed	Unauthorised possession of cannabis
September	28	Driver	Unauthorised possession of cannabis
September	28	Fitter	Unauthorised possession of cannabis
September	26	Plumber	Unauthorised possession of cannabis
September	27	Clerk	Unauthorised possession of cannabis
September	22	Student	Unauthorised possession of cannabis and LSD
September	23	Unemployed	Unauthorised possession of cannabis and LSD
October	17	Unemployed	Unauthorised possession of LSD
November	20	Labourer	Unauthorised possession of LSD
November	21	Unemployed	Unauthorised possession of LSD
November	20	Electrician	Unauthorised possession of LSD
November	19½	Unemployed	Attempting to procure dipipanone
December	17	Unemployed	Unauthorised possession of LSD
December	20	Unemployed	Attempted larceny from chemist

NOTES

(1) Where the person concerned was involved in more than one charge etc. these are listed numerically in the first and final columns.

(2) Four persons charged etc. with drug offences in 1968 were also charged in 1996. Seven persons charged etc. with drug offences in 1969 were also charged in 1970.

APPENDIX E

NOTIFICATION SENT BY PSYCHIATRISTS TO THE DEPARTMENT OF HEALTH OF CASES OF DRUG DEPENDENCE OR ABUSE COMING TO THEIR NOTICE DURING THE YEAR ENDED 31 DECEMBER, 1970

	Total No. of Notification	Total	Male	Female	Sex not stated
		159	106	50	3
Age	Under 16	5	2	3	–
	16 to 21 ... ... …	80	60	20	–
	22 to 25 ... ... …	19	17	2	–
	Over 25... ... … …	53	27	24	2
	Age not stated	2	–	1	1
Conjugal Status	Married... ... … …	32	15	15	2
	Single... ... … …	124	91	32	–
	Windowed... ... …	1	–	1	–
	Separated... ... …	1	–	1	–
	Status not stated. … …	1	–	–	1
Employment	Employed... ... …	47	34	12	1
	Unemployed... ... …	78	53	25	–
	Employment not stated	34	19	13	2
Living at Home	Living at home... ... …	112	76	34	2
	Living away from home	43	27	16	–
	In prison... … … …	2	2	–	–
	In hospital... ... …	1	1	–	–
	Not stated... ... …	1	–	–	1
Nationality	Irish... ... … …	137	89	46	2
	Irish (returned within 3 months) ... ... … …	13	11	2	–
	Non-Irish... ... … …	6	4	2	–
	Nationality not stated …	3	2	–	1
Previous Treatment	Those who had previous treatment … … …	72	45	25	2
	Those who had not previous treatment … …	86	61	25	–
	Not stated … … …	1	–	–	1
Degree of Dependence	Unable to maintain normal living … … …	31	20	10	1
	Require drugs to maintain normal living… …	57	32	23	2
	Use drugs sporadically (parties) … … …	64	47	17	–
	Degree of dependence stated… … … …	7	7	–	–

Occupation	Number of cases	Drugs mainly involved	Number of cases
Manual Worker … … …	20	(*a*) Hallucinogenic (LSD, etc.)	37
Student … … … …	20	(*b*) Cannabis	22
Housewife … … … …	11	(*c*) Other drugs classified as narcotics: –	
Professional (including medical and ancillary personnel)	10	Heroin	
Others … … … …	18	Pethidine	
Not specified … … …	80	Morphine	20
		Dipipanone	
		Dextromoramide	
		(*d*) Sedative and Hypnotic	
		(i) Barbiturates … …	30
		(ii) Non-barbiturates …	4
		(*e*) Amphetamines and Amphetamine compounds	13
		(*f*) Tranquillisers and Anti-depressants … … …	6

Notification submitted by Psychiatrist or Hospital	Number of cases	Mode of Referral	Total
Drug Advisory and treatment..		General Practitioner … …	36
Centre, Jervis Street … …		Direct … … … … …	19
Hospital … … … …	107	Gardai and Courts … … …	11
Practising psychiatrists … …	9	Relatives and friends … …	91
St. Brendan's, Dublin … …	14	Not stated … … … …	2
St. Patrick's, Dublin … …	12		
Our Lady's, Cork … … …	5		
St. Senan's, Enniscorthy …	3		
St. Luke's, Clonmel … …	2		
St. Finan's, Killarney … …	2		
St. John of God, Dublin… …	2		
St. Mary's, Castlebar … …	1		
St. Canice's, Kilkenny … …	1		
St. Conal's, Letterkenny …	1		

NOTES ON DRUG CASES

(*a*) In 38 cases the drug was first used for medicinal purposes.

(*b*) In 120 cases the drug was not first used for medicinal purposes.

(*c*) In 1 case purpose of first use was not stated.

APPENDIX F

BIBLIOGRAPHY

The following is a list of publications which were consulted by members of the working party during the course of its deliberations. This list includes a number of publications which are referred to specifically in the report. It does not purport to be an exhaustive list as far as the literature under the different headings mentioned is concerned but should form a useful guide to authoritative sources of information on various aspects of drug abuse.

Cannabis:

Report of "Indian Hemp Drugs Commission" (10 Vols.). Excerpt of Summary and conclusions reprinted in "The Marihuana Papers", ed. Solomon, D., Indianapolis, p. 192.

Mayor's Committee on Marihuana, New York, Lancaster, Pennsylvania. The Marihuana Problem in the City of New York (the "La Guardia Report" (1944), reprinted in the "Marihuana Papers", *ibid*.)

British Home Office Advisory Committee on Drug Dependence "Cannabis" (H.M.S.O. 1968).

Razor, R.W. "Narcotic Addiction in young people in the United States" (in "The Pharmacological and Epidemiological aspects of Adolescent Drug Dependence", Ed. C. W. M. Wilson, Oxford, 1968).

Drug Taking Sub-Culture:

Kerouac, J. "On the Road" (London 1958).

Lipton, L. "Holy Barbarians" (W. H. Allen, 1959).

Education and Publicity:

Wiener, R. S. P., Ph.D. "Drugs and Schoolchildren" (Longman London 1970).

McKennall, A.C. and Thomas, R. K. "Adults' and Adolescents' smoking habits and attitudes", (H.M.S.O. London).

Department of Education and Science, England. "A Handbook of Health Education" (H.M.S.O. 1968).

Christian Education Movement, Annandale, North End Road, London N.W. 11. "Probe" No. 2 1967 (Magazine).

British Medical Association, Family Doctor Publication, 47-51 Chalton Street, London N.W. 1. "Pot or Not?" (A plain guide to drug dependence by A. J. Wood, M.B., B.S., D.P.H.).

Do. "Behind the Drug Scene" (by Michael Schofield and others).

Cleary, C. V. H. "About Drugs" (Garden City Press, Letchworth, Herts, 1965).

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Booklet:

Newell, P. and others. "Drug Abuse-Escape to Nowhere". (A guide to educators).

"Teenagers and Drugs". (Symposium of articles from "Education" June-July, 1966. "Croydon Times Ltd., London).

U.S Department of Health Education and Welfare.

Leaflets:
"Narcotics – Some questions and answers".
"The Up and Down Drugs – Amphetamines and barbiturates";
"L.S.D"
"Alcohol and Drugs – Hidden Dangers" (1965).

Society for Promoting Christian Knowledge, London

Wood, A.J., M. B., B. S., D. P. H.

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PRESS STATEMENT ISSUED ON 3RD NOVEMBER, 1969, REGARDING INTERIM RECOMMENDATIONS MADE BY THE WORKING PARTY ON DRUG ABUSE

The following statement has been issued by the Government Information Bureau on behalf of the Minister for Health:–

The Working Party on Drug Abuse which was established by the Minister for Health in December, 1968 have submitted interim recommendations to the Minister.

The Working Party pointed out that the task assigned to them raises certain issues which will take some more time to consider adequately but decided to submit recommendations in regard to some matters on which they considered that action need not and should not be delayed pending submission of their final report.

Because of the emphasis in these recommendations on security measures and the role of the Gardai in combating drug abuse the Working Party felt that it might appear that they concentrated unduly on these aspects. They point out, however, that the importance of education and the need for adequate treatment and rehabilitation facilities in dealing with the problem of drug abuse is fully appreciated. The Working Party have not yet completed their examination of these matters which will be dealt with in their final report.

Extent of Drug Abuse in Ireland

In the view of the Working Party, there is at present a significant drug abuse problem in Dublin – available information indicated that in Dublin there are about 350 young persons who have been known to abuse drugs and the number is increasing.

The drugs involved have been mainly amphetamines, barbiturates and tranquillisers, usually obtained by larceny, and LSD and cannabis smuggled into the country. In addition to cannabis other narcotic drugs such as morphine have been involved to a lesser extent.

According to information supplied by the Gardai there is some peddling of drugs in Dublin but no large-scale organised "pushers".

While there is evidence of some drug abuse in a few of the larger towns throughout the country the smaller towns and rural areas appear not to have the problem at present.

Statutory controls

The Working Party recommended that the proposed legislation, announced by the Minister, in dealing with the unauthorised possession of certain drugs etc. should be enacted as soon as possible.

Security of Drugs

The Working Party supported the measures taken to alert health authorities, drug manufacturers and wholesalers and retail chemists of

the need for stringent security to prevent theft or pilferage of drugs liable to abuse. Some of the measures were in fact the subject of special recommendations by the Working Party. The need for continued vigilance and an awareness of their responsibilities by those concerned with the security of drugs is emphasised.

Smuggling

They recommended that the appropriate authorities should consider the position regarding the smuggling of drugs into this country.

Strengthening of Garda "Drug-Squad"

The "drug squad", which is doing good and effective work, should they suggested be considerably strengthened as soon as possible and the Gardai concerned should be specially trained and equipped for their work. A Ban Garda should be attached to the squad and close liaison with the police in neighbouring countries should be maintained.

Sources of Drug Dependence

Apart from abuse by young persons whose supplies of drugs had been obtained illicitly there are also cases of drug dependence which have developed out of use under medical supervision over a period of time of certain drugs. Other problems in this respect can arise where a patient attends more than one doctor simultaneously; through the use of forged prescriptions, over-prescribing and/or inadequate supervision by the medical practitioner.

The Working Party suggested that the Minister of Health should as a matter of urgency consult with the appropriate medical and pharmaceutical bodies with a view to considering ways of dealing with these problems.

Amphetamines

The Working Party fully endorsed the action taken by the Minister in seeking the voluntary co-operation of the medical profession in the restriction in the use of amphetamines in medicine.

Treatment and Advice

They also endorsed development of the out-patient centre for drug abuse at Jervis Street Hospital on lines recommended by them. At this centre persons who abuse drugs can receive the special kind of care and advice which they need, while at the same time it should help to co-ordinate the efforts of all those persons in prevention, treatment and rehabilitation. The Working Party advised that the centre should form the hub of future investigation into drug abuse. The general question of the treatment and rehabilitation of persons suffering from drug abuse is to be further considered by the Working Party. It is recommended that there should be a system of registration of persons dependent on drugs.

Publicity and Education

The dissemination of information on drug abuse, the Working Party said, is a matter calling for great care lest it should excite an unhealthy interest in the subject and do more harm than good. The Working Party have not completed their examination of these aspects of the drug problem which will be the subject of subsequent recommendations. It is acknowledged that the press in particular have a major role to play in fostering a proper approach to drug abuse. While the facts relevant to the problem should not be cloaked, reporting of a sensational nature should be avoided; in other countries, according to the Working Party, it apparently did much to accelerate the growth of the problem.

Summary of the action taken, arising out of the Interim Recommendations, as at 3rd November, 1969

The Minister has accepted the Working Party's recommendations in principle and has initiated urgent and appropriate action on the various matter raised.

The following is a summary of the measures which have been taken by the Minister to deal with the position:

The Department of Justice is considering the Working Party's recommendation regarding the strengthening of the Drug Squad.

The question of drug-smuggling has been taken up with the Revenue Commissioners and with the other Departments concerned and the position is being fully examined in conjunction with these Departments.

Consultations with representatives of the medical profession regarding the restriction in the use of amphetamines in medicine have reached an advanced stage. Consultations will also be held with the profession and with the pharmaceutical bodies on the question raised by the Working Party of drug dependence developing out of the use of certain drugs under medical supervision or through the use of forged prescriptions.

The approval of the Government has been obtained to the preparation of comprehensive legislation which will include provisions to deal with the unauthorised possession of certain classes of drugs liable to abuse which do not come within the scope of the Dangerous Drugs Act, 1934. The text of the legislation is at present being prepared. In the meantime, as an urgent interim measure, the Minister has introduced an amendment to the Health Bill, 1969, which is at present at Committee stage in the Dail, which will enable the unauthorised possession of such drugs to be made an offence.

Towards the end of last year and early in 1969 the authorities of all hospitals and dispensaries throughout the country, as well as drug manufacturers and wholesalers and retail chemists, were alerted to the need for stringent security to prevent thefts or pilferage of drugs liable to abuse. Since then these warnings were supplemented by further advice as to the measures which the bodies concerned might take to deal with the matter.

As mentioned above some of these measures were, in fact, the subject of special recommendations by the Working Party.

The general position regarding security is being closely watched and it is proposed to continue to impress on all concerned the need for vigilance as recommended by the Working Party.

Some initial difficulties which had arisen in the operation of the outpatient centre for drug abuse at Jervis Street Hospital have been resolved, and the centre will operate in close liaison with an inpatient unit at St. Brendan's Hospital which has recently been completed.

The question of implementing a system of registration of persons dependent on drugs is being examined.

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