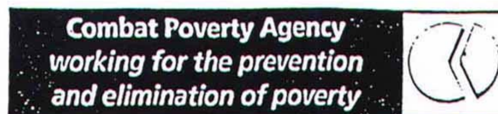

REVIEW OF LITERATURE AND POLICY ON THE LINKS BETWEEN POVERTY AND DRUG ABUSE

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FOREWORD

The Agency commissioned Dr Kathleen O'Higgins of the Economic and Social Research Institute to undertake this literature and policy review on the links between poverty and drug abuse. The review was commissioned in the context of a programme of work in the area of poverty and drug use initiated by the Agency in 1997. The Agency's key aims in this area are to highlight the links between poverty and drug use, to support community development responses to tackling drug use and to explore how best to ensure that community-based drug work has the maximum impact on policy.

The Agency believes that drug abuse is a very important issue in terms of anti-poverty work and is keen to ensure that the work it initiates and supports builds on and complements other work in this area, for example, the work of the National Drugs Strategy Team and the locally based Task Forces. To this end, the Agency has initiated a grants scheme, *Poverty, Drug Use and Policy* which will run until the end of 1999, specifically aimed at enhancing the contribution of local groups to policy making on the drugs issue. Under the scheme the Agency is supporting seven groups[1] to develop the policy dimension of their responses to drug use at a local level, in a way which enhances their capacity to engage with policy making processes. The objectives of the scheme are to support work which:

- enhances the capacity and experience of groups to analyse, reflect and consider the policy implications of locally based activity in response to the drugs issue
- identifies particular policy gap(s) in relation to the drugs issues and develops strategic approaches to addressing such gaps
- links local work to regional and/or national policy processes.

The purpose of this literature and policy review, therefore, is to help inform the Agency and the groups that it is supporting, on the current research and policy in relation to the links between poverty and drug abuse. It is also hoped that this literature and policy review will help to promote a greater understanding of this link.

There are a number of important points raised in the report, including:

- the lack of scientific estimation of drug abuse
- research that has been undertaken found high levels of opiate use in deprived areas of Dublin; that the majority of those being treated for drug abuse have high unemployment levels and poor education levels; and that the age profile of drug abusers is getting younger.

[1] These are: Addiction Response Crumlin; Athlone Youth Community Project; Ballymun Youth Action Programme; Coalition of Communities Against Drugs; Community Action Programme Ballymun; Drogheda Youth Sector Computer Scheme; and Franciscan Social Justice Initiatives (Merchant's Quay Project)

- there has been a lack of research on women's involvement in drug abuse
- the importance of considering drug abuse within the context of the environment in which it is taking place - poverty predisposes young people to a different and more risky style of drug use than would be commonplace amongst their more affluent peers
- policy responses to drug abuse in Ireland first focused on supply reduction, but more recently there has been increased recognition of the need to reduce demand
- policy responses have also recognised the relationship between deprivation and drug abuse
- there is a need for evaluation of interventions and programmes, greater understanding of the structural factors that influence young people's decisions to abuse drugs and more aftercare and rehabilitation.

The Agency has previously argued that the drugs problem is part of a much larger social problem caused by poverty and social exclusion and that tackling social and economic deprivation must be a priority if the demand for drugs is to be reduced[2]. The Agency is of the view that strategies that consult with and actively encourage the involvement of local people are most likely to lead to a reduction in the demand for drugs. There is also a need for greater infrastructural investment in disadvantaged communities, for instance: treatment and rehabilitation programmes, employment opportunities, social and recreational facilities, social services and in-school and out-of-school programmes for young people. This literature review has reiterated the strong link between drug abuse and deprivation and has given valuable insights on current and future policy and practice in this regard.

The Agency would like to thank Dr O'Higgins for this very useful literature and policy review and those who commented on an earlier draft of the report.

Combat Poverty Agency

[2] Combat Poverty Agency (1996) Submission to the Ministerial Task Force on Measures to Reduce the Demand for Drugs. Dublin: Combat Poverty Agency. Copies of the Agency's submission are available on request.

SUMMARY

This Review, commissioned by the Combat Poverty Agency, set out to examine what the literature had indicated regarding the links between poverty and drug abuse and the response of policy to those links.

In fulfilling its objectives, the Review in the first section discussed conceptual and methodological issues. It was pointed out that there were problems with definitions and the complexity of the field itself was regarded as the reason for these difficulties. The particular definition of drug abuse was confined to abuse of illicit drugs. Following on then the Review undertook a commentary on concepts of social deprivation relevant to drug abuse. These were poverty, social exclusion unemployment, alienation, fatalism, powerlessness and homelessness.

The methodological approaches used in measuring prevalence and social distribution of drug abuse were examined and examples of non-Irish studies quoted. Problems of data availability and validity and the dearth of scientific estimation of drug use or abuse in Ireland up to now was discussed.

Two of the types of research undertaken in the drug abuse field, general population studies and national prevalence estimation studies, have no relevant results to present in this Review. The literature search revealed that no *national* population studies have been carried out in Ireland and elsewhere they are relatively rare. As yet no *national estimation* studies have been completed in Ireland and few elsewhere. A *national estimation* study is being undertaken at present under the aegis of the European Monitoring Centre for Drugs and Drug Addiction. This study is still at a preliminary stage.

Reviewing research on prevalence of drug abuse in Ireland it was clear that the first and so far the only completed prevalence estimation study undertaken in Dublin is that of Comiskey who estimated the number of opiate users in Dublin. The findings of the Comiskey study show numbers of opiate users in Dublin comparable to those in other European cities where such research has been undertaken using similar statistical techniques. The reality of these high numbers for Dublin had not been known prior to this study. For the purposes of this Review one of the most important findings from the Comiskey study is that the highest level of opiate use is shown to arise in the areas of Dublin that would be regarded as deprived. This finding is based solely on postal code areas so more refined data, that would include socio-demographic characteristics of those involved, are needed.

Up to now the only available figures on numbers of drug abusers, either for Dublin or Ireland, were limited to figures from a number of treatment centres provided to the Health Research Board. Because of their limited nature these figures reflected only part of even the treated population and as is obvious from the Comiskey figures, bear little relationship to the actual number of opiate users in Dublin. However, they are a valuable indicator of the number of opiate abusers and the likelihood is that the

results mirror what is occurring in the wider community. The reports since 1990 consistently show that the majority of people who are being treated for drug abuse have high unemployment levels and poor education levels. The age profile of those in treatment is declining. The implications of the age profile of abusers becoming lower impinges on the education levels of these young people and such evidence as is available in Ireland, points to a low level of education associated with problem drug use. On the other hand, while there is no breakdown of the geographic and socio-economic distribution of the pupils in the schools involved the latest study of school pupils (ESPAD) the pupils are all in secondary schools and therefore not early school leavers. It is of note that the highest lifetime prevalence of any illicit drug in the countries responding occurred in the UK (42 per cent) with Ireland second with 37 per cent. The question is whether or not these secondary school pupils are or will become 'problem' drug users.

The social distribution of drug abuse in Ireland was explored and relevant research in Ireland and elsewhere on social disadvantage and social class, together with the influence of the Dublin dimension, the age and gender dimensions, the urban/rural, education, housing and employment dimensions were all included. The inference that may be drawn from the propensity of researchers to undertake small-scale localised studies is that there are particular areas that are perceived to have social problems and among these problems is higher prevalence of problematic drug use. For instance, although there is no automatic relationship between heroin and deprivation, when the social distribution of drug abuse is examined, the findings in studies elsewhere show that opiates, heroin in particular, are the drugs most likely to be associated with deprived areas. No doubt these studies have guided researchers in Ireland in the past to concentrate on the deprived area as a unit for study of problematic drug use.

A number of points were made about research needs including in particular the view that there would be general agreement on the lack of research into women's involvement in drug abuse. In Ireland, the author of one unpublished study that looked at female drug users and service provision stressed the need for a strategy that involves a wider spectrum of service response than that provided heretofore. If the finding from treatment data in the Health Research Board reports, that men in treatment outnumber women by three to one is accurate, the reasons for this imbalance have never been investigated.

One observation was that in the Irish context, there is a remarkable contrast between the level of opiate abuse in Dublin and the rest of the country, irrespective of deprivation. From me available evidence in Dublin the abuse of opiates seems to be associated quite distinctly with deprived areas, whereas in the rest of the country when a deprived area has some kind of drug problem, the drugs most likely to be involved are cannabis and ecstasy.

In some more discursive work, the importance of the trifold framework of the drug itself, the individual characteristics of the drug abuser and the environmental or contextual factors for the drug abuser is stressed. What it suggests is that poverty predisposes young people to a different and more risky style of drug use than would be commonplace amongst their more affluent peers. It is suggested that it is necessary

to look beyond the immediate intoxicating effects of drugs and take account of what it means to use drugs in any particular social setting. The example of the American soldiers in Vietnam is a case in point where a high proportion of addicts managed to break the habit after their return to America. With their return to the usual social and moral restraints in their home society, the likelihood of their becoming involved in drug abuse was reduced considerably. The findings of a number of other studies supported this view of the importance of the 'setting' in the individual's drug abusing behaviour, and the setting being an environment where poverty and deprivation were more likely to encourage rather than discourage drug abuse.

The second element covered by this Review was the area of policy responses to drug abuse and in particular the response to the problem of the association of drug abuse with deprivation. There were two main types of policy response - policy aimed at supply reduction and policy aimed at demand reduction. Supply reduction involved mainly the Department of Justice while demand reduction would have .as its main player the Department of Health with input from other Government Departments such as Department of Education and Department of Social, Community and Family Affairs.

The Review considered the evolution of policy response and noted that the first response to evidence that a drug problem existed was supply reduction in the form of legislation focused on control of drugs and their chemical or pharmacological content. The sudden increase in the abuse of opiates in Dublin and the implications of that increase for the spread of HIV and AIDS made it imperative that a reconceptualisation of drug policy was required with new ideas about risk behaviour and risk reduction. At first the main treatment model was abstinence. Then with the findings of the National Co-ordinating Committee on Drug Abuse Report *Government Strategy to Prevent Drug Misuse* in 1991 a major shift occurred in the attitude of the Government and a number of new treatment options were provided.

In the context of the lack of recognition by policymakers of the links between poverty and deprivation, this Review documented how policymakers had ignored such links contrary to evidence assembled by research-studies, voluntary, bodies and community workers. Although a Task Force, set up as far back-as 1982, had acknowledged that drug problems were largely explicable in terms of poverty and powerlessness in a small number of working-class neighbourhoods, these findings were not referred to in information issued in the Report of that Task Force. This Review shows that the first serious attempt by policymakers at recognition of the relationship between deprivation and drug abuse was in the work of the 1996 Ministerial Task Force to Reduce the Demand for Drugs. What has been lacking is a clear understanding of the influence of structural factors in a person's decision to abuse drugs while the policymakers response up to now has concentrated on the actual decision-making itself.

Details of recent changes in legislation are given. During the latest period of Ireland's presidency of the European Union a number of pieces of legislation relating to drug dealers and abusers were implemented, together with a number of new initiatives aimed at combating drug trafficking and organised crime associated with drugs.

In the area of health policy, the role of the Department of Health is documented. That department, having first responded to the problem of drug abuse because of the danger to society from the spread of AIDS/HIV through the increase in opiate abuse, continues via the Health Boards to be active in expanding a range of treatment services to drug abusers. Some support has been provided to voluntary groups and a number of these work with the statutory bodies to supply services. Community programmes are being put in place and the model being used is that of a partnership between the statutory and the voluntary services.

The establishment of the National Drugs Strategy Team is noted and this team is now in the process of commissioning an evaluation of the local Drugs Strategy Teams set up in Dublin and Cork. The result of this evaluation will determine the future approach of the NDST in the areas covered by the local teams.

Communities themselves have played a significant role in the development of services for drug abusers. While the actions of some community activists were condemned by the statutory authorities, nevertheless overall the activities of communities, besides helping to plan and operate interventions, contributed greatly to raising awareness of the- problems in deprived communities exacerbated by drug dealers and drug abusers.

Finally the Review considered research on interventions particularly where these had been considered successful in assisting the drug abuser to gain control over his or her addiction. The critique of interventions ranged from the useful approach of Einstein who recommends a focus on failure and on the reasons why interventions fail in order to enable more appropriate interventions to be made, to the research of others in the field who consider the likelihood of a 'maturing out' process for a high proportion of drug users.

The conclusions and recommendations section focused on the policy aspects in the Review and stressed the need for evaluation of interventions and programmes; for a continuation of the emphasis on the deprived area as a unit of study concentrating on the structural factors that influence young peoples' decision to abuse drugs; for an acknowledgement of the extent of the problem of opiate abuse in Dublin and finally for more accent on aftercare and rehabilitation.

REVIEW OF LITERATURE AND POLICY ON THE LINKS BETWEEN POVERTY AND DRUG ABUSE

Kathleen 0'Higgins

Introduction

This review of literature and policy on the links between poverty and drug abuse was in response to a commission awarded by the Combat Poverty Agency to produce such a review. The purpose of the review is to examine available research (both Irish and international) on the social dimension of drug abuse, focusing especially on the links between drug abuse and social deprivation and on policy and community interventions which take those links into account.

The terms of reference for the Review were that the study report would include information on the following:

⇒ conceptual and methodological issues;
⇒ prevalence and social distribution of drug abuse;
⇒ assessing the social dimension of drug abuse;
⇒ policy responses to drug abuse in Ireland;
⇒ policy responses in other countries;
⇒ successful interventions;
⇒ conclusions and recommendations.

In its first section the Review considers conceptual and methodological issues, giving definitions and classifications of drugs and drug addiction. A commentary on concepts of social deprivation relevant to drug abuse follows. Then the methodological approaches used in measuring prevalence and social distribution of drug abuse and problems of data availability and validity are examined.

Section 2 of the Review looks at prevalence and social distribution of drug abuse and in this section (a) the research on prevalence in Ireland and (b) the social distribution of drug abuse are considered. Included are variables such as social class, urban/rural, the Dublin factor, age, gender, education, housing the unemployment.

The focus in Section 3 is on the policy responses to drug abuse in Ireland charting the evolution of policy responses from an emphasis on the purely chemical or pharmacological content of drugs and their control to the notion of aiding the drug user, through to recognition of the relationship between social deprivation and drug abuse. Recent developments, with specific reference to criminal justice, health services, education and employment, are reviewed as are in particular the number of pieces of legislation introduced during the Irish presidency of the European Union from July to December 1996, the focus of which was crime and drug abuse.

Section 4 is concerned with policy responses in other countries and the divergent policies in such countries as Sweden and Netherlands among others are discussed. This section also looks at policy as it affects women.

Following on the policy responses, Section 5 is an examination of what particular interventions have been successful both in Ireland and elsewhere.

A final section is devoted to some conclusions and recommendations.

Appendix A gives drug classifications and Appendix B is a bibliography.

Section 1 - Conceptual and methodological issues.

Definitions and classifications of 'drugs' and 'drug abuse'

In general defining drug problems might appear to be an academic irrelevance Butler (1997) argues and he goes on to point out that the presumption underlying the linguistic usages 'drug abuse', 'drug misuse' and the 'drugs problem' used interchangeably, without definition, is that there is a cultural consensus on the danger and undesirability of using illicit drugs. It is as though all sections of society - with the exception of a deviant minority of fools, knaves and conscientious objectors - are at one in their identification of this common enemy and in their commitment to its eradication. Commentators from a variety of ideological and academic backgrounds internationally have regularly expressed their criticism of the tendency to speak of the "drug problem" or "drug abuse" as though it were a self-evident, discrete and unitary pathological entity, open to technical resolution without the necessity to do any fundamental rethinking or reordering of society. One could also argue, as Rush (1996), does, that the fuzziness in definitions and boundaries is simply a necessary consequence of the complexity of the field itself with its rather imprecise definitions of drug "problems" and "treatment" of these problems. There are numerous arguments and perspectives in the area, from Gossop's (1996) wide perspective which would take in tobacco and alcohol, to the definitions which tend to emphasise the chemical properties and the medical values of a specific substance. For instance in *Living, with Drugs* Gossop (1996) says that various substances originally intended for non-drug purposes have been used to alter perception, mood or other psychological states. Among them are certain industrial solvents, cleaning fluids, nail polish removers, petrol and glue. It is precisely when faced with such forms of drug taking that the deficiencies of any substance-based definition of drugs become most obvious. Many preparations are readily available and the impossibility of bringing under control all substances that can be used for their psychoactive effects should be clear from the way in which petrol, paint and glue can be used for such purposes. He argues that in the final analysis, the concept of a 'drug' is a social artefact. What we regard as a drug depends as much upon its social meaning and the way in which people use it as upon its pharmacological or physiological properties.

Hartnoll (1995a) in examining definitions in European studies highlights a few selected points. His first criticism is that many studies suffer a lack of definitional clarity and an intrusion of non-scientific, often moralistic criteria. He feels that it is

essential to use definitions which distinguish the behavioural facts of drug consumption (e.g. in terms of frequency, dose, time period) from the range of consequences that may or may not result and to express both in objective, measurable units.

Hartnoll further cautions that this haziness surrounding definitions has important implications for sampling, for interpretation and generalisation of the results and for comparability between studies and between countries.

While acknowledging the definitional problems outlined above, for the purposes of this review there are a number of definitions of terms to be set out. These are drug use, drug abuser, drug abuse/misuse, addiction/dependency.

The definition of **drug use** is where a person is taking a legal drug, excluding alcohol and tobacco, without any problem occurring for that person with that drug. This includes taking of sedatives or anti-depressant drugs on prescription. While some sedatives such as barbiturates, even when taken under prescription, can produce high physical and psychological dependence and severe withdrawal symptoms when the patient stops taking them, this behaviour is regarded as drug use because it is under medical supervision. This area will not be covered in this review.

Carr, Hart and Kelly (1980) defined the term **drug abuser** as denoting an individual who as a result of taking psychoactive drugs has suffered either medical, psychological or social complications. A psychoactive drug may be seen as *any chemical substance, whether of natural or synthetic origin, which can be used to alter perception, mood or other psychological states.* Gossop (1996) has some difficulty with this definition but agrees that it is reasonably acceptable. While terms such as **drug abuser** and **drug misuser** are used interchangeably, the term drug abuser will be used throughout this Review.

Drug misuse/abuse is the action of a person who is using a drug which is illegal but also may be a legal drug or substance, excluding alcohol and tobacco, which has been procured illegally and is being used in a way not intended. Hutchinson *et al* (1995) defined drug abuse as persistent or sporadic use of a drug, inconsistent with or unrelated to, acceptable medical practice. The term drug abuse will be the one used in this Review.

One definition of **dependency/addiction** comes from (McCarthy, 1997) quoting Sainsbury (1979) who noted that there are two types of dependence. The first is psychological dependence, which refers to the overwhelming repetitive need to seek whatever ease, pleasure or stimulus is provided by a drug. Psychological dependency is common to all drugs. Where physical dependency is concerned, for the course of repeated administration of drugs, the body's metabolic processes adapt themselves to these drugs. If such a drug is withdrawn, the metabolic balance achieved is upset leading to withdrawal symptoms. Hutchinson *el al* (1995) defined drug dependence as a state characterised by a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence.

As regards classification of drugs there are five lists of schedules of drugs in the national legislation. I. Cannabis, LSD, Mescaline, Opium; II. Cocaine Heroin, Methadone, Morphine; III and IV. Other psychotropic substances; V. Specific preparations. Appendix A gives the list of drugs included in the Council of Europe (Pompidou Group - Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs) *Definitive Protocol on Drug Treatment Reporting Systems and the First Treatment Demand Indicator* (1994).

Concepts of social deprivation relevant to drug abuse – poverty, social exclusion, unemployment, alienation, fatalism, powerlessness and homelessness.

The evidence indicates that researchers incline towards studying selected populations when studying drug abuse and concentration of research in Ireland has generally been limited to small-scale studies in deprived areas and reports on treated drug abusers. Given that respondents in the first group have been selected on the basis of their social deprivation and the second are limited in scope to those receiving treatment, it must be accepted that particularly these latter studies have consistently revealed that, as Butler (1997) observes, the attendees at the drug treatment centres for serious drug problems do not come from randomly distributed geographic areas or from a variety of socio-economic backgrounds but that their areas of residence tend to cluster in neighbourhoods characterised by poverty and general disadvantage. Butler further comments that when these epidemiological data are considered from the Zinberg (1984) framework of the (a) the drug itself, (b) the set (individual factors) and (c) setting (environmental or contextual factors), what they suggest is that poverty predisposes young people to a different and more risky style of drug use than would be commonplace amongst their more affluent peers. The motivation of young drug users in this institutionalised setting of poverty, boredom and hopelessness may be seen in terms of self-medication; the drugs used are generally more addictive and the style of administration - intravenous use tends to be the norm - carries with it more indirect risk. By contrast, young drug users from middle-class backgrounds may be seen, as using drugs to enhance what is already a relatively interesting and promising lifestyle and as having much clearer cause to take care of themselves and to minimise risk.

One interesting viewpoint on the influences which affect the likelihood of drug taking is that of Gossop (1996). He cites the study by Robins (1974) of the experience of American soldiers in Vietnam and asserts that psychologically the experience of suddenly being removed from a safe familiar environment to a strange, foreign and extremely threatening one, increases the pressure upon the individual to take drugs. Drugs are a useful means of coping with the mixture of fear, physical tiredness and boredom that is such a familiar feature of military life during a war, Gossop argues that socially the tour of duty in Vietnam was characterised by a removal of many of the usual social and moral restraints that reduce the likelihood of drug-taking thus implicitly arguing that social and moral restraints in a society reduce the likelihood of becoming involved in drug abuse. As a form of inward desertion, says Gossop, drugs represented a way of altering subjective reality itself. There was also the physical availability of all kinds of drugs.

But the same unusual combination of factors which led to so much drug taking in Vietnam is also the key to understanding why such a high proportion of addicts managed to break the habit when they returned to America. The effectiveness of all three of the influences was reduced and as a result the pressures to go on using drugs were correspondingly less. In order to understand the ways in which people use drugs, Gossop argues, we need to look beyond the immediate intoxicating effects and take account of what it means to use drugs in any particular social setting, thus echoing Zinberg's set and setting. In Vietnam, the social and psychological influences acted together in a unique manner. Although this does not happen very often, there are other interesting (though less striking) examples of how social factors can influence the ways in which drugs are taken.

Schaffer and DeBlassie (1984) explore the conditions that give rise to adolescent prostitution through a review of the literature. Important factors are found to be alienation from the family, parental abuse, low educational level and limited employment opportunities available to lower class females. Among the motives for prostitution was drug abuse. Also included were economic purposes, the problems of runaways, lack of parental attention and desire for self-worth, sense of adventure, response to institutionalisation and hostility to rejecting fathers.

In a study in Mannheim (Welz, 1986) comments that suicidal behaviour, alcoholism and drug abuse are often seen as a response to social anomie and alienation and share other common characteristics as well. For example, individuals who are chronic alcoholics or who take illicit drugs have a higher risk for subsequent suicide or attempted suicide. Also it was found that drug abuse and alcoholism often occur in neighbourhoods distinguished by social anomie and lack of social integration. The authors conclude that while there is no conclusive evidence as to which variables connect social anomie and individual behaviour, it is possible that drug abuse, alcoholism and attempted suicide are more probable in areas where the deviant behaviour of others sends a suggestive message.

Pearson (1987) states that the relationship between. heroin use and urban deprivation is not a new discovery. Even eleven years ago when Pearson was writing, it had been a matter of concern for many years prior to that in some North American cities such as Chicago and New York. Pearson quotes a study by Chein *et al* (1964) where those authors speculated from their data on whether the sense of futility and hopelessness in slum districts increased the likelihood that young people would experiment with narcotics. Later, Pearson (1993) compiled evidence from research on local and regional variations in drug misuse in Britain during the 1980s. The prevalence was particularly associated with forms of social deprivation, e.g. housing decay and unemployment.

The concept of alienation is used in the context of group alienation versus adherence in 'Dependence, Death and Family' (Vukov and Mijalkovic, 1993) The authors argue that adolescent drug abuse is a form of chronic suicide with genesis in the family. The issue is examined in relation to weakened family and social value systems, diminished importance of religion and tradition, inability to transcend

hardship and group alienation versus adherence. It is argued that teenagers choose drugs as a surrogate for a sense of living.

Homelessness is intuitively linked to drug abuse but as Hammersley and Pearl (1997) note, very little work has been conducted to test this relationship. When they studied homeless young people in Glasgow, they found that housing issues and drug problems were intimately (if not causally) related. Of course the difficulty of studying homeless people, lies not only in the complexity of defining homelessness but also because it is difficult to sample homeless people properly. This then compounds the lack of good research on the subject. In the Glasgow study 100 homeless young people in a Glasgow homeless project were interviewed. Over three quarters had used cannabis, hallucinogens or amphetamines and just under half felt they had been addicted to, and a third severely dependent on, a substance other than tobacco. As the authors point out these are high levels of abuse.

Methodol6gical approaches to measuring prevalence and social distribution of drug abuse.

Satisfaction has not been registered at the amount or type of research undertaken to study the prevalence of drug abuse even in the wider European context. At the Joint (Pompidou Group/EMCDDA) Scientific Seminar on Methods for Estimating the Prevalence of Drug Abuse held in Strasbourg in 1996, one of the main contributors (Stimson) maintained that research studies are usually conducted on selected populations of unknown representativeness and with little opportunity for methodological development or collection of time-trend data. The difficulty in undertaking research to truly study a population which is to a large extent 'hidden" has had a restraining effect on those who would wish to undertake research. It should be pointed out that it is particularly difficult to obtain accurate prevalence estimates of, for instance, opiate addiction with direct methods and the need for *estimation* of prevalence is connected with the nature of the phenomenon - it is sufficiently rare to be difficult to measure through other means.

In looking at the research undertaken in Ireland up to the present, this assertion was certainly borne out and work had tended to concentrate on (a) small-scale localised studies and (b) on data on drug abusers who have come for treatment (see, for example, Carr *et al* 1980 and 1981 who studied attendees at one treatment centre in Dublin; Dean *et al.* 1985 who also studied attendees at a treatment centre in Dublin; Dean *et al* 1987 conducted a follow-up of the 1985 study; O'Connor *et al* 1988 -studied 45 pregnant opiate users on a special treatment programme; McCarthy and McCarthy's 1997 study was carried out in the south inner city and in (b) the reports on treated drug misuse from the Health Research Board). As noted, there had been no studies of the estimation of prevalence of drug abuse carried out in Ireland or even in Dublin. However, there are now two studies (by Comiskey) estimating the number of opiate users in Dublin. The first of these has been completed. The second, a more extensive study based on 1997 data, is continuing at present. Both of these studies used a capture/recapture methodology. This particular methodology is an indirect method that generates a prevalence estimate of a hidden population, i.e. opiate users

not in treatment, not involved with the Gardai and not in hospital. The method is based on the degree of overlap between two or more separate samples of the population under study. In addition the method allows the confidence intervals of the hidden population estimate to be calculated. This technique has been used widely for estimating hidden populations - see, for instance, Hartnoll *et al* (1985) in Britain or Korf *et al* (1994) in the Netherlands. The two Comiskey studies are confined to Dublin and by their nature are confined to looking at the prevalence of opiate users only. The justification for the choice of limitation to opiate users is that the main drug of misuse in Dublin is an opiate and opiates are the drugs which are regarded as causing most serious problems, both to the abusers and to the communities from which they come. For instance, the first report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) concentrated on opiates, particularly heroin, saying in its introduction "As heroin abuse, both in its own right and in its connection with other serious communicable diseases in the Greater Dublin area is without doubt the most pressing problem facing the community at present, the Task Force has concentrated in this report on identifying strategies to address this situation".

So far no general population surveys of drug users or abusers have been undertaken in Ireland. One obvious argument against population surveys is that they require large samples in order to identify behaviours that may be quite rare in the population. However, the European Monitoring Centre for Drugs and Drug Addiction had sought tenders in each of the 15 member states for a *national prevalence estimation* study of drug abuse in the population, as distinct from a general population survey, and this study is being undertaken now under the supervision of a German coordinator.

As regards other national studies, the most recent study is that of a school population carried out under the aegis of European School Survey Project on Alcohol and Drugs (ESPAD) (1997) for the Council of Europe. Data on Ireland were included. The results showed use of drugs was very common among Irish students relative to their European counterparts. This study will be discussed in more detail in the section on studies in Ireland. Earlier studies by Morgan and Grube or Grube and Morgan (1986, 1989, 1990 and 1994) sampled only Dublin School populations and the 1994 study compared the results with those of a similar study carried out by the authors in a school in San Francisco.

Hartnoll (1995a) in his overview of research on illicit drugs in Western Europe has found that many countries use indirect indicators (e.g. treatment demand, drug-related deaths, arrests, seizures of drugs) to monitor trends in drug use or more commonly in some of the more problematic aspects of drug use. "However" adds Hartnoll (p. 4) "rigorous methodological work in this area is less common". He notes that the multi-city studies of the Pompidou Group of the Council of Europe have been developing this approach within a comparative framework since 1992 but feels that much remains to be done in terms of improving validity and comparability.

It may be noted that Hartnoll (1995a) in discussing methodological aspects of addiction research in Europe was of the opinion that the quality of addiction research in Europe is extremely variable. He does not regard it as surprising given that, in many

countries, this is a new field and any area of science usually takes several decades to establish a coherent body of theory and methodology.

On the social distribution of drug abuse there are indications that different drugs can have different social class usage in most societies, says Hartnoll (1995b). In some cities (e.g. Amsterdam, Barcelona) drug use (largely cannabis), as measured by population surveys, tends to be higher in middle-class areas or amongst people with higher educational level. In Oslo, however, cannabis use is higher amongst young people who do not complete school. As regards addiction, there is a strong association in several cities between high prevalence and relative social deprivation (e.g. Barcelona, Dublin, Paris, Stockholm). This is not true in all cities for example, heroin addiction is more widely spread across social groups in Geneva and possibly London (see Hartnoll, 1995b).

On the related question of middle-class illegal drug use, this area also remains largely undocumented possibly because the patterns of drug use, such as the type of drug used, differ from those of the lower socio-economic groups. Class differences are likely to occur in that it is perceived that middle-class drug abusers will tend to use cannabis, ecstasy or even cocaine. They will be more likely to have the financial means to purchase these drugs without being observed by the law and they do not need to commit crime to obtain the money necessary to purchase the drugs. McCullagh (1996) for example, holds that "While many are prepared to argue that much serious crime is caused by heroin addicts trying to finance their habit, there have been few similar claims about the users of ecstasy. This may reflect class differences in the users of the different drugs". This perception was confirmed by Keogh, whose report on illicit drug use and associated criminal activity in the Dublin Metropolitan area was published in 1997. It was Keogh's assumption that while the level of cocaine misuse was small in Dublin. Hearsay evidence would give the impression that cocaine is occasionally being used as a recreational drug by the better off members of society and certainly cannabis and ecstasy are used by all strata of society. A number of general practitioners in the Eastern Health Board area are providing patients with methadone maintenance. However, there is no information published on the class breakdown of these patients. The majority of general practitioners do not make returns to the Health Research Board and details of their patients are therefore not included in their figures in the reports. If returns were made, more accurate socio-demographic details of those in treatment would be available.

In a prevalence estimation study of drug misuse in Liverpool, that included a spatial analysis of known addiction, Squires *et al* (1995) found a strong correlation between material deprivation and the number of known drug users per '000 population in each electoral ward.

Problems of data availability and validity

It would seem that the problem of data availability stems from the already mentioned complexity of the field itself with its rather imprecise definitions of drug "problems" and "treatment" of these problems. Also difficulties in describing the extent, nature and impact of substance use and misuse present considerable scientific challenges. It

has been pointed out that most of the research undertaken so far has been small-scale studies undertaken in deprived areas so that the deprived area seems to be regarded as a given in the context of problems with drugs. In Britain, Hartnoll (1991) tells us that most surveys are carried out at local level, although some indicators are monitored at national level. He describes an example of a successful multi-source and multiple method model used in local studies and he stresses the importance of both quantitative and qualitative approaches. He would say that most service delivery and prevention activities occur at local level and that therefore it is here that research can be interpreted in the local context, thus giving richer and more relevant insights. He again stresses that it is important that a range of methods and sources are used, since any one approach is partial and can easily lead to bias. On the aspect of area of study, it has also been the case in the European context as, for instance, in later work Hartnoll (1995a) comments on research in Europe as being predominantly descriptive rather than analytical and has usually been carried out at a local level. “National studies” he says “are relatively rare, though there are some data from population surveys in several countries”. It should of course be reiterated here that national studies require large samples in order to identify behaviours that may be quite rare in the population. Therefore their usefulness for policy planning could be questioned.

Section 2 - Prevalence and social distribution of drug abuse

Prevalence of drug abuse in Ireland.

As pointed out earlier difficulties in describing the extent, nature and impact of substance use and misuse present considerable scientific challenges, and as regards the extent, the need for *estimation* of prevalence is connected with the nature of the phenomenon - it is sufficiently rare to be difficult to measure through other means.

Up to the present the only available count was limited to an indicator of drug abuse i.e. those who attend treatment centres. The treatment data was and remains the best developed of the indicators used by the Pompidou Group for its work. Indicators are used in the absence of more accurate data as the best available to enable comparisons to be made between countries. Data collection of numbers in treatment prior to 1995 had all been confined to the Greater Dublin area. O’Higgins (1996), in her five-year review of treated drug abuse in Dublin, found that the numbers in treatment rose by almost a thousand from 2,037 in 1990 to 2,919 in 1994 and the majority of these were opiate abusers. O’Higgins had stated that this expansion in numbers may reflect a development of service provision for drug abusers but also may reflect an increase in the numbers involved in drug abuse. However, she added that without a study of prevalence which would give a reliable estimate, it is not possible to state with any certainty the actual number of abusers. It is most likely to be greatly in excess of the numbers in treatment. The publication of the Comiskey (1998) study of prevalence in the Dublin area will make an accurate estimate available. The O’Higgins and Duff (1997) report confirmed a further rise in the number of those in treatment in Dublin for 1995 and the Moran *et al* report on the 1996 data again showed an increase in the number of those attending treatment centres in Dublin whose primary drug was an opiate. The number of all contacts was given as 3,994 but if one considers the raw data alone from the forthcoming Comiskey study, the number of opiate users in Dublin in 1996 was 6,264. This difference between the figures may

be explained both by the gaps in the returns to the Health Research Board from both treatment centres and general practitioners and by the number not in treatment.

Other studies of prevalence were concerned with secondary school pupils. The 1990 study by Grube and Morgan was confined to Dublin school populations and focused mainly on smoking and alcohol consumption. While rates of cigarette smoking were high in comparison with other countries, the level of alcohol consumption was midway between high consumption countries like France and low consumption countries such as Israel. In the area of illicit drug use while 22 per cent of the students had tried illegal substances at that stage, the most frequently used of these substances were solvents (like glue) and marijuana. About 13 per cent had tried these. In comparison with other countries, the authors found the use of other substances rather low. By the time of the later Morgan and Grube (1994) study, again of a Dublin school population, there had been a dramatic increase in the number of young people drinking alcohol, with no association of drinking with social background. The authors were anxious to see whether the general increase in alcohol consumption would indicate an increase in the use of illegal drugs. Their results showed that for some substances there was little or no change, especially for those substances that are regarded as more serious drugs. However, the lifetime prevalence for the use of marijuana has almost doubled, while the increase for solvents, while not being as dramatic, was quite substantial.

One study undertaken in the Western Health Board (McKiernan 1995) was of subjects aged between 12 and 18 years old from a random sample of 37 schools throughout Galway, Mayo and Roscommon and a cluster sample in a selected year. McKiernan found that the prevalence rates for drug use among adolescents from the Western Health Board are similar to those reported from the Southern Health Board and are between two-thirds to three-quarters the rates found in Dublin. One quarter of the boys and one-fifth of the girls reported ever using any of the 11 listed drugs in order to get “high”. As regards drug type, the commonest drug reported was cannabis, closely followed by volatile substance use. The prevalence rates increased from 8 per cent at age 13 to 33 per cent at age 18 years. The mean age at first drug use was 14.5 years.

From the results of the ESPAD study (European School Survey. Project on Alcohol and Other Drugs, 1997) the author of the Irish section (Morgan) found that the Irish students were near the top of the European league in terms of the use of tobacco, alcohol and certain illegal drugs such as cannabis and ecstasy. However, there was little evidence of the use of heroin. We are not given a breakdown of the geographic and socio-economic distribution of the schools involved in the study. In this review of the links between poverty and drug abuse and the general consensus that, in Dublin, the abuse of heroin is confined to deprived areas, it would have been useful to know if any of the schools were situated in such areas. Given the evidence from the reports on treated drug abusers by the Health Research Board that the majority of those attending treatment centres had very low educational standards, it may be safe to assume that the secondary school pupils in the 16 years old bracket would be unlikely to have been involved in heroin abuse. Morgan points out *(The Irish Times,* 7 November, 1997) that “While a lot of people have given a good deal of attention to illegal drugs, it remains the case that the main problem in Europe is legal

drugs like cigarettes and alcohol and this is especially the case among teenagers in Ireland".

international comparisons

On the European level, Hartnoll (1995a) notes that as drugs have become of political interest, so the question of prevalence has become more important. In most countries there are surveys of drug use amongst the school or young population, but adds Hartnoll. "These are usually conducted on an *ad hoc* basis at a local or regional level using different instruments and methods, making it difficult to compare countries or monitor trends over time". Only in countries such as Germany, Norway and Sweden have regular surveys been carried out which enable trends to be described in those countries.

A further follow-up activity to the previously mentioned Strasbourg Seminar was the implementation of pilot studies to improve comparability and reliability of methodologies for estimating addiction prevalence at, local and national level. As is noted in *General Report of Activities 1996* (1997) of the European Monitoring Centre for Drugs and Drug Addiction, a Call for Tender was launched in October 1996 for two methodological pilot projects, one on local and the other on national level estimation of prevalence. These projects compared different methods in a limited number of cities or countries. As already noted earlier, following the results of these pilot studies local estimation studies have been undertaken and a national estimation study in the 15 countries is now under way with a German coordinator.

On a cautionary note, the *Annual Report on the Stale of the Drugs Problem in the European Union 1997* in the chapter entitled 'Prevalence and patterns of use' warns that often objective and reliable information is just not available at national level. Thus at European level the complexities are multiplied by national differences which would render even perfect national data incompatible. The authors caution that as a result of these incompatibilities, national differences seen in the tables in their report may reflect real differences in drug use and problems but may also (or instead) reflect differences in definitions, in how information is collected and in the treatment or enforcement systems from which much data emanate.

Social distribution of drug abuse in Ireland, with special reference to social disadvantage and social class, urban/rural differences, the Dublin factor, the age and gender dimension, education, housing and unemployment.

social disadvantage and social class

Hartnoll (1995b) contends that any association between drug use and measures of social class is not simple. The relationships may differ for drug use *per se* and for more serious patterns of addiction. Gossop (1996) on this theme would be of the opinion that opiates are regarded as the drugs most associated with more deprived areas and lower social classes, except where artists or musicians are concerned. Opiates have high physical and psychological dependence and stimulants such as cocaine have low levels of physical dependence but high levels of psychological

dependence. Ecstasy is also seen as recreational but is used by all classes. With the apparent increase in the use of Ecstasy (MDMAs) throughout all levels of society and the alleged mixing of that drug with heroin to 'chill out', the problem of heroin addiction may spread across the social spectrum. Keogh (1997, p. 6) slates that Ecstasy users in general do not become involved with the Gardai. The drug is consumed when and where it is purchased. E is relatively cheap to buy and in general, users can afford to fund it from their own financial resources, without having to resort to crime. However, the alleged introduction of heroin to ecstasy users may change this. Cocaine or crack are not yet regarded as a problem in Ireland. As previously noted, opinion generally, again from informal Garda sources and not based on any empirical evidence, is that cocaine, which is expensive, is mostly used as a recreational drug by those who can afford it.

Although the evidence is now rather old, Scher (1967), quoted in Carr *et al* (1980), notes that in the USA two distinct patterns have emerged. Narcotic addicts tend to display a low level of educational attainment whereas abusers of psychedelic drugs tend to be high academic achievers and to be located mainly in third level educational institutions. It is possible to argue that nowadays for psychedelic drugs one could read amphetamines and again this demonstrates social class differences.

One study of problematic drug use and social deprivation to establish whether the prevalence of drug misuse is related to social conditions was undertaken by Wilkinson *et al* (1987). Their discussion claims that their findings suggest a clear relationship between drug abuse and deprivation. The authors then ask if their findings are a true reflection of the situation and is drug abuse more likely to be found in deprived inner cities? They indicate that they would qualify their findings to state with confidence that the relationship between those drug abusers *known to the agencies* and deprivation is highly significant. This finding would be directly comparable to the findings of the Health Research Board from the limited data received from the treatment centres.

Parker *et al* (1987) in the UK found indications of a rapidity and depth of penetration of opiate abuse not previously encountered. Their study detected the 'new' heroin users of Wirral were predominantly young, family-based, unemployed and socially deprived, in contrast to the typical London-based heroin user of the later 1960s and early 1970s, who was in his late 20s and early thirties and of a more 'Bohemian' lifestyle.

urban/rural differences

In Ireland, evidence from the reports on those in treatment in 1995 (O'Higgins and Duff, 1997) and again in 1996 (Moran *et al,* 1997), shows that the differences are not between urban and rural areas only but there is quite a distinct difference between the incidence of drug use and the type of drug used in Dublin *vis-a-vis* the rest of the country regardless of whether urban or rural area. Dublin's main drugs of abuse are opiates, almost always heroin. Outside of Dublin cannabis and ecstasy are the main drugs of abuse. The study undertaken in the Southern Health Board area *Smoking, Alcohol and Drug Use Survey, 1996 in the Southern Health Board* (Jackson, 1997), examined the interaction between these substances in Cork and Kerry. The study is providing a baseline epidemiological profile of substance use in the community. Of most relevance to the present context is that the author observed that "Heroin was

scarcely detected. Almost no injecting drug use". Jackson concluded, however, that drug use was widespread across all communities in that region, regardless of deprivation status.

In his Council of Europe multi-city study of drug abuse, which uses indicators of drug abuse such as treatment data, hospital admissions, number of persons charged with drug offences, drug-related AIDS cases and seizures of drugs, Hartnoll (1995b) remarks that surveys of drug use show higher prevalence rates for illegal drugs in the cities than in the country. These differences often diminish or disappear for solvents and mixtures of legal drugs (pills, alcohol). Similarly, addiction is concentrated in the cities. However, the "magnetic" effect of the illicit market in attracting people from outside of the city may give an impression of prevalence levels which are higher than those based on addicts who are native residents of the city. Also drug abuse is a collective activity in that availability of drugs is an important part.

the Dublin factor

As observer above, there is evidence based on available data from -the treatment centres and included in the national reports that there are some crucial differences between the populations in treatment in the Greater Dublin area and outside of that area. The notion of a lower incidence of drug misuse outside Dublin was confirmed using the indicator of those in treatment. The profile of the drug abuser in treatment in Dublin is that of a young, unemployed male who had left school early and was abusing an opiate, most likely to be heroin, possibly injecting it. However, the profile of the drug abuser outside of Dublin is more difficult to define. The one exception here is that he is most likely to be male, but he is younger than his Dublin counterpart, less likely to have left school early or to be unemployed at present. Most importantly, he is a great deal more likely to be a, cannabis or ecstasy abuser and it would follow that he would either smoke or injest the drug. He is somewhat more likely to have first abused his primary drug at a younger age but to use less frequently than his Dublin counterpart.

In commenting on the above-mentioned studies of treated drug misuse Butler (1997) underlines the plurality of values and a general cultural ambiguity implicated in this scene of differences between the Dublin-area and the rest of the country. The drugs concerned outside of Dublin are regarded as having a low potential for dependency, the health risks (while certainly not imaginary) are not particularly stark and the users are more mainstream in terms of their education and their work backgrounds. The findings of Jackson's (1997) study in Cork and Kerry would confirm this point of view.

So far the reason for the differences between Ireland and the Eastern Health Board area generally, but particularly Dublin, is not clear. As noted, the first wave of drug misuse arrived in Dublin in the 1960s and at that time, heroin was the most prominent drug causing disquiet (see, for instance, *Government Strategy to Prevent Drug Abuse, 1991*). This has remained true and although there have been troughs and highs in the level of the problem in Dublin heroin has remained the primary drug of the majority of drug abusers. Outside of Dublin, there was less concern about drug misuse because the incidence appeared to be much lower. No data had been collected from areas outside of Dublin until that collected for the 1995 (First National Report published by

the Health Research Board) Therefore it was only then that some concrete, although restricted, evidence was available.

It would be difficult to establish what influences create the area differences. Of course, as Hartnoll (1995b) had pointed out, large urban areas are more likely to have problems with drugs. However, outside of Dublin there are some large urban areas but heroin misuse has not so far become a problem in any of them. The above-mentioned Southern Health Board study presents evidence to that effect from that area.

On an associated note, the majority of the AIDS sufferers are in Dublin and also police sources would confirm that the majority of illicit drug-related crime takes place in Dublin (see, for instance, *Report of An Garda Siochana, 1996*).

level of education achieved

Such evidence as is available in Ireland points to a low level of education for those involved in drug abuse. Each of the reports from the Health Research Board and any of the small-scale studies which included education as a variable (for instance, McCarthy, 1997 study in the south inner city; O'Connor *et al* 1986's work with attendees at an Accident and Emergency Department in a Dublin hospital and Dean *et al* 1984 who studied a selection of drug abusers chosen by an investigation panel) have indicated a majority of the clients in treatment as having left school before the official school-leaving age.

In her survey of substance use among adolescents in the Western Health Board, McKieman (1995) indicated that early school leavers and adolescents from Galway city in particular are at increased risk for smoking, drinking and drug use. McKiernan, however, qualifies her results in that her sample was a census of early school leavers in the city and not a regional random sample so the results cannot be generalised to the population of early school leavers in the Western Health Board area. She recommends that a survey of a random sample of early school leavers in the Western Health Board region should be carried out to see if the results obtained in her study pertain to the population of early school leavers.

Keogh's (1997) study indicated that 91 per cent of the respondents in his survey had-deft school before the age of 16 and two-thirds of the respondents had no qualification on leaving school.

In her exploratory work on the social and psychological needs of children of drug users Hogan (1997) looked at some socio-demographic background characteristics of the parents and found that the education level of interviewed parents was very low.

The most significant category of the educational qualifications of residents in one estate in Dublin where there are severe drug problems is that of early school leavers (Morley, 1998).

Further comment on poor educational attainment and its effect on young people at risk of drug abuse is made in the Conclusion section.

gender

It would be generally agreed that the issue of women's involvement in drug abuse has been neglected to a significant degree. There are no published Irish studies which concentrate on female as distinct from male drug abusers. One unpublished study by Dunne (1994) charts the characteristics of female drug users and the implications for service response. The main objective of the study was to propose ways of improving the health and quality of life of a group of drug-using, marginalised women in Dublin. The author stressed the need for a strategy which involves a wider spectrum of service response-than that provided heretofore. Butler and Woods (1992) had looked at responses in Dublin to women who were infected with the HIV virus. In the Irish context, sources such as the Health Research Board reports had produced consistent evidence, based on the limited evidence of attendance at treatment centres, that women were less likely to be involved in drug abuse than men. For instance, in 1996 the proportion of men in the group coming for treatment for the first time that year was 72 per cent in the Eastern Health Board area and higher for the rest of the country being around 80 per cent. (See Moran-*et al,* 1997). Work done elsewhere, for instance Keogh (1997) in a Dublin sample of illicit drug use related to criminal activity, found that 84 per cent of his sample of drug users were males. Looking at the Comiskey (forthcoming) study, it would appear that while males are more likely to be vastly overrepresented in the police data, this is not as obvious in the methadone list data or the HIPE data. For instance, in the methadone maintenance list, the proportion of males in the 15 to 24 year age group is 67 per cent and the proportion of males in the 25 to 34 year age group is 72 per cent. From the HIPE (Hospital In Patient Enquiry) data the proportion are closer again. Fifty-seven per cent are males in the 15 to 24 year age group and 69 per cent in the 25 to 34 year group. Given that the highest proportion of drug abusers are in the 15 to 24 year age group, this probably indicates that the number of females in treatment is increasing since all previous reports gave much larger proportional differences between males and females in treatment. However, further work would have to be undertaken to confirm or deny this possibility.

On this point of the narrowing of the gap between the proportions of males and females in treatment. Grant (1996) giving results from the National Longitudinal Alcohol Epidemiologic Survey in the US notes that the rates of dependence among women were quickly approaching the rates among men in-the younger cohorts. Earlier the point was well made by Pearson (1990), both from his own research-in Britain and other sources, that while male problem drug abusers outnumber women to a significant extent, the UK Home Office statistics show that medically prescribed tranquillisers offer an exception to the rule with women twice as likely to use prescribed psychotropic drugs. Given the paucity of studies available on gender differences, Pearson urges caution in interpreting gender differences among drug abusers. Nevertheless, he would argue that it is reasonable to assume that young men will commonly be attracted to illicit drug use as a means of achieving status and demonstrating "manhood" within local peer networks, involving a motivational context of risk-taking and excitement. "By contrast" says Pearson "it has been argued that it is the socialisation of women into roles of dependence and passivity which determines to a large extent their more prevalent use of sedatives and tranquillisers".

Another aspect of the differences between men and women drug abusers is that, for instance, in Dublin, women were proportionately more likely than men who were

abusers to be living with a drug abusing partner. Evidence from Frankfurt provided by Hedrich (1990) submitted that a woman's cessation of drug abuse was strongly related to her social relationships and emotional support from other people.

In the UK Klee (1993) had suggested that economic and emotional dependence of women on partners leads to underlying anxiety and that injecting males prefer non-drug-abusing partners. A study also in the UK, Gossop *et al.* (1994), found that women were more likely to have a sexual partner who was a drug user and to be living with another user than were the men in the study. The authors believed that this closer social attachment to other drug users presented a high risk factor for women with regard to prognosis, and treatment. The research of Powis *et al* (1996) in a study in London of the differences between male and female drug users comparing community samples of heroin and cocaine users, also stresses that male partners do have a important influence over women's drug use. Also these authors say that although gender-related issues are often cited as playing an important part in determining patterns of illicit drug use, little is known about the differences between male and female drug users outside treatment settings. Their sample was of 558 heroin and cocaine users recruited from a range of community settings, were interviewed by what are known as Privileged Access Interviewers - people who had worked in treatment settings. Differences between the sexes were found on age, women were younger than men; on amount used - women used smaller amounts for a shorter duration and were less likely to inject than their male counterparts. Men were financing themselves through more criminal activities than women. The authors concluded that structural differences in patterns of drug use found among female drug users and the influence of male sexual partners are likely to play an important role in determining appropriate treatment options for women drug users.

The US study by Davis and deNitto (1996) examined gender differences on 16 social and psychological problems among substance abusers and non-substance abusers in a community population to determine whether such differences were simply a reflection of differences between men and women in the general population. Women in the overall sample were more troubled by family problems, had more parents with psychiatric problems and received more out-patient psychiatric treatment. Problems associated with substance abuse, not gender, include divorce, problems controlling violence and parents with substance abuse problems. The authors state that their findings suggest that substance-abusing women experience a 'double whammy' because they incur both the problems of women and the problems of substance abusers. These authors also conclude that disaggregating gender and substance abuse effects has implications for treatment-matching and relapse prevention, specifically for suggesting strategies that address the special vulnerabilities of substance-abusing women.

Focusing on the social care needs of women (Dorn *et al,* 1992) assert that this often involves striking another seam of care, the less public and often invisible range of tasks conducted by many women in the home and community. The editors considered that women within illicit drug cultures would be no exception to this rule and that a partner with HIV would add to what the feminist sociological literature on informal caring has termed women's 'double burden of care' (e.g. Groves and Finch, 1983; Glendinning, 1983). The wider context had added a sharper edge to this

consideration in that the 1980s had seen the ongoing debate about community care take new shape amid policies which dramatically altered the balance between public and private responsibility for health and welfare, involving major implications for the informal caring roles played by many women.

Henderson (1992) gives special focus to the problems facing HIV-positive women in London in 1989 - isolation, stigmatisation (of self and children), coping with their own and-others' fears, making decisions about pregnancy, continuing to care for themselves, their children and any male partner and trying to pull together resources. Two principal themes emerged from the accounts of personal experiences. First, the major impetus behind public service responses to women in the context of HIV had been a concern over the spread of infection via reproduction. This focus on women's reproductive role was perceived to have been at the expense of a concern for the overall health of individual women. It also had not been accompanied by initiatives to meet the challenge of HIV in relevant services. Family planning, obstetrics and foster-care services appeared to be sadly under-developed in relation to HIV strategies and the general demise of family planning clinics was noted with some dismay. Second, where women's sexuality outside of reproduction had received public attention, it had also been within a context where limiting the spread of HIV infection was prioritised over a concern for the well-being of women. The focus here had operated in such a way as to 'outlaw' signs of active sexuality in women - such as non-monogamy and selling sex - redrawing historically familiar lines of female respectability and deviance.

Another aspect of the gender issue is the intergenerational effect. Eighteen families with a drug-using member were interviewed for the McCarthy (1997) study. The authors concluded that grandmothers who should be enjoying an easing off in responsibilities in their late middle age are having to bring up a new generation - the children of their drug-using children, either because their own children have died or because they are incapable of bringing up their families because of the effects of drug abuse.

age

Studies in Ireland where age has been a variable have found an age of between 15 and 24 years for the average drug abuser (see, in particular, the reports on-the treated drug abusers from the Health Research Board but also McCarthy and McCarthy, 1997, Lavelle, 1986 and Dean *et al* 1984). The most recent report from the Health Research Board (Moran *et al* 1997) reiterates previous findings that the average age of those who come for treatment is declining. That Report noted that the number of teenagers receiving treatment had more than tripled since 1990. The report suggests that the key groups to target for health promotion and prevention activities are those in their teens and younger children. While this evidence is limited to those who attend for treatment it is probably reasonably safe to assume that the age first drug use generally is most likely to be decreasing.

Shiner and Newburn (1997) writing about Britain attest that although the picture they have is also incomplete, it is clear that drug use and age are linked. They note from the work of the Institute for the Study of Drug Dependence's review of the research, that although rare during the early teens, use of drugs increases sharply

during the next couple of years so that the late teens are consistently found to be a peak period of illegal drug use.

On the comparison between generations of drug abusers, in Grant's (1996) study of the prevalence and correlates of drug use in the United States, he found that members of the youngest cohort, between the ages of 18 and 24 years at the time of interview, were more likely to use drugs, to become dependent and to persist in dependence compared to the older cohorts.

housing

In his section on neighbourhood studies in the UK Pearson (1987) set out from his own research in the north of England to identify a small number of neighbourhoods where heroin abuse had become a serious problem and to see whether these localities differed in any other significant ways from the surrounding area. The results suggest a close local relationship between heroin abuse and neighbourhood levels of social deprivation and unemployment.

Later in a paper delivered to a UK police conference on drugs and crime, Pearson (1991) noted that attention to the mechanism of the housing market helps to provide a more active understanding of the so-called process of "drift' which leads, among other things, to the geographical association between social deprivation and high rates of crime and deviance. "It is" says Pearson, alluding to work done by Dear and Wolsh, (1987), "an argument with a wide range of applications, including the generation of 'ghettos of dependency' as a result of the accelerated process of mental hospital closure and de-institutionalisation whereby discharged mental patients have been pitch-forked into the community".

Gabbay (1995) remarks that typical drug related crimes coincide with many of those which are most problematic to inhabitants of housing estates. Most serious is the gang violence related to suppliers of controlled drugs competing for market share. Acquisitive crime is from dwellings, cars, muggings and shops. This raises the cost of goods to the public and drives businesses away from housing estates, increasing unemployment and the cost of travel to work and cheaper shopping. In housing estates the-social costs include crime and the fear of crime, the negative influences on children who may see drug abuse as an attractive option for them, high insurance costs, stretched police resources, an unsafe environment due to personal crime, carelessly disposed of injecting equipment and a shift of resources and employment away from areas with high drug abuse.

While Hogan's (1997) work on the social and psychological needs of children of drug users was an exploratory study to generate specific research questions and hypotheses yet it may be noted that the parents interviewed were either in local authority housing or homeless.

A study by a team from the Economic and Social Research Institute, National University Maynooth and University College Cork is underway at present looking at strategies to improve the quality of life in urban local authority housing estates. Added to this is a research module on the community dimension of drug abuse in Ireland which approaches the problem of drug abuse from the point of view of the community

and the effect on the community rather than the individual drug user who has usually been the focus of study. While the larger study is commissioned jointly by the Katharine Howard Foundation and the Combat Poverty Agency, additional funding has been forthcoming from the Department of the Environment and Peace and Reconciliation. The module on drugs is funded by the Combat Poverty Agency.

unemployment

As is the case with social deprivation generally, there is no necessary or automatic relationship between unemployment and heroin use, or indeed any drug use, since many people in, for instance, the entertainment world use heroin. Also Pearson (1993) warns against the so-called 'ecological fallacy' in area analysis whereby one cannot reliably infer from established correlations at area level to the characteristics of individuals living in that area. Pearson gives the example that the fact that heroin use is concentrated in areas of high unemployment does not necessarily mean that all individual heroin users are unemployed. Pearson cites research in-the US and the UK supporting this opinion. However, evidence from the studies of treated drug abuse undertaken by the Health Research Board show the proportion of unemployed among the clients at the treatment centres in the Eastern Health Board area amounted to 80 per cent or over. While there was a variety of levels of unemployment among those in treatment in other health boards areas in Ireland, the levels were all lower than those for the Eastern Health Board. It is clear that there is undoubtedly an important and significant relationship between the problem of unemployment and the abuse of heroin. All other Irish studies that include unemployment among the variables in their enquiries, for instance, Hutchinson, 1995, O'Kelly *et al.* 1988 and O'Connor *et al,* 1986, while being small-scale studies, observe that the vast majority of their subjects are unemployed. Unfortunately these studies are mainly undertaken in areas of high unemployment anyway, but on the other hand these are the areas where the problem is seen as being most visible.

Only 3 percent of the respondents in Keogh's (1997) study of illicit drug use and related criminal activity in the Dublin Metropolitan Area were in full-time employment and the most likely category was "unemployed' (84 per cent). In contrast to this the Jackson (1997) study in the Cork and Kerry area encountered the highest association with taking of drugs among part-time employees with 46 per cent having a life-time use, 36 per cent recent use and 14 per cent were currently using. The rates for unemployed and employed people were similar to each other and only half those of the part-time employees. However, it may be difficult to come to any conclusion about a comparison since the Keogh study was targeting a particular population in Dublin (those known to the Gardai) while the Jackson study was a random sample of a total population in the area of Cork and Kerry, with some boosting of the sample in deprived areas.

All of the parents interviewed in Hogan's (1997) study of the children of drug users were unemployed although this finding must be treated with caution since, as pointed out above, this was an exploratory study to generate specific research questions and hypotheses.

Morley (1998) found an unemployment rate of 74 per cent in the area of her study which is of a deprived housing estate in Dublin.

Elsewhere, for example in Britain, notably in Parker's Merseyside (1988) research, a strong correlation was found between the prevalence of heroin use in the different townships of the Wirral peninsula and local unemployment rates. Also in Britain Pearson (1987) maintains that the circumstances of unemployment will make it more likely that heroin abuse will spread more rapidly within a neighbourhood, once the drug has become available. He cautions that it is availability that is the important variable in a neighbourhood and not the existence of high unemployment *per se.* However, Pearson does assert that "...the absence of a work status, with its rewards and commitments to compete with the claims of heroin, will make it more difficult for a user to relinquish the drug and its accompanying life-style".

In a report which presented data on problematic drug use collected from treatment and care services in the North West of England (University of Liverpool and University of Manchester, 1995) the level of unemployment was 84 per cent which "fits well the profile of the drug abuser elsewhere as well.

Squires *et al* (1995) found that the strongest correlation between drug abuse and a single marker of deprivation was with unemployment.

Zinberg (1984) makes the point that it is the absence of valued life commitments, such as employment, which makes a stable form of recreational drug use less likely. The direction in the findings of the research is that unemployment precedes drug abuse and not the opposite. In one Spanish study (Rodriquez-Kauth 1996) the author points out the obvious fact that unemployment brings about many social and psychological ills. Drug abuse is one possible ill brought about by unemployment. Evidence from the United States of the link between unemployment and drug abuse includes Amuleru-Marshall's (1989) study of substance abuse among Americans urban youth and the findings of Johnson and Kaplan (1990). Both show that continual daily drug use is a significant consequence of early psychopathology and a significant antecedent of psychological symptoms that in young adulthood are related significantly to unemployment and physical health limitations.

Section 3 - Policy responses to drug abuse in Ireland

Evolution of policy responses to drug abuse in Ireland

In 1968, largely prompted by public disquiet at the increasing evidence that abuse of illicit drugs was escalating in Dublin, the then Minister for Health set up a Working Party to examine the extent of drug abuse. The report of that Working Party established the benchmark of the first wave of drug abuse in Dublin - drug abuse was not seen as presenting a problem of any significance outside of Dublin. The recommendations of this Working Party covered statutory controls and other preventive measures. Action on the over prescribing of drugs and on the registration of persons dependent on drugs was proposed in addition to recommendations on education, treatment and rehabilitation. The recommendations which were subsequently adopted created structures for prevention and treatment such as the

strengthening of the Garda Drug Squad; the *Medical Preparations (Control of Amphetamines) Regulations 1969,* which imposed rigid controls over the manufacture, importation and sale of amphetamines; the establishment of a statutory outpatient treatment facility in a Dublin hospital - the National Drug Advisory and Treatment Centre and the introduction of rehabilitation services such as Coolmine Therapeutic Community. The recommendations also led to the introduction of the *Misuse of Drugs Act 1977.* This Act was the first piece of legislation to recognise in law the dimension of drug-related crime and led to the conviction of a number of major drug dealers. All previous legislation had focused on the control of drugs and their chemical or pharmacological content.

The assumption guiding the policy makers upheld that the objective of drug policy should be to maintain people in or restore people to a drug-free lifestyle. The main treatment model was abstinence. In the creation of structures for treatment and prevention, however, was the recognition of the wider dimension than just that of criminal behaviour. Policies aimed at the reduction of-drug abuse were now aimed in two parallel directions - supply reduction and demand reduction. But with the sudden and dramatic rise in the use of opiates by young people in the inner city areas of Dublin in the early 1980s a number of further measures were introduced, this time following recommendations from the 1982 Report of the Eastern Health Board Task Force. That Report used evidence from the National Drug Treatment Advisory and Treatment Centre, the Coolmine Therapeutic Community, the Garda Drug Squad, general practitioners and hospital emergencies departments, to document the sudden and dramatic rise in the numbers of young people in Dublin abusing drugs, predominantly opiates. In response to this evidence the Government established in 1983 a Special Task Force to examine the question of drug abuse with particular reference to the inner city areas. The need for this action was patently obvious but allied to that there was a need for the recognition that drug abuse had wider dimensions than harm or supply reduction. Little or no recognition had been given to the need for policies focusing on causal relationships between drug problems and social problems such as poverty, urban decay and unemployment. Some recognition that drug abuse had wider dimensions than supply and demand reduction had been reflected in the terms of reference for that Special Governmental Task Force. However, the report of that Task Force was never published. Butler (1991, p. 220) asserts that "One of [its]-most interesting and radical sections... contained the clearest and most explicit acknowledgement ever made by Irish policy makers that drug problems in Dublin were largely explicable in terms of the poverty and powerlessness of a small number of working-class neighbourhoods" but no reference was made to these findings in the press releases issued on the report.

Directly arising out of the recommendations of that Task Force, the following measures were undertaken over the next few years:

- the *Misuse of Drugs Act, 1977* was extended and amended and became the Misuse of Drugs Act, 1984:
- the *Criminal Justice Bill, 1983* was drawn up and later became the Criminal Justice Act, 1990;
- 'life skills' programmes were introduced in a number of schools;
- a diploma course in Addiction Studies was introduced in Trinity College;

- funding was provided to the Medico-Social Research Board to carry out research on drug abuse;
- the Drug Treatment Reporting System was set up and produced its first report on treated drug abuse for the Greater Dublin Area for the year 1990.

That sudden increase in the abuse of opiates by a young population in Dublin in the early 1980s had come later than in other European countries. As part of its role in developing an appropriate drug demand reduction programme the Irish Government, along with the measures mentioned above, reconstituted and strengthened the National Co-ordinating Committee on Drug Abuse (an interdepartmental committee) in 1990. The report of that Committee emitted *Government Strategy to Prevent Drug Abuse,* published in 1991, was adopted and became the basis for all subsequent policy. The report was based on recommendations put forward by the NCCDA and embodied the views of statutory and voluntary bodies involved with drug abusers in Ireland. It also incorporated the recommendations from other major international bodies. This response to the evidence of a rising serious problem appeared to be a major shift in the attitude of the Government of the time and previous Governments to the increasing evidence of the escalation of drug abuse.

The notion of aiding the drug abuser had not been seriously considered until the recognition of the interests of public health and the hazards of the transmission of AIDS and the HIV virus posed by increasing levels of intravenous drug use became visible in the late 1980s. Ireland was not alone in this approach. In the UK, for instance, Stimson and Lart (1991) inform us that since 1986 there has been a major reconceptualization of drugs policy in England in response to HIV and AIDS with new ideas about risk behaviour and risk reduction and health behaviour minimisation. Pearson (1992) notes that British drug-control policy remained health oriented in the face of mounting research evidence that the heroin epidemic was particularly associated with forms of social deprivation.

It was as a response to the reality of major health hazards that, in Ireland as elsewhere, while a drug-free society was still regarded as the ideal, it had to be acknowledged that many drug users could never even aspire to that ideal, certainly at the initial stages of their treatment. Therefore a pragmatic, solution was arrived at and the response was the provision of a number of treatment options. Now harm reduction, in the sense of first providing methadone maintenance to heroin users to break their use of injecting as a means of using heroin and thus reduce the risk of contracting the HIV virus with the added danger of developing AIDS and second rehabilitation, became the predominant statutory approaches to the problem.

The study of the Merchants' Quay Project (1993) criticised the approach in the *Government Strategy to Prevent Drug Misuse* which stated that "...it is impossible to separate policies relating to drugs from those of AIDS/HIV transmission" (Department of Health, 1991, p.8). The Merchants' Quay study regarded this as an overstatement of the connection saying that the problems associated with drug use and HIV are only partly related and policy response has tended to treat them jointly. As the authors of that study point out, drug use and HIV/AIDS are different problems in the sense that each can exist without the other. Drug use is not a necessary condition for contracting AIDS and many persons have AIDS who are not drug users. The Project

report also criticised the fact that nothwithstanding the substantial overlap in public policy between drugs and HIV/AIDS there are a number of elements in the policy on HIV/AIDS that were not targeted specifically on drug users (see: Merchant's Quay Project, 1993, p. 9). The first of these was a national HIV surveillance programme to determine the incidence and prevalence of HIV among the population at large and among at-risk groups in particular. The second element in the HIV/AIDS policy involved setting up AIDS Resource Centres in the main centres of population; the third was the appointment in September 1992 of a Consultant in Infectious Diseases at the Mater and Beaumont hospitals to facilitate in-patient care for persons with AIDS on the north side of Dublin. St. James' Hospital on the south side of the city already had a medical consultant specialising in AIDS. Finally, the fourth element in the HIV/AIDS policy was prevention and this mainly involved the dissemination of information on HIV and AIDS through mass media, posters, leaflets, booklets, videos and outreach initiatives. The criticism of the Merchants' Quay study was that these latter were being targeted at a wider audience such as the general public and drug users were not specifically targeted.

Following on an apparent hiatus in the problem of drug abuse at the beginning of the 1990s, in the past few years there has occurred an increasing awareness of a renewed and growing serious problem, particularly of heroin abuse, in Dublin. No doubt as a response to that an upsurge has occurred in community activity with groups of concerned parents and others taking an active part in the effort to remove drug dealers from their communities. The defunct National Co-ordinating Committee on Drug Abuse had been reconstituted in 1995 to respond to the observed upsurge in drug abuse and this was replaced in late 1996 by the National Drugs Strategy Team, which takes a more active and direct part in liaison between the people in the field and the administrators and policy makers. The setting up of the NDST was in response to a recommendation in the *First Report of the Ministerial Task Force to Reduce the Demand for Drugs.* This Ministerial Task Force was established in July 1996 as part of the action programme implemented by the Government in February 1996. The work of the Task Force was to review the arrangements for a co-ordinated approach to drug demand reduction and, in the light of the review, to identify for Governmental action any changes or additional measures needed to provide a more effective response to the problem. The Chairman of the-Task Force was Mr Pat Rabbitte, T.D., Minister of State to the Government.

The deliberations of this Task Force included the first published serious attempt by policy makers at recognition of the relationship between deprivation and drug abuse in Ireland. The first report of this Task Force was confined to opiate abuse and identified areas where particularly high numbers of persons were attending treatment centres for drug abuse and these areas were also identified as areas of high deprivation and were mainly in Dublin. The Task Force recommended that focus should be on these areas to study the problems and introduce policies which would positively affect the life of the residents in these areas. The Task Force was responding to the mounting evidence from, for instance, reports such as the annual reports emanating from the Health Research Board on treated drug abuse which produced persistent evidence of the abusers who were in treatment being predominantly from areas of high deprivation and unemployment and also from the numerous submissions made to the Task Force

by a variety of organisations and individuals (see *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996*).

New treatment, education/prevention and rehabilitative measures in relation to drug abuse were announced. The establishment of new structures designed to achieve a more effective, co-ordinated delivery of the drugs service at national level was recommended. The first level in the matrix of structural arrangements for delivery of services, is the Cabinet Drugs Committee, the second level is the National Drugs Strategy Team that was mandated to implement the Government's strategy in relation to drugs and in particular to maintain a close liaison with the eleven areas identified as having the most acute drugs, particularly heroin problem, to ensure that their problems and priorities are continually monitored at central Government. The third level in the matrix was the setting up of these eleven local Drugs Task Forces one for each of the areas identified by the report as having the most acute drug problems. Ten of these teams are in Dublin and one in Cork. This recommendation was approved by the then Government and is now being implemented by the present Government. Extra monies will be expended in areas most affected by the problem leading to an expansion in the number of treatment centres, particularly in Dublin. Further comment on some difficulties which arose in connection with this expenditure is set out in following paragraphs.

The local teams have representatives of the local community working in the areas concerned, the Gardai, the Probation and Welfare Service, the Prison Service, the Health Boards and the Department of Education. Also involved are Dublin Corporation together with local voluntary drug workers. In the preparation of any action plans, consultation will be held with representatives of community groups. It is planned that access from those working at the local level to the national team would be made simple and direct so that local problems could be discussed with the policy makers and others in authority.

With the change to the Fianna Fail/ Progressive Democrat Coalition, no major changes in the policy as set out by the previous Government appeared to be planned. However Butler (1997), in commenting on the Fianna Fail pre-election manifesto. *A Radical Approach to Drugs and Drug Related Crime,* noted that there was a proposal to demote methadone maintenance from its current position in Irish drug policy and he feels that there were hints at a return to abstinence policies. Butler also commented on the apparent contradiction in the document where a proposal to establish a *National Commission on Drugs* which might be comparable to Britain's *Advisory Council on the Misuse of Drugs,* would have the effect of challenging much of the philosophical thrust of the party's policy as set out in their formal statement. As possible confirmation of this stance, the Budget provision of £1.25 million to the anti-drug fund for youth was in total contradiction to the previous Government's promised allocation. In response to severe criticism the Government, in a complete U-turn, promised £30m. over three years for a young peoples' facilities and services fund. At least £20m, of this money will be destined for those areas where heroin is the main problem. This rethink of the expenditure level reinstates the youth development fund set up by the previous Government in May, 1997.

Zinberg's framework of (a) drug (b) set and (c) setting when looked at from an Irish perspective shows that policy concentrated for the most part on (a) drug and (b) set to the almost total exclusion of (c) setting. Using the "war on drugs" metaphor, policy was aimed largely at eliminating the supply of illicit substances while policy aimed at reducing individual demand through education, as Butler (1997) asserts, echoing Dorn and Murji (1992) and his own 1994 work, at its crudest includes exhortations to "Just say No". These exhortations focus on individual decision-making, with little or no reference to structural factors which influence such decision-making.

Further on educational programmes for drug abusers, McCann (1991) observes that education is seen, and properly so, as an important tool in making effective responses. "However" adds McCann "there are no absolutes when it comes to the content of an educational programme. Ten such programmes may have ten different content areas, such is the complexity of drug addiction".

While there has been no desire on the part of the policymakers to move towards a change in the legislation to legalise any illicit drug, recently there has been some discussion in the media in Ireland about legalisation of cannabis, Further, for instance, Murphy (1996) had put forward the view that the legalisation of the psychoactive substances that are currently prohibited by law is a highly effective and available means of harm reduction. He went on to say that the regulation and standardisation of drugs and the development of informal social controls are among the more obvious benefits of legalisation. While advising caution that any change in the law should certainly be undertaken gradually and with due care, Murphy argues "Harm caused by drugs is far less likely to take place when drug policy is founded on regulation, informative education and openness. Impure drugs and ignorance thrive where the illicit drug market is subjected to no controls or scrutiny whatsoever and where official 'information' concerning the substances emphasises only the dangers - an aspect of drugs that users know is only a partial account" (p-57).

Recent developments with special reference to criminal justice, health services, education, employment.

The Irish Presidency of the European Union, *from* July 1996 to December 1996 was dedicated to focusing on crime and drug abuse and an amount of new legislation was introduced during and subsequent to that period.

criminal justice

According to the criminal law, possession of cannabis is not punished as severely as possession of other drugs. As regards use, normally occasional use or use for the first time is punished with a warning or a fine. After that, imprisonment of up to one year for a 'lesser' crime but up to 14 years for an indictable crime.

No legislation exists for an offender to undergo compulsory treatment but it is possible for a judge to order a drug offender who is already in custody to undergo treatment. At the time of trial a sentence may be deferred when a drug offender voluntarily agrees to undergo treatment.

As part of the new legislation introduced in 1996, Part VII of the *Criminal Justice Act 1994,* the provisions of which are essential for Ireland to discharge its obligations under a number of Conventions recently ratified, was brought into effect by order of the Minister for Justice on 15 November 1996. For instance, in September 1996 Ireland ratified the *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.* As a party to this convention Ireland will be able to play a full part in international co-operation against drug trafficking, ranging from practical co-operation on drug trafficking at sea to judicial co-operation in obtaining evidence and in confiscating the proceeds of drug trafficking. The Department of Justice will act as the Central Authority in this jurisdiction for the purposes of international cooperation under the Convention.

In December 1996 Ireland also ratified the Council of Europe *Convention on Mutual Assistance in Criminal Matters* (and the additional Protocol to that Convention) which came into effect as regards Ireland in February 1997; and the Council of Europe *Convention on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime* which came into effect as regards Ireland on 1 March 1997.

Another piece of legislation which was passed in 1996 was the *Proceeds of Crime Act 1996* which provides a powerful new mechanism for the freezing and forfeiture of the proceeds of crime. It enables the Irish courts to freeze property worth more than IR£10,000. where satisfied, on the balance of probabilities, that the property represents the proceeds of crime. This Act complements the confiscation provisions of the *Criminal Justice Act, 1994,* under which a person who is convicted of an offence on indictment is liable to have confiscated any property which the court believes on the balance of probabilities, represents the proceeds of that offence. Together, these provisions represent a major step forward in the ability of our criminal justice system to deprive serious offenders of the proceeds of their crimes.

The *Criminal Justice (Drug Trafficking) Act 1996,* which provides for detention of up to 7 days for drug trafficking offences, allows for the presence of Customs Officers at interviews of suspects and allows inferences to be drawn by a Court from the failure of an accused to mention particular facts when being questioned by a Garda.

The *Disclosure of Certain Information for Taxation and Other Purposes Act, 1996* provides for more effective exchange of information between the Gardai and the Revenue Commissioners.

A number of other crime prevention initiatives were undertaken in 1996 under the aegis of the Department of Justice. A major development was the establishment by the Government of the Criminal Assets Bureau. This new body, which has staff drawn from the Gardai, the Revenue Commissioners and the Department for Social Welfare (now the Department of Social, Community and Family Affairs) will ensure closer and more concerted co-operation between the State agencies in dealing with drug trafficking and organised crime. The *Criminal Assets Bureau Act, 1996* has put the Bureau on a statutory footing. The Bureau has the capacity to mount a sustained and focused attack on the illegally acquired assets of criminals involved in serious crime and forms a central part of the Government's anti-crime measures.

Other new initiatives included:

- increase in the number of Youth Diversion Projects;
- strengthening of Juvenile Liaison Officer Scheme;
- establishment of a Crime Council;
- expansion of a closed circuit television system;
- specialist Garda vehicles for surveillance and rapid response;
- radio technicians for Garda Communications Network.

The Garda authorities have reviewed their operations in regard to combating the drugs problem particularly, in Dublin and the Garda Commissioner introduced their new strategy *Operation Dochas* in October 1996. This new strategy functions in all Dublin districts and involves the deployment of in excess of 500 uniformed and plain-clothes Garda. Uniformed Gardai adopt a high profile through both foot patrols and mobile patrols and are working with local communities, both community leaders and individual families. Backup is provided by specialist mobile units and other units. *Operation Dochas* is subject to ongoing review as are all Garda operations. It, will continue operating and will be revised as circumstances indicate or require. However, no reports on or assessments of the success or otherwise of this operation and no figures are publicly available so, without such evidence, it is not possible for the purposes of this review to say here whether or not the operation has resulted in an increase in the quantity of drugs seized and an increase in the arrest of those suspected of being involved in drugs.

In suggesting the likely benefits of a combined discipline approach, Bennett (1990) states that the available evidence suggests that the relationship between drug abuse and crime is probably not a simple one and that there may be benefits from combining the efforts of criminologists and drug researchers in the study of the nature of the relationship between drug/alcohol use and crime. He suggests that something might be gained by focusing on the various situational factors which link drug/alcohol use and crime. He feels some help might be forthcoming for this endeavour from criminology which has in recent years developed a body of knowledge on the role of situational determinants of crime. Research from within this perspective has been helpful in informing strategies for intervention over a wide range of crimes and crime settings. In particular, Bennett draws attention to the wealth of crime prevention ideas that has arisen out of situational analyses of alcohol-related public disorder. He proposes that further research be conducted which draws on this approach in an attempt to increase our understanding of the micro-social processes involved.

On the law enforcement theme, evidence from the UK. (Collison, 1994) would show that official statistical data on sentencing and law enforcement suggests that the courts and the police have not followed injunctions to divert the user and punish the cynical dealer in clear-cut ways. Rather the criminal justice and penal systems continue to deal in judicial forms with the users of drugs.

In his foreword to the report by Keogh (1997), Morgan says that it is especially noteworthy that for the majority of people in the survey, their involvement in crime began before their involvement with drugs. “However” adds Morgan “it would be equally inappropriate to say that drug-taking has not influenced their criminal behaviour. It is probably more accurate to say that involvement with crime and drugs

is part of a larger ‘syndrome’ which is determined by personal and background factors in these people’s lives”.

Little research has already been done or planned in the area of drug-related crime. McCullagh (1996) in his examination of crime in Ireland noted that the development of an economy around the importation, sale and consumption of illegal drugs has had an impact on crime. However, the scale of drug-related crime is difficult to estimate. Police statistics record the number of offences, such as importation, dealing and possession of illegal drugs, committed against the Misuse of Drugs Acts. McCullagh argues, however that these offences are more a measure of police activity than an accurate indication of the level of crime involved. Since drug abusers can themselves often be the victims of the crimes, they are not likely to report them to the police. Also family and close friends may be involved.[1]

A National Crime Forum has been established in order to inform public policy on crime and responses to crime. The National Anti Poverty Strategy had acknowledged a link between crime and poverty, in particular in relation to drug abuse and the Combat Poverty Agency in its submission to the Crime Forum stresses that the deliberations and outcomes of the Forum should have particular regard to the National Anti Poverty Strategy.

The association between drugs and crime is a complex one. One example of a study in the US that is of interest here is that of Linnevar and Shoemaker (1995) who discovered that most research documenting the relationship between crime and the use/sale of drugs analyses individual level data, ignoring the possibility that the socio-demographic characteristics of communities may condition these relationships. Aggregate level data from 136 counties and cities in the state of Virginia are used to investigate whether communities with higher rates of juvenile arrests for murder, robbery, property crimes and Part II offences have higher rates of arrests for selling and possession of drugs. Controlling for measures of urbanisation, family disruption, relative deprivation, the subculture of violence and graduation rates, it is found that the rate of juvenile arrests for murder is not associated with the rates of arrests for selling and possessing drugs. Arrests for robberies are associated with the rates of arrests for selling, but not possessing, drugs. Arrests for property and Part II offences are positively associated with both the sale and possession of drugs. It is concluded that, at the aggregate level, the association between crime and drugs varies. The explication of this association requires researchers to differentiate among types of crime and types of drug-related arrests. The relationship between crime and drugs, except homicide, does not depend on the community’s socio-demographic characteristics. In short, communities can decrease their arrest rates for violent and property crimes by decreasing their rates of arrests for selling and possessing drugs.

Squires *et al* (1995) has shown the link between drug abuse and crime is of great importance. The negative interdependence which exists between the Drug

[1] While this paper is a review of literature and policy on the links between poverty and drug abuse and there is no documentary evidence available, it is no doubt fitting that the name of Veronica Geurin should be mentioned and tribute paid to the contribution she made to assisting the criminal justice system with their work in the arrest and conviction of a number of the main players in the drug-dealing arena.

Dependence Unit and police databases in this study suggests that those drug users not attending the methadone based service are 7.2 (95 per cent CI= 4.6-11.4) times more likely to commit crimes of possession than those in treatment. This result contradicts reports suggesting that methadone treatment for heroin addiction is ineffective. The benefits of providing drug services are wider than the benefit to the individual drug user as a result of decreased levels of crime. This should be borne in mind in any consideration of the cost of providing drug services (see Stevenson, 1986).

drug abusers in prison

The whole area of drug abusers in prison has received considerable attention from the Department of Justice and the media in the past year. Prisons are now well recognised as having significant levels of drug availability and individuals in detention are at increased risk of contracting HIV, hepatitis B and C and other blood borne viruses as a result of increased risk taking behaviour. The establishment of a drug free therapeutic unit in Mountjoy prison has been one response to the problem. Currently the appointment of a consultant with specific prison sessions could enhance links between the prison and community services. Infrastructures to support this senior level of input have to be put in place. Development of protocols and standards for treatment that would support the continuity of treatment services for persons entering and leaving prison are under consideration.

O'Mahony's 1997 study of the profile of prisoners in Mountjoy Prison showed that there was a considerable increase in the use of cannabis over the 1986 figures of usage. Also more than three-quarters of the sample (77 per cent) had experience of drugs other than cannabis. For a large majority of these, heroin was the drug of choice and the main drug of addiction. O'Mahony points out that this amounts to 66 per cent of the total sample or two out of every three prisoners had used heroin. He adds that these prisoners were specifically heroin users but did not use heroin in a narrow or exclusive way. "They were in fact," says O'Mahony "overwhelmingly polydrug users who had experience of, at least on an occasional basis, a wide variety of drugs, including stimulants such as ecstasy and cocaine; hallucinogens such as LSD and narcotics such as heroin and physeptone".

No accurate current information is available on the total-number or proportion of drug abusers/addicts in prison, either on a census day or cumulatively. There is a lag of a number of years on information from the Department of Justice's *Annual Report on Prisons and Places of Detention* but improving facilities for the recording of information on the prison population through computerisation of records should make more up-to-date information accessible in the future. Some information on drug abusers in the prison population but no exact numbers is available from a Prisons Information Handout dated 15 March 1996. The 'special topic' covered in the handout was drug abuse in the Irish Prison System and the details given were that:

- at least 40 per cent of prisoners have a background of serious drug misuse;
- at least 25 per cent of offenders are serving sentences for drug-related crime: muggings, burglaries etc. to feed their habit;
- five per cent of offenders are serving sentences for direct drug offences: importation, possession with intent to supply etc.;

- all prisoners have access to HIV testing on a confidential basis and follow-up counselling as required, irrespective of the outcome of the test;
- unlike some other jurisdictions, clean needles are not provided to prisoners;
- of 25 deaths in custody over the last six years, at least 7 are thought to have had a background of drug abuse.

The above document focused on drugs in the prisons but there is also the problem not mentioned in the document and that is the cost of the service. The staff-prisoner ratio is more than one to one, making the service a very expensive one. The Irish Penal Reform Trust in their newsletter (1998) comment on the cost of the service and particularly on the lack of alternatives *\to* prison for women. The theme of their next conference will be 'Why prison for women?' A section is also included in the Newsletter on drugs in prison and the IPRT will be holding a seminar addressing that issue.

health services generally

In this section the health services for individuals who experience problems related to their drug abuse are considered. Treatment and rehabilitative care is available through a mix of specialised substance abuse programmes such as detoxification, assessment, inpatient and outpatient hospital services. Treatment may also be availed of in more generic settings such as psychiatric hospitals and in prisons. Funding for these services is mainly from Government sources, principally the Departments of Health and Justice. Obviously, the coverage here would not claim to be comprehensive as the services, both statutory and voluntary, are too numerous to be detailed in an account such as this. Also interlinking occurs between statutory and voluntary services. Other services are included in the later section on community programmes.

Statutory services are provided in treatment clinics in each of the Health Board Areas. Because of the concentration of heroin abuse in Dublin the largest of the services is that of the Drug Treatment Centre Board at Trinity Court in Dublin. This is an out-patient service providing detoxification, methadone maintenance, social, psychological and psychiatric assessment, urine screening, needle exchange, counselling and advisory service. The Eastern Health Board is responsible for providing, co-ordinating and funding treatment programmes for drug abusers in its area with the exception of the DTCB which is funded directly by the Department of Health. An inpatient detoxification service is provided in the form of a number of beds in two centres attached to general hospitals in Dublin, one on the north side of the city and the other on the south side (Beaumont and Cherry Orchard hospitals).

As the treatment services expanded, the role and requirements of the outreach services, workers specifically employed to contact those either not willing or unable to obtain a place on a treatment programme, naturally changed. At present, needle-exchange facilities are available in certain 'at risk' areas. No details on the clients are gathered. However, through this service, contact is made with abusers and encouragement given to them to seek treatment.

While it is believed that needle exchange services and methadone maintenance seem to have gone a long way to containing the spread of HIV there is concern about the spread of Hepatitis C which does not respond to either of the above two preventive

measures. The estimate of HIV infection rates among new presentees to the services is about 8 per cent but Hepatitis C figures are reported to be between 50 and 70 per cent.

A mobile clinic is now operated by the Eastern Health Board on sites in the north inner city of Dublin. This clinic is an effort to expand the methadone maintenance treatment services. This service reaches more chaotic drug users who are addicted to opiates, are injecting their drugs and are incapable of stabilising on methadone maintenance. There is a 'night run' service in Dublin for clients who also would not be suitable for a structured methadone maintenance programme. A number of these clients would be HIV positive and they are provided with methadone dosages.

The Eastern Health Board summarises their service provision in their *Service Plan: 1998.* The outline of service provision sets out the service development which took place in 1997 and the planning for further service development in 1998. The EHB note that the number of treatment places increased from 1,861 to 2,776 during 1997. The Young Persons' Programmes which have been, developed at three addiction centres had 95 attendees. Aftercare and rehabilitation programmes are assisting those who have completed treatment to develop skills with the ultimate goal of attaining social inclusion and self sufficiency. In this context Gossop *et al's* (1994) comments are apt. They have stated that there can be few questions more central to this area than what happens to drug-dependent patients after they leave a treatment programme but they conclude that "it is unfortunate that this apparently simple question has received so little research attention". The Service Plan comments that the measures targeted at the drug users in the Board's region with particular emphasis on the areas identified in the *First Ministerial Task Force Report* are contributing enormously to the health and social gain in these regions.

Outside of Dublin because of the different nature of drug problems, (the majority of drug abuse concerns cannabis and ecstasy and therefore methadone maintenance or needle exchanges do not feature in treatment centres) the main emphasis would be on providing non-medical drug-free programmes for teenagers, adolescents and adults. Treatment would be mainly in the form of therapy with one to one counselling backed by multi-disciplined professionals.

There is also a programme which has been developed by the Department of Health Promotion Unit in conjunction with Cork Social and Health Education Project of the Southern Health Board. This project recognises that young people and their parents must be provided with assistance to help them deal with the problems posed by both licit and illicit drugs. To this end a course has been developed which focuses, not only on drugs themselves, but also on the skills and personal attributes that help people deal with drug situations. These skills relate to such areas as listening, communication, self-esteem, conflict resolution, discipline and similar issues.

The Health Promotion Unit of the Department of Health undertook a media campaign, called *Drugs Destroy Lives* aimed primarily at parents and young people and consisting of radio, television and print media advertisements. The campaign started in June 1996 and the first burst included a free telephone information line. The telephone line set up by the Health Promotion Unit was an information line only and did not have any follow-up service. The television and radio advertisements have

continued intermittently. There has also been a one-hour per day information line set up in Cork organised by the Southern Health Board. Again no follow-up service is offered. More recently the Eastern Health Board now runs a Drugs/AIDS freephone Helpline for members of the public, drug abusers, their parents and families, professionals working in drug services and other health care workers. The Helpline is operated by trained Helpline staff with a variety of skills and is open office hours Monday to Friday.

voluntary services with some statutory support

One example of this type of service is the Clondalkin Addiction Support Programme which is a voluntary satellite clinic with statutory support, operated by a general practitioner who has access to the specialist medical and counselling staff at an addiction centre. Services include methadone on prescription which is dispensed by retail pharmacists, urine screening and counselling.

A drug free therapeutic community, Coolmine Therapeutic Community, operates with the approval of the statutory bodies and specialises in detoxification of drug abusers.

Two large and important services would be centres such as the Merchants' Quay Project, a drugs and HIV/AIDS service in the inner city of Dublin and the Ana Liffey Drug Project, a non-prescribing street agency offering counselling and support at day-care level.

Outside of Dublin, the main focus of voluntary service is on the provision of counselling, preventive services and education on the harmful effects of drug abuse.

The Health Promotion Unit at the Department of Health gives financial and practical assistance to a parenting programme *Working Together* developed by Community Awareness of Drugs - a voluntary organisation. It aims to assist parents in exploring attitudes, beliefs and decisions about the issue of drug abuse.

voluntary services

A small number of voluntary agencies and one or two private clinics, for instance the Rutland Centre, provide assessment, counselling and therapy at residential and day-care level.

There are voluntary groups organising community based programmes to care for drug abusers in their family settings giving support and advice. In this event the patients would stay in their social environment and attend daily or at whatever frequency is required.

housing policy

Concern was voiced about certain aspects of *The Housing (Miscellaneous Provisions) Bill, 1996,* such as that the definition of anti-social behaviour in the Bill was too broad and that there were constitutional and civil liberty implications involved (see, for instance, Kelly, 1997). Prior to its enactment the Bill was debated in the Dail (see Dail Debates, Volume 475 Nos. 2 and 3) and the concerns of those who had contacted

deputies were aired. The subsequent amended Bill became *The Housing (Miscellaneous Provisions) Act, 1997.* This Act, is described as forming part of a wider range of measures dealing with among other things, the problems arising from drug pushing and related criminal activity in local authority housing estates. The Act incorporates measures such as exclusion orders for persons believed to be engaging in anti-social behaviour and an estate management programme which will facilitate residents, councillors and local authority staff working together in a partnership process to improve the management and maintenance of estates. The Act also provides for the speeding up of procedures to evict known drug dealers from local authority housing estates. The concerns of those who commented on the Act at the Bill stage may not have been fully allayed and the actual implementation of the measures in the Act is awaited to see how the definitions adopted work in practice.

community programmes

Each Health Board area in the country has been launching information and awareness campaigns to inform young people and their parents about the dangers of drug abuse. These campaigns include the information and prevention programmes in schools and the methadone maintenance programme. There have been numerous examples of parent groups organising and lobbying members of the Government to take action to help them with the problem of having their children either actually involved in drug taking or exposed to the risk of becoming involved.

The Government has recognised that the drugs problem can differ from area to area. Thus the local Drugs Strategy Teams which operate mainly in Dublin will ensure that effective local arrangements are put in place to develop and co-ordinate action against drugs in those particular areas. A critical aim in establishing these teams was to ensure not only that the relevant agencies come together but that local community representatives are involved.

The Eastern Health Board, where the greatest problems arise as regards drug abuse, continues to work on plans to significantly expand services for drug users in local communities through a number of initiatives:

- through the development of a small number of additional community drug centres in order to provide significant geographic coverage;
- through significantly expanding the involvement of general practitioners in the treatment of drug abusers;
- through expanding the involvement of community pharmacists in the dispensing of methadone under controlled conditions;
- through the introduction of a mobile bus or clinic that complements the other services listed above and is aimed at the more chaotic drug abusers.

As in other countries, community resistance to the establishment of services for drug abusers is directly linked to the marginal social status of the service abusers. The Eastern Health Board has been involved in a considerable level of community consultation over the past number of years and has successfully established a number of community drug treatment centres. The successful experiences need to be built on as further services are developed. Local needs assessment projects that develop

reliable estimates of the size of local problems should assist the communities in determining their commitment to appropriate local responses.

The Eastern Health Board's decentralisation programme with a mixture of specialist and primary care services is attempting to disseminate services as broadly as possible. Efforts are being made to communicate that the overall strategy aims to minimise congregation of abusers in small localities. The absence of services for local communities with serious drug problems gives rise to significant social and public health problems. The weight of evidence for the benefits of such services is strong and needs to be convincingly communicated to all interested parties- The community drug centres are being identified as an important local resource with a broad role including the provision of advice and information, access to rehabilitation programmes and to support prevention, education and information programmes for parents, community groups and schools. A member of the strategy group has specific responsibility for community liaison and this should ensure effective communication in both directions.

In the important area of after-care and rehabilitation the Eastern Health Board provides a rehabilitation, development and training programme for men and women from all areas of the city who are drug free or at least three months stabilised on a methadone programme. This programme is situated at the Soilse Project in the south inner city.

The need for locally based services is a key aspect of the Eastern Health Board strategy. The Board is aware that it is important that professionals, politicians, policy makers and the broader community understand the public health importance of such services and their overall value to the community.

Along with the statutory sector development there has been substantial growth in the voluntary sector with a number of strong organisations both in the specialist area of drug services but also as part of broader community groups. A number of day programmes have been introduced. These programmes cater for drug free and methadone maintained individuals.

community action

The first evidence of community action centred around the Concerned Parents Against Drugs (CPAD) which was formed in 1983 and Cullen (1989) writing about a case study of community action in the eighties describes the organisation as having many features of a social movement. "Most importantly" says Cullen "it had the mass participation of people around issues that were perceived as posing an immediate threat, in activities that were democratically decided". Cullen goes on to say that many people who were either involved in or observed the activities of the CPAD when it was first formed believed it had the potential to mobilise working class communities in Dublin around wider social and economic issues and that it raised the possibility of real change. However, "This" says Cullen "did not happen".

The essential differences between drug problems for the individual and community drug problems are highlighted in Cullen (1994). He suggests that an individual's drug problems relate to the social, financial and psychological consequences for them of their use, abuse and indeed non-use of psychoactive drugs

which have addictive or habitual effects. For the community, on the other hand, problems arise when there are concentrations of individual drug problems in particular communities. “Although the evidence for this concentration has by now been well researched and documented” says Cullen “its wider community effects and impact tend to be more difficult to identify and understand”. That author would regard some effects as obvious, such as increases in local crime, greater demands on health and social services and so on. However, argues Cullen, some of the more debilitating effects relate to the loss of community morale, the acceptance of the inevitability of young deaths, the internalisation and denial of grief and a sense, in many communities, that their social predicament has little public interest other than that of media sensationalism and political sound-bytes.

Kelleher-and Whelan (1992) writing about six projects in *Dublin Communities in Action* explain that it is a detailed study of the process of community development in six major community development projects in the greater Dublin area. They note that groups were engaged in a wide variety of such activities addressing three main areas: local economic initiatives, community-education, housing and environmental renewal.

Parent and other community groups in a number of areas such as the north and south inner city and outside the inner city groups such as Killinarden Drug Prevention Group and Rowlagh Residents Association do meet on a voluntary basis. They are part of community action and support groups who, among other activities, lobby members of the Dail for action in their areas against drugs and for services to help their children. Duggan and Ronayne (1991) comment on the support given by local community groups to people in their area. In Fettercairn, for instance, researchers on the study of strategies to improve the quality of life in urban local authority housing estates were told that the community drugs programme was seen as a very important resource. The programme was regarded as having improved the quality of life of the drug abusers in many ways although it was difficult for the abusers to stay away from street drugs. In spite of that, there was a perception that the supply of heroin was not increasing and that the problem could be contained within the area. There had been a problem with general practitioners dispensing beuzodiazapines to their patients in Fettercaim and this in turn caused a problem for the programmes of detoxification. This practice has now been halted by the intervention of the community workers.

There is a partnership based rehabilitation and training programme called *Saol* which offers, a-two-year training and development programme for 16 women in recovery or stabilised on methadone attending the City Clinic in Dublin. This is a day programme and is supported by way of grant aid from the Eastern Health Board.

The Inter-Agency Drugs Project (IADP) in their submission to the Ministerial Task Force on Measures to Reduce Demand for Drugs mentioned their initiation and support for the development of a relatives support group as a response to a demand from a number of family members of drug users in contact with Inner City Organisation Network (ICON). The IADP recommended that in all areas where there is problem drug use parent/relative support groups should be facilitated, resourced and encouraged to engage locally with other groups to define their potential.

education policy concerning drug abuse

There is a nation-wide programme for second level schools, developed by the Psychological Service of the Department of Education, the Health Promotion Unit of the Department of Health, the Mater Dei Counselling Centre and with support from the European Union. *On My Own Two Feet* is an educational package for use with post primary students aimed at the development of personal and social skills for the prevention of substance abuse. The overall aim of the package is to enable students to develop their ability to take charge of their health and specifically to make conscious and informed decisions about the use of drugs (legal and illegal) in their lives.

A substance abuse programme developed by the Departments of Education and Health is currently being introduced in primary schools.

There has been some scepticism about the value of drug education programmes. For instance in Britain Plant (1989), quoting among others Bandy and President (1985), argued that sadly drug education appears to have been largely ineffective and may-even be counterproductive. Plant added that there is little to support high-profile national anti-drug campaigns; such ventures are frequently motivated by political rather than scientific reasons and are seldom evaluated in an acceptable way. Information on whether of not Plant would approve of the outcome evaluation of the impact of drug education on a representative sample of 1,197 school pupils in Glasgow by Coggans *et al* (1991) is not available to us but that study revealed no effects of drug education on drug-related behaviour or drug-related attitudes. However, drug education raised levels of drug-related knowledge. The long term implications of these findings, the authors felt, would require further study. Comparison of process and outcome measures indicated that, with the exception of knowledge, teachers' positive views of drug education were misplaced. The authors also discussed critical aspects of good practice, both at the level of the individual teacher and in terms of whole-school factors.

While Ives (1996) recommends that drug education should take place within a broad framework of health and social education which embraces discussion about healthy living, he also warns that this approach inevitably means entering difficult territory. Health education is a highly charged topic and there is disagreement about what 'healthy living' actually means. Teacher training, both initial and in-service, is vital he contends. Also in his discussion of drug education, Ives sounds another cautionary note, saying that secondary school pupils' knowledge is often considerably greater than the teachers' and in many cases likely to be gained, through personal experience of drug use. The young, says Ives, are more likely to have used drugs than older people: in this respect they have more knowledge about drugs than many of their teachers. Therefore didactic drug education on its own is unlikely to be effective, although it may be necessary to counter some of the misinformation that young people have about drugs with a clear account of the facts appropriate to their age and their level of understanding.

These criticisms in the UK of national anti-drugs campaigns may have led to consideration of different approaches. For example, Clements and Buczkiewicz (1993) and Jack and Clements (1994) argue that because young people may be more likely to listen to other young people than they are to adults, one way of getting messages across are 'peer led' approaches, which are currently popular in the UK,

particularly in informal education but also in schools. These cover a range of approaches involving both older children delivering harm reduction messages to their younger school-mates and 'same-age' peer education involving pupils educating their class-mates. As regards peer education there is also the opposite effect which Parker (1997) in his address to a seminar in Dublin on young people and drugs pointed out. In his experience and research it was clear that young people who wanted to get drugs could easily do so from friends of friends, not from pushers. He added "A young person who does not want to have anything to do with drugs thus has to say 'No' not once but dozens of times during their adolescence".

At present programmes that are available are focused on education of young people about drugs but there is a more serious problem of providing an appropriate prevention programme for children at risk of dropping out of school with the additional risk of becoming involved in drug abuse which seems to have an association with early school leaving. There is a distinct gap in this regard in the level of services required from the Department of Education to provide relevant education for these young people at risk (see, for instance, McCann, 1991 but also. Footnote 2, p. 48).

out of school programmes

The Department of Education is also involved in *Youthreach* which provides an out-of-school programme for young people in the 15-18 year age group who have left school early with no qualifications. The Department of Education has 2,000 places in over 60 centres and FAS (Employment and Training Authority) provides around 1,700 places. Expansion to provide a further 450 places in the Vocational Education sector is under way at present. Trainees on the programme are very disadvantaged; many have -experienced violence and have been involved in substance abuse and approaching 30 per cent have had some contact with criminal activity.

All *Youthreach* centres integrate a substance abuse programme as an important part of the personal development element of *Youthreach.* The programme *On My Own Two Feet* mentioned above is used in all centres and staff have attended inservice training on this. One centre has produced a guide and a. video-which-have been made available to all centres. Information includes the issues of-alcohol and drug abuse and the referral services available.

There, is increased evidence of heroin abuse and this affects the *Youthreach* centres in Dublin Inner City. There is a practice of leniency in the courts if offenders who are abusers can be shown to have enrolled on a *Youthreach* programme. As part of the extension of the 450 *Youthreach* places under way, proposals have been invited from the Vocational Education Committees to cater for groups with specific needs, such as drug abusers, lone parents and ex-offenders. The most serious problem for *Youthreach* is to contact and try to help those who have left school before the official school-leaving age because of drug abuse and some of these may be as young as 12 years old.

Quinn (1997) charts the social and economic factors in offending behaviour in a study *Copping On: National Youthreach Crime Awareness Initiative* linking the level

of anti-social behaviour, manifesting itself in drug abuse, with poor educational achievement and low socio-economic group membership.

It must be said that *Youthreach* comes ‘after the event’ as it were and, as pointed out above, much more intensive work needs to be undertaken and effective programmes introduced much earlier for those most at risk, since it has been shown that early school leavers have in reality not been part of the education system in any meaningful way and have effectively detached themselves from involvement long before they actually leave the school

Section 4: Policy responses in other countries

The diversity of responses of societies to drug abuse is exemplified in Europe firstly by the repressive Swedish model which, according to Gould (1994), focuses on the consumers of drugs, to outlaw their behaviour, to harass them, to intervene in their ‘drug careers’ as early as possible and to take them into care compulsorily if necessary. In a climate where drug abuse had clearly come to be seen as such an enormous social threat, it was not easy to argue that the threat of HIV infection was an even greater one. Harm reduction in general and syringe exchange in particular were regarded as dangerous steps on what was regarded as the slippery path to the legalisation of drugs. In sharp contrast to the Swedish attitude is the liberal response pervading in the Netherlands where the Dutch take the approach of acknowledging that the international repressive, prohibitive approach leads to unintentional negative side-effects, both for the individual and for society. They opt for what they regard as a realistic and practical approach to the drug problem rather than for what they see as a moralistic and over-dramatised one. The Dutch alternative is the normalisation of the drug problem as a pragmatic compromise between two extreme options (see, for instance, Engelsman, 1989). Decriminalisation of cannabis use, although not legalisation, is a case in point.

In his work on drug use and drug policy in Western Europe, which looked at epidemiological findings in a comparative perspective, Reuband (1995) found that the liberal policy of the Dutch does not seem to have had the effect of increasing drug use as-its critics have often assumed. With respect to other countries, Reuband continues on this theme and finds that it cannot be said that countries with liberal policies have more or less similar levels of drug use: Denmark, with a pretty liberal cannabis policy as well, has a much higher rate than Germany or the Netherlands. Reuband concludes that a clear-cut relationship between drug policy and drug prevalence (mostly cannabis use) does not exist.

Reuband (1995) also commented that in each country an increasing number of people plead for a change in drug policy but that what is asked for is not identical from country to country. As Reuband remarks “People tend to plea for changes demanding what is considered atypical for their own national drug policy”. “But” he continues “ what is typical and what is atypical is not the same everywhere. Where a repressive drug policy has been practised, liberal reactions are becoming more popular among “experts’ and the population in many countries. And where a liberal policy has been more dominant, a repressive policy is more frequently advocated”.

Hartnoll (1995a) cautions against the danger of an increasing tendency to appeal to short-term simple populist, repressive and stigmatising reactions, rather than to take a longer term more considered and therefore complex approach. He feels that the tensions between policy makers and researchers, which have always existed, could thus increase as one group becomes more simplistic and the other more sophisticated. "The dynamics of this situation" continues Hartnoll "are complicated by the growing scepticism expressed by experienced professionals, including senior law enforcement officials about the wisdom of existing drug policies that are pursued by many national authorities and international bodies". Hartnoll concludes the argument by saying that the situation is also complicated by tensions between national policy makers, who may feel politically vulnerable if they are seen to discuss alternative policy approaches and local authorities who are often forced by reality to look for different strategies.

The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has established a network of national focal points - the Health Research Board acts as such in Ireland. It is expected that the planned network of national documentation centres and the dissemination of a European thesaurus of terms used in drug abuse research will help greatly in improving information exchange between European researchers. The problem caused by language differences in comparing the results of studies has always been a critical one.

In his paper presented to the already mentioned Joint Pompidou Group/EMCDDA Scientific Seminar on Prevalence in June, 1996, Stimson commented that debates were taking place at policy level but there was insufficient consensus about the nature of the phenomena and about appropriate responses. In examining the role of prevalence estimation in policy making, he argued that in reality, prevalence estimation has not been important in policy making. Thus far, said Stimson, much of the interest in prevalence estimation has been in providing gross measures to show that a city or a nation has a large drug problem. He recognised that it may be important to know what percentage of the population has had some experience of illicit drug use and what proportion have recent experience. It may be important to know what percentage of the population has been exposed to particular risks, such as injecting and what proportion has problems linked with their drug use, for example, dependency problems. However, Stimson expressed a doubt-that knowing that 15 or 30 per cent of young people are regularly using-cannabis, or-knowing that .5 or 1.5 per cent of the population has injected drugs, is going to make that much difference to the policy decision-making process.

Following on that conclusion, Stimson felt that what is potentially more important is the use of prevalence estimates in order to improve decisions about the investment of resources in different kinds of interventions and in the assessment of the impact of those investment decisions. For example, estimating the size of the population of problem drug takers that may benefit from substance abuse treatment should be crucial in the decision about what resources to allocate to drug treatment. Similarly, investment in a harm reduction programme such as syringe exchange needs to be based on evidence about the size and location of the population at risk. Furthermore, estimating the scale of drug-related crime, or the size of drug markets, can also lead to informed decisions about investment in different kinds of interventions.

It was Stimson's hope that estimates can be used to aid decisions about where to spend money. Of course, he continues, this requires some consensus about what the problems are. If (a) drug use itself is seen as a harm we need to measure the scale of drug use and estimate how different interventions might influence this. If (b) it is specific harms to health that concern us, such as overdose or risk of infectious disease, then we need estimates of the specific target populations at risk of these problems. If our concern is with the scale of drug markets or the scale of drug-related crime, again our target population and measures will differ.

There will inevitably be tensions between scientific rigour *versus* the adequacy of information for decision-making. Scientists want precision, policy makers want only sufficient information to be confident that they have made the correct assessment and correct decisions. There will be a tension between time taken to conduct good scientific work and policy-makers' need for rapid provision of information and speedy reactions. Stimson adds that there will also be tensions about the cost of providing information and whether investment in providing information leads to improvement in policy-making. He argues that we should be modest in what we think we can achieve and the contribution that it will make to policy-making. Prevalence estimates are but one kind of information that is likely to be assessed along with a wide range of other information. Both the astute policy maker and drugs researcher need to be able to understand the relevance of prevalence estimates alongside a range of other information which provides a picture of the unfolding state of drug problems within a country.

A proposal for a type of harm reduction policy as an alternative for current policy was made by Lewis and Klinenberg (1994) in their work on suggestions for the redefinition of US drug policy. Its goals would be to promote health, increase safety and provide care for those who need it. They suggested a more sophisticated policy analysis with better measures of drug harm and an analytical framework that goes beyond analysis of supply and demand. They argue that a more scientifically based and dispassionate rhetoric concerning drug policy is essential and that inevitably, disproportionate reliance on criminal law as an instrument of drug policy must change.

In their study of young homeless people and drugs in Glasgow, Hammersley and Pearl (1997) argue that policies which attempt to exclude drug-using young homeless people from housing or other services will invariably fail. "If" say these authors "screening had in fact been successful, then most of this sample would not have been housed in the project surveyed. Screening simply encourages applicants to deny substance problems and enter services with their problems undetected". It is argued that what homeless services need is not more stringent screening, which simply excludes naive or honest substance users, but coherent drug policies which include staff training, disciplinary procedures other than discharge, and referral to independent addiction services.

Data on homeless people with chemical dependency and mental health problems in the US are presented by Cohen and Burt (1990), who suggest that while providers of services to homeless people must make special efforts not only to provide shelter and food but also to have services available, such as on-going personal counselling,

group counselling or drop-in services. However, they point out that the need is greater among those homeless with histories of mental illness or chemical dependency and they suggest numerous special services dedicated to these two sub-groups of the homeless.

Dorn *et al* (1992) noted the policy response to HIV/AIDS among drug users brought with it a further official spur to consider the needs of women drug users. The British *Report of the Advisory Council on the Misuse of Drugs* (1988), which warned that HIV was overtaking illicit drug use as a danger to public health, lent official support to a shift in drug treatment policy and practice away from purely abstinence goals and towards an emphasis on reducing harm from drug use.

For women, Dom *et al* (1992) state that in addition to multiplying the possibilities for encountering *dis*-service, motherhood also added to the dimensions of fear, anxiety and loss for women. HIV-positive mothers felt great responsibility for-the effects of informing their children. Decision-making could be complex and fraught. Choosing the right time to burden them with the "responsibility of keeping quiet to avoid harassment, of facing the often dire consequences of public knowledge or of fearing for their mother's health and possible death was no simple and straightforward task. When illness made some kind of explanation essential, ways to tell young children about the nature of HIV and life's uncertainty did not readily offer themselves. Fear and guilt complicated the situation when mothers suspected or believed that their children) was/were also infected. An infected partner complicated the issues even further.

Section 5: Successful interventions

Einstein (1994) catalogues what he terms 'the glaring examples of common intervention failure and/or their sources'. Both Labouvie (1996) and Gossop (1996) speak of a 'maturing out' process for some drug abusers and Granfield and Cloud (1996) examine the characteristics of those who terminate their addictions without the benefit of treatment. However, a number of interventions have been successful in assisting people to discontinue abusing drugs. Some of these successful interventions are reviewed here. Further mention of Einstein, Labouvie, Gossop and Granfield and Cloud will follow the discussion on successful-interventions. However, any Irish data on successful interventions or evaluations of programmes will be considered first.

It is clear from an analysis of the results of O'Connor *et al's* (1988) study of pregnant opiate abusers in Dublin that these women were a very young and unstable group with a long history of addiction. Their youth, poor educational attainment, unemployment status and criminal involvement makes active intervention very difficult. The researchers asserted that when evaluating possible treatment strategies, a realistic approach was essential, bearing in mind that almost half the group had made previous unsuccessful attempts at formal rehabilitation. A further indication of the extent of their social and personal disintegration was the fact that almost half the sample used heroin intravenously as their first illicit drug. Although over half the group returned to illegal activity and drug abuse following their pregnancies, forty-five per cent had a positive response to the programme. It is interesting to note that one-third of this group were included in the study carried put by the Medico-Social

Research Board in Dublin North Central which identified a large number of young intravenous opiate addicts in that particular area.

Evaluation of interventions is needed in order to assess the level of success or failure of an intervention. O'Mahony (1990) in his study *Abstinence in treated and untreated opiate abusers: a study of a prison sample* notes that in recent years, there has been a growing awareness of the need for long-term follow-up in the evaluation of treatments for all forms of addiction. In the absence of reliable Irish data in this area, this paper provides information on the exposure to treatment and the pre-incarceration abstinence status of a small group of imprisoned male, opiate users.

The Eastern Health Board Service Plan 1998 states that evaluation of services within the substance misuse area is an important component of the delivery of care, the outcomes of which enable services to be altered or enhanced. An evaluation of the first year's activity in the detoxification unit in Cuan Dara, attached to Cherry Orchard hospital, was carried out during 1997. This evaluation showed that 71 per cent of admissions completed the first two weeks of the detoxification phase of the programme and that 26 per cent remained opiate free when followed up after ten weeks.

Evaluations were also conducted on the detoxification programme running in Fortune House, the interim programme in the Aisling and City Clinics and the satellite clinics in St. Aengus, Jobstown and Brookfield in Tallaght. The results of these evaluations are not available yet.

A call for tender for an evaluation of the work of the Task Forces has been sent out and the results of this evaluation should prove important and helpful to the further work of the Task Forces.

At the local community level Kelleher and Whelan (1992) in their study of Dublin communities in action concluded that formal evaluation of work is relatively new in community development. Groups which had undertaken it found it helpful for internal planning and development. The use made of the findings of evaluation at a wider policy level is less clear.

The provision of a model for the development of participatory structures such as the Local Task Forces was the hope of the authors of the *Interim Report of the Inter-Agency Drugs Project* (1996) in their setting out details of their involvement in the development of the IADP. In their opinion it had been a positive experience to date and offered potential for the greater co-ordination and targeting of services to match the needs of the community in which it operates.

Turning to some work done outside Ireland on the topic of successful interventions, first a look at Stimson (1973) who in 1969 began a study of a representative group of heroin addicts attending drug clinics in London. These addicts were followed up in great detail by a research team. After 7 years, almost one-third were known to be no longer physically dependent on opiates (or on any other drug) and were living in the community. The author comments that this shows that drug

addiction is far from the irreversible condition that has sometimes been assumed and that appropriate treatment can be successful in helping people to a drug-free lifestyle.

In a report *Youth Investment and Community Reconstruction: Street Lessons on Drugs and Crime* written by the Milton S. Eisenhower Foundation (1991) although the tone of the report is set in the context of the 'war on drugs' metaphor, it does propose new, politically feasible, national policies for the inner city that build on practical experience in day-to-day street-level implementation. The authors feel through trial and error there are now some answers to seemingly intractable questions such as the effectiveness of specific anti-crime and anti-drug strategies; the relative roles of minority non-profit community organisations and the police; the uses and limitations of volunteers; can a wise policy invest simultaneously in both individual high risk youth and the neighbourhoods where they live and what might be the economic costs involved? In response to these questions the report authors feel that they can anticipate one central conclusion. They say "Community-based organisations *can* create effective strategies to reduce: crime-and drug abuse in inner cities". However, they caution that effective programmes cannot be developed "on the cheap". "Our experience" say the authors "tells us that these inner-city ills require comprehensive solutions, not piecemeal, hit-and-miss efforts. The most successful programs reach well beyond the immediate symptoms of crime or drug abuse to address the deeper problems of the surrounding community, and particularly the multiple needs of disadvantaged youth". They add that providing comprehensive, multiple remedies for those overlapping problems requires a serious commitment of resources.

One study of treatment for drug abuse by Leukefeld *et al* (1992) recognises that drug use is both chronic and relapsing once an individual is addicted but that treatment can be effective in reducing drug use/abuse. Therefore they examine means for improving drug abuse treatment in an overview of research and practice recommendations. The current status of drug abuse treatment in the US is evaluated, emphasising clinical and policy issues. Recommendations include the need for uniform funding, linkage with community agencies, technology transfer, training and expanding research and evaluation efforts.

The analysis of factors that lead young amphetamine abusers to seek help and the implications of this for drug prevention and harm reduction by Klee *et al* (1994), shows that factors such as physical health problems were not effective predictors of their attitudes towards treatment and its perceived relevance to them. More potent were psychological problems and behavioural abnormalities that were attributed to the use of amphetamines. Most of the respondents were highly sociable and belonged to cohesive peer groups. Klee posits that interventions might be more effective if they emphasised those visible social consequences that risk alienation by peers because they are associated with mental ill-health, rather than focusing on physical damage.

Because of a strong relationship between longer treatment and positive outcome and because programmes for drug users are plagued with high rates of dropout, Gainey *et al* (1995) note that researchers have begun to study individual and programme-specific factors that influence premature termination of treatment. Italian

research (Pani *et al,* 1996) found that restrictive regulation can be counterproductive for retaining patients in treatment.

McCusker *et al* (1995) concluded that while a high percentage of patients who complete detoxification programmes relapse, detoxification programmes do have the potential for reducing relapse to drug use when followed by residential drug-free treatment.

On the topic of economic evaluation of interventions French (1995) argues that while research has shown that drug abuse treatment can help many individuals, yet funding is often lacking for treatment because these programmes compete for scarce resources with other important and effective social programmes. The French study shows how drug abuse treatment programmes can be made more attractive to decision makers and funding agencies by first highlighting why economic evaluation is a critical component of drug abuse treatment research. An evaluation methodology says this author includes aspects of cost-and-outcome analysis, cost effectiveness analysis and benefit-cost analysis. He then discusses methods and findings from most of the major economic evaluation studies of drug and alcoholism treatment and concludes with presenting guidelines for conducting future economic evaluations along with suggestions as to how the results can be used for policy purposes and programme planning.

The concept that addictive behaviours have a natural history, i.e. are characterised by specific patterns of developmental change, of itself suggests the need for caution in the interpretation of short-term treatment outcomes with addicts. For instance, Gossop *et al* (1997) argue that the widespread belief that treatment of opiate dependence is largely ineffective, has been powerfully reinforced by the reliance on the short-term occurrence or avoidance of relapse as the chief measure of failure or success. Gossop reports figures from the Maudsley Relapse Study which showed that at least one third of opiate dependent patients who had relapsed by six weeks after treatment, had nonetheless become stably abstinent at six months of treatment. He concludes that an initial lapse after treatment, although often taken as a measure of treatment failure, is not in fact a sign of inevitable readdiction and as a consequence, many outcome studies fail to do justice to the positive effects of the treatments they evaluate.

The element of failure in interventions is undeniable and is the focus of Einstein's (1994) article where he sets out his belief that substance abuse intervention, both in the private and public sectors, continues to be associated with failure. He alleges that these failures exist both empirically and anecdotally. Included here are two of a number he cites in what he regards as some glaring examples of common intervention failures and/or their sources. For instance, the preselection *of homogeneous* treatment goal (i.e. abstinence) for a *heterogeneous* population; arbitrarily limiting and *homogenizing* treatment processes by institutional setting and/or ideology with little or no consideration given to the needs and the 'demands' of the process, the identified patient(s), change agent(s), programme and community. Since, argues Einstein, times and definitions change, there will never be an end to failure or the need to learn from failure. He considers failure a value and having value on a multidimensional, dynamic gradient, being describable, discernible, catagorizable, understandable, while being culture-site-ideologically-bound/influenced. "Exploring FAILURE" says the author

“offers us - in our various substance use intervention roles - the opportunity to learn from what we have done and to more appropriately plan, implement and assess what we may want to and/or need to know and to do”.

If we leave aside Einstein’s useful although pessimistic outlook, we can turn to what might be termed non-treatment termination of drug abuse for some individuals.

Gossop (1996) in *Living with Drugs,* tries to counteract what he regards as the myths surrounding drug usage, by arguing that in fact the addict, like anyone else, faces choices between different options. The decision to give up may be a difficult one. Turning that decision into reality is even more difficult but it is far from impossible and sooner or later most addicts do give up. Many will also give up without any formal treatment. Many people with alcohol problems (including alcohol addiction) give up without treatment and the vast majority of cigarette smokers who give up, do so without any sort of treatment. Many people who use drugs such as heroin and cocaine also give up without; treatment. Indeed, some of the most interesting clinical treatments for addictive behaviours have incorporated principles of self-change. Gossop continuing on this theme of ability to give up drug abuse says that contrary to junkie myths about the irreversible and inescapable decline into addiction, some drug takers stop using precisely *because* they become aware that they are drifting into physical dependence There is a ‘maturing out’ process. For the addict as for many drug users, the balance sheet of costs and benefits gradually tends to shift away from an overall benefit to increasingly heavy costs. Some of these costs provide the most important reasons why addicts decide to give up.

Labouvie (1996) also writes about the “maturing out’ of substance abuse using data from a longitudinal study of young adults. Based on the concept of self-regulation of development, the process of maturing out was examined as a manifestation of both selection and self-correction. Findings by Labouvie confirm a normative trend towards greater conventionality that is evidenced by decreases in individuals ‘own and their friends’ perceived use of alcohol, cigarettes and illicit drugs. Marriage and parenthood are important personal goals for a majority of young adults. Path analytic results indicate that by age 28/31 reductions in use are more pronounced among individuals who have remained married since their early, 20s, those who have become married and those who have become parents. These self-corrective -changes in use are facilitated by selection of, and different association with, friends who are also married and have children by age 30. At the same time, however, there is also evidence for developmental continuity in use. Besides strong autoregressive effects, such continuity, is enhanced by other selection processes indicating that young adults are inclined to select friends and spouses on the basis of shared behavioural norms with regard to substance use.

The focus of Granfield and Cloud’s research (1996) at first may not appear wholly relevant to a review such as this since it examines the characteristics of middle-class alcoholics and drug addicts. However, the authors explore the factors in their respondents’ lives that promoted natural recovery. It is clear that the social context of the drug user’s life may have significantly influenced the ability to overcome drug problems. As these authors note “The social contexts of our respondents served to protect many of them from total involvement with an addict subculture” (p. 54). This

finding would refer us back to Rush's work and the similarities with the experiences of the American soldiers in Vietnam and after they returned home.

It is undoubtedly true to say that there exists no single method of treatment that is suitable for all drug users so alternative treatments must be available. To conclude this section we return to an Irish report. The authors of the report of the Inter-Agency Drug Project (1996) ask that it should be accepted that addressing the issue of problem drug use alone is not feasible unless seen within the overall social, economic and cultural context locally, nationally and internationally. If problem drug use is accepted as an effect rather than a cause of wider social circumstances then multi-agency measures to tackle poverty, educational disadvantage and community neglect must be a priority of all Governments and statutory agencies.

Section 6: Conclusions and Recommendations

It is clear from this Review that Gossop's (1996) contention that 'Attempts to isolate drug problems from their social context are doomed to failure' has been substantially upheld. The reports on treated drug abuse in Dublin carried out since 1990 and for Ireland since 1995 are one piece of Irish evidence. While limited to one indicator of the level of drug abuse that of treatment demand, the Reports have revealed that problem drug users tend to be educationally disadvantaged and unemployed. Butler (1997) among others would argue that this complex package of personal difficulties cannot reasonably be attributed to drug use alone. These Reports have consistently revealed that, as Butler (1997) states, the attendees at the drug treatment centres for serious drug problems do not come from randomly distributed geographic areas or from a variety of socio-economic backgrounds but that their areas of residence tend to cluster in neighbourhoods characterised by poverty and general disadvantage. 'Drug problems' do not exist in a social vacuum and drug abuse is not randomly distributed.

It should be stated that, in general, the problem causing the most concern both for the persons involved and for society in general from the health and welfare aspects is and has been opiate abuse. While there are problems with abuse of cannabis and ecstasy, those problems straddle all communities but heroin abuse for the most part seems confined to areas which would be deemed deprived even though there is no automatic relationship between heroin abuse and deprivation.

In the first scientific study of prevalence estimation, the deprived area has also been identified as having a higher prevalence of opiate abuse in Dublin. The findings of the Comiskey study will add greatly to the level of our knowledge of the prevalence of opiate abuse in Dublin. The implications of the findings in the Comiskey study, both at the level of acknowledgement of the extent of the problem and the service response, will have to be carefully considered by the policymakers. It would be expected that the results will assist planners and policy makers in their assessment of which services should be focused on the identified communities. What has to be decided upon by policymakers is the use to be made of the information obtained in this prevalence estimation study. As Stimson has held, decisions have to be made about the investment of resources in different kinds of interventions and in the assessment of the impact of these investment decisions. This study by Comiskey was

the first such in Ireland and in order to track reliable trends further similar studies will have to be undertaken at whatever intervals are considered useful.

There is already at statutory level an awareness of the need for the expansion of treatment services and based on the evidence from the studies included in this Review it is obvious that a range of services is required as any one approach is likely to only partially meet the problem. Also it is necessary to reiterate the finding that there exists no single method of treatment that is suitable for all drug users so alternative treatments must be available. In fairness to the policymakers, they do seem to be aware of the variation needed in providing services and in particular the work of the Local Task Forces will add to their sum of knowledge of local needs leading to presumably improvement in the level of provision and variety of service. The evaluation of the work of these Task Forces can only improve the flow of response to the problem if the findings are acted on. In planning services it is crucial that the focus should be on the context and structural factors which influence the decision of a person to become a drug abuser and not on the decision-making itself.

Aftercare is an important and often neglected aspect of treatment for drug abusers. Numerous studies have pointed out the necessity to follow-up on treatment with support. The question about what happens after treatment is not the only seriously neglected question. There is a need for evaluation of treatment interventions. A knowledge of what happens to particular people after particular treatment is necessary so that a full understanding and assessment of treatment intervention may be made.

The continuation of the work of the community based organisations is essential. They can and have been effective in reducing crime and drug abuse in their areas. However, any programmes introduced in an area must also direct their action at the deeper problems in the community, going beyond the immediate symptoms of crime and drug abuse. In this context the importance of the families of the drug abusers had to be acknowledged and that they need help also. The families of drug abusers could be vital to the recovery of abusers and their continuing to be drug free or assisting the family member to maintain their attendance at a treatment centre. One example was the Ballymun Youth Action Project where a two-pronged approach was-identified. “By educating people about the addiction already there, helping them to identify whether their reactions were constructive or destructive and promoting recovery for everybody, not just addicts, from the pain and fear of addiction, then alternatives would be built from that recovery process” (McCann, 1991:17). In the Fettercairn area of Tallaght, the drug treatment programme runs on a sponsor system whereby an acceptable relative or friend holds the medication and dispenses it daily.

One of the most pressing issues which is closely related to harmful drug/alcohol use is that of the young people who either drop out or are expelled from the education system early, sometimes as young as twelve years of age. This issue was raised, for instance in McCann (1991:38). That report of the Ballymun Youth Action Project had lobbied, again with concerned agencies like the local schools’ social workers, for an alternative education programme to be made available to these children in the schools. It is an indictment of the Department of Education that so little has been done by them to address the issue in any community since then. Some programmes have been introduced, such as, *Youthreach* and expanding of the anti-drugs programme into

primary schools or the *On My Own Two Feet* programme in secondary schools but this is after the event, as it were for those most at risk. Later these are the young people most vulnerable to becoming involved in drug abuse. A concerted effort is required from the Department of Education which, as McCann points out, has the ultimate responsibility to address this issue and ensure that all children have access to education which meets their needs and develops their potential.[2]

The gender issue has never been addressed in policymaking and some recognition should be given to the special needs of women. One example could be women who cannot attend a treatment centre because of lack of child-minding facilities or fear of losing their children to care.

This Review has ranged over a wide spectrum of studies of drug abuse and has produced irrefutable evidence of the strong link between poverty and drug abuse. The review has also examined policy in relation to drug abuse and reiterates the call for the recent acknowledgement of the link between deprivation and drug abuse to be built on in any future policy response to the problem. Services should be directed at geographical areas of material deprivation and should include primary education programmes to prevent the initiation of teenagers into drug use in areas where drugs are more likely to be readily available.

The strong correlation found between drug misuse and deprivation has been noted before and Squire *et al's'* 1995 study confirms that drug misuse is part of the well-documented picture of inequalities in health. This information should guide the purchasing of appropriate levels of services which are aimed at preventing new drug use and supporting those already addicted.

In this conclusion and recommendation section it is accepted that there are no 'quick-fixes' and no utopian solution to the problem of drug abuse. There have been useful interventions and finally an acknowledgement by policymakers that poverty and deprivation are important factors in the abuse of drugs. Action on that basis has to continue and when help is sought by drug abusers it needs to be available within a reasonable period of time. Continuation and extension of the process of cooperation between the statutory bodies and the communities is essential. The policymakers have to become more informed and more appreciative of the problems of the workers in the field dealing with the chaotic nature of the lives of those who are drug abusers. Einstein's thesis of the inevitability of failure of interventions is persuasive in that it urges the necessity of acknowledgement of failure when planning policy and in learning from failure by confronting the notion of continuous evaluation of programmes. Since times and definitions change, much can be learned from facing up to the likelihood that some interventions have failed, must be replaced and new methods continually tested.

[2] Since the completion of this Review there have been some new initiatives undertaken by the Department of Education to address this issue of early school leavers. One example is the pilot programme for children aged between 8 and 15 years at risk of leaving school early.

APPENDIX A

DRUG CLASSIFICATION

1 Heroin and Other Opiate-type Drugs

unspecified opiate-type
heroin
opium & morphine preparations
codeine & codeine compounds (street or nonmedical use)
synthetic opiates (street or nonmedical use)
opiate agonist-antagonists (street or nonmedical use)
substitute opiates/opioids prescribed for drug treatment
other specified opiate-type

2 Central Nervous System Stimulants

unspecified stimulants
cocaine
amphetamines
amphetamine-like stimulants
MDMA (ecstacy)
other specified stimulants

3 Hypnotics and Sedatives

unspecified hynotics and sedatives
barbiturates & other hypnotics (not benzodiazepines)
benzodiazepines
major tranquillisers
other sedatives and anxiolytics

4 Hallucinogens

unspecified hallucinogen
LSD
mushrooms and other plants/derivatives
other hallucinogenic substances

5 Volatile Inhalants

unspecified volatile inhalants
specified volatile inhalants

6 Cannabis

unspecified cannabis
specified forms of cannabis

7 Alcohol

8 Other Psychoactive Drugs

unspecified other drugs/substances
unspecified medicaments
speedball (heroin & cocaine cocktail)
antiparkinsonian drugs
antidepressant drugs
other specified drugs

9 Not Known

Source: Council of Europe Pompidou Group Definitive Protocol on *Drug Treatment Reporting Systems.*

APPENDIX B

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