

THE MEDICO-SOCIAL RESEARCH BOARD

DRUG MISUSE IN IRELAND, 1982-1983:

INVESTIGATION IN A NORTH CENTRAL DUBLIN AREA, AND IN GALWAY, SLIGO, AND CORK

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Summary

In July 1982 a preliminary investigation of heroin abuse in a North Central Dublin area revealed an apparent 9% prevalence of such abuse in persons aged 15-24. An attempt was therefore made, commencing in September 1982, to make a definitive assessment of the period (one year) prevalence of heroin abuse in that area and in three other Dublin areas; to put together a profile of the heroin abuser; and also to make a preliminary assessment of drug misuse in Galway, Sligo, and Cork.

For a variety of reasons the Dublin study had, in the event, to be confined to the original North Central Dublin area. The definitive 1982-83 prevalence of heroin abuse in that area among those aged 15-24 was found to be 10%; but in those aged 15-19 it was 12%, and among females aged 15-19 it was 13%. These Irish prevalence figures are in some respects slightly better, in other respects a good deal worse, than equivalent 1970 figures for New York black ghettos. In particular, the figures for females aged 15-19 and aged 20-24 were markedly worse.

The heroin abusers had a poor educational record, and a poor work record; 73% were involuntarily unemployed at the time of interview. Almost all were heavy smokers, but rather less than half were drinkers, though more than one third of them were from families in which drink had posed a problem. One or both parents were dead in the case of a third of the abusers, and parental separation had occurred in the case of a fifth. The vast majority of heroin abusers, most of whom were mainliners, also abused other drugs, commonly administering them with heroin. Between about one-fifth and three-fifths had been arrested, often more than once, for each of a range of offences such as theft, assault, and drug pushing; the offences occurring both in connection with the heroin abuse and separately from it. Considerably more than a half had been in prison.

In the provincial cities there was very little heroin abuse, but there was some abuse of other opiate drugs in Cork, and abuse of a variety of other drugs (and of solvents) in all three cities. On the basis that the Irish drug misuse problem will probably worsen before it can be contained, and that, in particular, heroin abuse almost certainly

occurs now in a substantial number of Dublin areas and perhaps in some provincial centres, a programme of further research is put forward, together with proposals for tackling the drug misuse problem on both the national and regional levels. A prominent role in Ireland's response to its drug problem is envisaged for the Catholic Church.

Introduction

In June 1982 Dr. Geoffrey Dean, Director of the Medico-Social Research Board, was asked by the then Minister of Health to investigate reports of a great increase in heroin abuse in Dublin during the previous twelve months. Accordingly, at Dr. Dean's request, I visited Dublin for three days in July 1982 and talked with relevant persons, both heroin abusers and some of those seeking to help them in a North Central Dublin area and a Dublin 8 area, both reputedly foci for heroin abuse, and in the rehabilitative Coolemine Community; and with various persons at the Jervis St. Drug Advisory and Treatment Centre and at the Dublin Garda Drug Squad Office.

A report, dated 19 July 1982, was then prepared (and indeed, the present report is meant to be read in conjunction with it). The position that report outlined was as follows: until the spring of 1981 there had apparently been very little abuse of heroin in the Republic; but at that time an epidemic of abuse began in Dublin, probably sparked by a huge influx of heroin on to the world market consequent on the Iranian revolution in late 1980. I was told by seemingly reliable sources that increasing heroin abuse was now present in various Dublin areas, probably to some extent in most of them, and that it was particularly heavy in the two areas mentioned above. It was said, though with less authority, to be quite heavy also in the Dun Laoghaire-Blackrock-Ballybrack-Killiney area.

The abuse was mainly by young people: in the North Central Dublin area 9% of those aged 15-24 were estimated to be abusing heroin, which by any criterion represented an extremely high prevalence. A good deal of crime was associated with this abuse since purchase of the needed heroin commonly called for the expenditure of £100 day and

more by each abuser. Other opiate drugs, originally obtained on prescription, were often abused in place of or together with heroin.

Neither the law enforcement agencies nor the Jervis St. clinic personnel nor the Coolemine Community director nor those involved in various local initiatives were, on the whole, anything but pessimistic about a possible further increase in heroin abuse and about their own efforts at treatment, rehabilitation, education, and elimination of the supply and distribution of heroin; and their pessimism seemed justified.

Dr. Dean and I were satisfied that the position was as grave as indicated, and in particular in the most carefully studied area, that of North Central Dublin; and this was true even though, inevitably in relation to such a short ad hoc investigation, we had provided something short of definitive scientific proof for our conclusions.

A report with recommendations was prepared on the basis of this investigation (which will be referred to as the Phase I Dublin study), and it was widely circulated; and thereupon a number of persons, most of them worthy of respect, expressed the view that the various supposed addicts and those trying to help them locally had, perhaps unwittingly, greatly exaggerated the problem, and so therefore had the report.

The apparently very grave situation revealed by the Phase I study (and the corresponding need for more hopeful remedial action), and these doubts concerning its real gravity suggested strongly that a more exact, definitive study be carried out; and, in fact, the Department of Health requested such a study in September 1982 and provided the moneys needed to conduct it.

This second study had the following objectives: first, to quantify the heroin abuse problem definitively in at least one Dublin area, and preferably in three or four areas, and to obtain a profile of the heroin abuser (Phase II Dublin study); and second, to carry out a Phase I study in selected provincial centres.

Quantification of the problem in Dublin would provide both justification for remedial action and a yardstick for the scale of such action; and knowledge of the abuse profile would help to determine its nature. Galway, Sligo, and Cork were chosen for an initial Phase I provincial study as being three city ports, each about 150 miles from

Dublin, on the rim of a wheel that had Dublin as its hub. It was anticipated that, if they turned out to be unaffected by heroin abuse, this Phase I study could subsequently be extended step-wise along the spokes of the wheel until any centres were identified closer to Dublin that did have a heroin problem, and then Phase II studies could be carried out in those places.

METHOD – GENERAL

Dublin Phase II: Quantification of Heroin Abuse and Heroin Abuser Profile

Estimates of the prevalence of heroin abuse in the North Central Dublin and Dublin 8 areas in Phase I had been on the basis of lists of names of persons living in the areas and suspected by members of the respective area committees of practising such abuse; the committee in the first area being an ad hoc body and that in the second being the Weaver Square Youth Development Project Management Committee. They will be known respectively in this report as the North Central Dublin Committee and the Dublin 8 Committee.

The other area mentioned during phase I as having a substantial heroin abuse problem (Dun Laoghaire-Blackrock-Killiney-Ballybrack, hereafter referred to as Dun Laoghaire) is much larger and more dispersed than the other two areas and, perhaps correspondingly, reports concerning heroin abuse there were much more vague. They nevertheless seemed to carry some weight and therefore, while no effort had been made in Phase I to make even a rough assessment of the size of the problem there, it seemed appropriate to try and do so in Phase II.

Finally, at a very early stage of Phase II the suggestion was made that there might well be a substantial heroin abuse problem in the Ballyfermot district of Dublin.

In mid-September 1982 investigations were therefore begun by myself in the four areas named.

Phase II: Modus operandi

The North Central Dublin Committee had seven people on it plus one co-opted member. Of these eight people four lived in the area, three of them also working in it, the fourth being a housewife, while the other four worked but did not live in it. The Dublin 8 Committee had 12 members of whom five lived and worked in the area while a further four worked in the area. The members of the committees were social workers, welfare officers, local parents, priests, teachers, a nun, a doctor, etc.

It became clear in Phase I and in the early stages of Phase II that the members of the committees had a unique combination of qualities relevant to the investigation proposed: first, detailed knowledge of the people and the goings-on in the areas and, more particularly of who was abusing heroin, pushing it, and so on; second, the quality of being trusted by the heroin users, and of being able to establish rapport with them; and third, a willingness to co-operate in an investigation and – though as regards some committee members only – the education and ability to do so efficiently. Furthermore, each committee collectively was even more competent: any deficiency of knowledge or rapport in one member would almost certainly be made good by another.

For reasons of confidentiality I had been supplied with the numbers but not the names of heroin abusers in these two areas during Phase I of the study, and early in Phase II the committees made it clear that continuing confidentiality would be a condition of their co-operation. However, despite this small, necessary drawback, it was felt, after consultation with Dr. Dean and other interested parties, that much the most promising route – if not, indeed, the only practicable one – to assessing accurately both the quantity and the quality of heroin abuse in these and other areas was via the committees or equivalent bodies.

We were proposing to carry out, in fact, what we believed (and do still believe) to be an investigation of a type never before attempted anywhere in the world: to assess the prevalence of heroin abuse in a community by asking those suspect of it to admit that they had used or were using heroin (such use and possession being both illegal), and to co-operate in the completion of a lengthy questionnaire carrying queries about heroin,

other drugs, and various very personal matters. This was clearly a most delicate undertaking, and the subjects would be notoriously unreliable. Some critics said that, even with the help of the committees, we certainly should not get co-operation from the addicts. One or two clumsily conducted, early interviews might, if news of them got round, jeopardise the whole project. Clearly our only hope of success was to work through the committees.

Even had a third party (for example, myself) had access to the names of suspected heroin abusers it would not have been possible for him quickly to interview them since he would not be able immediately to associate a name with a person, a set of relevant habits, and an address and a corresponding location. These were not captive patients in a ward, but free-living young people, used to evading authority in any form. Moreover, trust and rapport would certainly not have been immediate and, in the event of any of the numerous possible hindrances to interviewing, the interviewer would not have known to which local people he might fruitfully turn for help.

At the same time, great though the advantages of relying on the committees might be, it did carry the disadvantage that the prime investigator would be entirely reliant on the good will of the committee members, and, though willing to help, they were not all used to the disciplines of scientific investigation and were dealing with a stranger coming from a strange and official body. Doubts and suspicions did, in fact, surface repeatedly in the early stages of Phase II. Lastly, it would certainly not be possible to apply to the very independently minded committee members the full pressures (for speed, accuracy, etc.) normally applied by the leader to members of a team carrying out epidemiological investigations. To do so would risk forfeiting their good will, perhaps for good.

This matter has been dwelt upon at length because it is the clue to a series of frustrating delays to which the Phase II Dublin study was subject as well as to the success it was demonstrably to achieve in the end.

Phase II: Stages These were envisaged as follows:

1. List of abusers The relevant committee or some appropriate section of it would draw up a list of supposed heroin abusers, the supposition to be on the basis of usual residence in the area of an agreed date and of some agreed criterion of abuse, e.g. that two members of the committee should nominate a person as abusing heroin. From this master list, containing names, a working list would be prepared, consisting merely of the initials of the persons, the entries on the list being serially numbered for ease and certainty of identification. The presence of an entry on this list would be regarded as prima facie evidence of the existence of one corresponding heroin abuser. Moreover, provided a sufficient proportion of committee members took part in its compilation the list might reasonably be presumed to be exhaustive.

2. Administration of Questionnaire A questionnaire would be administered to each person who was both listed and willing to be interviewed, the interview being conducted by one or other committee member in whatever place and manner seemed to him/her appropriate. The questionnaire would provide information on the personal and family background of the person, and of his use of heroin and of other drugs, etc. – that is, it would provide all the information needed to determine the prevalence of heroin abuse in a stated period (in the event, the year 1982-83), and for the preparation of a profile of the heroin user, though the accuracy of the profile would clearly depend on the proportion of the listed persons willing to be interviewed.

3 (a). Validation of authenticity of individual entries on the list. A mere willing participation in the completion of a heroin-positive questionnaire in respect of himself would be very strong evidence that the person in question was indeed a heroin abuser: possession and use of heroin are serious illegal activities, and it is difficult if not impossible to envisage what circumstances would encourage a heroin non-user to admit to use of the drug (and therefore of possession). The seeming genuineness of each individual history, as revealed on the completed questionnaire, would reinforce (or detract from) this individual authenticity.

3 (b). Validation of authenticity of the list as a whole. Clearly the list as a whole would be authenticated, as distinct from the legitimisation of individual purported abusers, to the extent that a majority of the persons on the master and working lists took part in the completion of a positive and seemingly authentic questionnaire (the bigger the majority the more certain the validation).

Second, consistency as from one questionnaire to another would very strongly suggest their authenticity; and again, the greater the number showing such consistency the greater the probability that the totality of the list was valid.

To put these two list-validating aspects at their crudest: it is perhaps just conceivable that a tiny handful of listed persons would, though not heroin abusers, admit to being so, and that they would tell a story that that was not merely untrue but consistent from one to another; but it is really not credible that something more than a handful of listed persons would be willing to tell an incriminating lie, let alone that they would be able to achieve consistency among themselves in their various answers. The greater the proportion of 'positives' and the greater the number showing consistency the less the possibility of error.

Third, an attempt would be made to discover how many of those whose names were on the aster list had attended the Jervis St. clinic. It is the only centre in Dublin for the treatment of heroin dependence, and clearly, if it could be shown that a high proportion of the listed abusers had indeed attended there, this would be very strong evidence for the authenticity of the list as a whole. This was not, in fact, regarded as a particularly promising approach because the Phase I study had suggested that, thanks to the relatively recent appearance of heroin abuse in Dublin and the youth of most of the abusers, only a minority of them, in fact, had resorted to Jervis St.

Fourth, the interviewing of a small random sample of persons named on the master list was to be conducted by a committee member in the presence of one or other of a small number of persons expert in the taking of medical histories or in interviewing; so that those experts could form a separate judgement as to whether the person in question

was indeed a heroin abuser or not. If all or most of the random sample were so validated, this would be strong evidence that the list as a whole was valid.

Concordant results from the four validating methods would, of course, strengthen the case for authenticity beyond cavil.

Galway, Sligo, and Cork – Phase I Study

This was to be conducted on the same basis as the earlier Dublin Phase I study: viz., I would in each city visit a selection of persons who between them might be expected to be knowledgeable about the local drug scene; the persons being either known to me in other connections, or else suggested to me as appropriate persons to approach by those whom I knew.

This study too began in mid-September 1982, and the target date for completion of both studies was 31 December 1982.

METHOD – DETAIL

Dublin, Phase II

Ballyfermot One visit to the area and a discussion with two local priests was sufficient to establish that there was no group of people knowledgeable about the area in the same way as the North Central Dublin and Dublin 8 Committees were about their areas; that, while there was some abuse of drugs and of wine by young people, there was apparently little or no abuse of heroin; and that to establish certainty on the latter point, and perhaps, if there was substantial heroin abuse, to subject it to reliable Phase II analysis would not be possible in the time available. Ballyfermot was therefore dropped from this particular study.

Dun Laoghaire The possibility of carrying out a Phase II study in this area was examined intermittently between mid-September and mid-November. Various persons, mostly outside the area, were convinced that there was a substantial heroin-abuse problem there. They could not identify heroin abusers in it, but they could and did name persons who they thought should be able to do so; but in turn none of these people was so able, though

at least two of them passed me on to further persons who they thought would be able to. These in turn were not able to make any of the required identifications.

However, I did interview one young man (son of a second-hand contact) who seemed to me to be speaking the truth, and who said that he estimated that there were at least 100 heroin abusers in the Dun Laoghaire borough itself. Many of them were casual users. He correctly identified the time of the start of the habit in Dublin as spring 1981, and named correctly the family he believed to be supplying heroin to the area. (My confirmation came from the gardai.) He said he would be afraid for his safety if he were to get involved in any kind of investigation of the problem.

Again, because of the nebulous nature of this information and the time factor, Dun Laoghaire was abandoned as a possible area for Phase II investigation in the present study.

Dublin 8 After a meeting with the committee, and two meetings with members of it separately, and numerous telephone calls it was again felt that a Phase II study in this area would not be feasible in the time available. Various difficulties were put forward: that the professional position of some of the possible interviewers (that is, committee members) would be compromised if they administered a questionnaire; that the heroin-dependent persons might not be articulate enough to provide answers; that the committee members had co-operated in investigations by official bodies before on the strength of a promise of subsequent help which had not, in the event, been forthcoming; and that their co-operating in administering the questionnaire might destroy their relationship with the local people. A further element was that the key member of the committee took up another appointment in the course of the discussions.

Eventually after the Phase II study in this area had been abandoned because of the time factor and attention was fully engaged elsewhere, news came through that the committee would feel able to co-operate in administering the questionnaire though not for the time being.

The abandonment was especially disappointing in that the Phase I study had suggested the prevalence of heroin abuse in the Dublin 8 area to be even greater than in the North Central Dublin area.

North Central Dublin The committee there was on the whole very co-operative, and after a series of meetings with the committee or individual members preparation of the necessary master list of persons having the Mountjoy A Ward as their place or residence and suspected of being heroin abusers by at least two committee members was under way by early November 1982; though it was not completed until 1 December 1982, delay being due to a variety of reasons. The Mountjoy A electoral ward was chosen for study because it was clearly defined and corresponded more or less to the committee's area of interest.

Unfortunately between 1 December 1982 and late January 1983 little was actually achieved. This was due to a number of factors. Fr. Paul Lavelle, one-time chairman of the committee and undoubtedly its original moving spirit, was moved in July 1982 to a church outside the North Central Dublin area. Between mid-November and late January, of the eight remaining committee members (the eighth being appointed to work in the area in September) four moved off to new appointments, and one decided against co-operating in administering the questionnaire because of the feeling it would arouse among neighbours.

The left three members: one of these was a welfare officer with a full work load, and the other two, as well as being busy, were not suited to the essential co-ordinating work needed in connection with administration of the questionnaire, and were in any case for quite some time disheartened by the apparent collapse of the committee, its loss of its premises, etc.

Of the four who moved to new appointments one, who had taken on the local co-ordinating work in connection with the questionnaire, tried to cope with that and with his new appointment only to find eventually that it was not possible to do so; and another, who took over the work from him, himself moved to a new position elsewhere in Ireland after a short time.

By late January, after two months and more of frustrated effort, it was quite clear that the Dublin Phase II study would be completed only if some quite new initiative was taken; and accordingly Dr. Dean approached the ecclesiastical authorities to ask if Fr. Paul Lavelle might be seconded to the study for a period of some weeks. Although Fr. Lavelle had left the North Central Dublin area six months before, he had maintained his contacts there, his knowledge of the local people and activities was unrivalled, he was persona grata to everyone involved, and he certainly had the ability to act as co-ordinator for the Phase II fieldwork.

His Grace, Archbishop Ryan agreed to his temporary release from parochial duties, and for the next two months Fr. Lavelle conducted a large number of questionnaire interviews himself, encouraged other committee members to complete their smaller quotas of such interviews, arranged for the validation interviews, and conducted liaison with the Jervis St. clinic.

Questionnaire

A copy of the final version of the questionnaire used in the Phase II study is attached to this report. Three drafts in all were prepared, and comments on the first two were secured from a large number of relevant experts (medical, health educational, and sociological) as well as from the gardai, committee members, and independent local workers. Irish Market Surveys, Punch and Programming Services, and the Computer Department of the Public Services also kindly provided comment and advice.

Galway, Sligo, and Cork – Phase I

This element in the investigation was carried out along the lines already mentioned. No difficulties having arisen, it was completed by early November 1982.

RESULTS

There were 103 names on the original master list: that is, of persons whose place of residence on 1 December 1982 was in the Mountjoy A area and who were thought by at least two members of the local committee to be abusing heroin.

In the course of the study this total was reduced as it was discovered that, in fact, some of those whose names were on it lived just outside the Mountjoy A Ward; and it was increased by a handful of new names as a result of miscellaneous information collected in the course of the study and leading to satisfaction of the same criteria for inclusion in the list.

The final master (and working) list contained 82 entries. All those on the master list agreed to be interviewed. Interviewing was performed between 12 December 1982 and 8 April 1983 by three committee members and Fr. Lavelle (carrying out 6, 6, 7, and 49 interviews) and by two co-opted assistants (6 and 8 interviews). Most of the interviews were conducted in February and March 1983. Twenty of the interviews were conducted in prison.

Of the 82 interviewees 81 admitted to having abused heroin at some time, and 79 to having abused it within a year of being interviewed (that is, in 1982-83). Of the two who did not admit such recent heroin abuse one was believed and he was omitted from the analysis of prevalence. The other was interviewed, in fact, by the interview (P.L.) with most experience of the local drug scene; and that interviewer stated that the interviewee was a well-known pusher (he had in fact, been arrested for drug peddling), that 'members of his family are into smack' (smack = argot for heroin), and that he (P.L.) was 'quite sure that he is a regular heroin abuser'. This subject was therefore included in the 'within a year' heroin abusers from the master list, bringing their total number to 80.

The master list was given to personnel at the Jervis St. clinic who confirmed, without revealing the identity of those concerned, that 61 of the 82 whose names appeared on the master list (that is, 74.4%) had attended the clinic as heroin abusers. In addition, the Jervis St. personnel knew of 7 further persons who had attended the clinic as

heroin abusers and whose place of residence on 1 December 1982 was the Mountjoy A Ward. Again their identities were not revealed, but letters were sent to them from Jervis St., asking if they would co-operate in the administration of the questionnaire by Jervis St. personnel. Two agreed and for them two questionnaires were so completed. Five refused, and for them the questionnaires were completed as far as possible by Jervis St. personnel from clinic records. The seven completed questionnaires were then handed to a committee member, the questionnaires being identified only by a number on each, which had been allotted in the same way as numbers had been allotted to all 82 of those whose names were on the master list.

Of these seven additional Jervis St. subjects only five had abused heroin within the past year. This meant therefore that there were 88 'ever abusers' of heroin for analysis in relation to the heroin-abuser profile, and 85 'within the past year' abusers for the prevalence analysis.

Validation The 12 persons who were to be subjects of the validation interviews were chosen at random from the working list (initials and identifying numbers only) by Dr. Dean and were allotted at random for validation to the three validators. Of the validation interviews Dr. Dean conducted 7, Mrs. Aileen O'Hare (Senior Sociologist of the Medico-Social Research Board) 2, and J.S.B. 3. All the interviewees were validated as 'within the past year' heroin abusers.

In addition, those three persons talked respectively with another 4, 4, and 3 non-validation interviewees, and Dr. Michael Mulcahy, and consultant psychiatrist, saw 2; and none of these four experts felt any doubts about the validity of the existence of heroin abuse 'within the past year' in these instances also.

Heroin Abuse Prevalence The following are the age characteristics of the 85 current abusers, to gather with the 15-24 population structure in Mountjoy A Ward according to the April 1981 Census, which provides the latest figures available. (There have been no major population changes in the interim.)

	<u>1982-83 Heroin Abusers, Mountjoy A Ward</u>				<u>Number per age group Mountjoy A (1981 Census)</u>		
	<u>Under 15</u>	<u>15-19</u>	<u>20-24</u>	<u>Over 24</u>	<u>15-19</u>	<u>20-24</u>	<u>15-24</u>
Male	0	17	27	7	156	245	401
Female	0	18	13	3	138	218	356
Total	0	35	40	10	294	463	757

Clearly, therefore, heroin abuse is heavily concentrated in the 15-24 year

age group; and in the succeeding table heroin abuse prevalence figures are given for Mountjoy A Ward by sex and age group (ages 15-19, 20-24, and 15-24), together with some New York figures for purposes of comparison.

	<u>1970¹ Estimated Age-Specific Narcotic² use prevalence in 3 New York Districts³</u>									<u>1982-83 Age-Specific Heroin Abuse Prevalence</u>		
	<u>Bay Ridge⁴</u>			<u>Bedford-Stuyvesant⁵</u>			<u>Fort Green⁶</u>			<u>Mountjoy A Ward, Dublin</u>		
	<u>All</u>	<u>Male</u>	<u>Female</u>	<u>All</u>	<u>Male</u>	<u>Female</u>	<u>All</u>	<u>Male</u>	<u>Female</u>	<u>All</u>	<u>Male</u>	<u>Female</u>
15-19	2.22	3.35	1.12	7.20	11.23	3.56	7.55	11.47	3.83	11.90	10.89	13.04
20-24	2.83	4.95	1.04	11.00	21.48	3.73	10.65	18.32	3.98	8.64	11.02	5.96
15-24	7	-	-	-	-	-	-	-	-	9.91	10.97	8.71

¹ 1970 was a year in which the effect of the Vietnam war on the use of narcotics in the USA would be pronounced.

² It is not clear whether ‘narcotics’ referred only to heroin or to other narcotics as well. If the latter, then all the New York figures for heroin alone would be less than those give, probably substantially less.

³ From: Lukoff IF. In: The epidemiology of heroin and other narcotics. National Institute on Drug Abuse Research Monograph 16, p. 195. Ed. Rittenhouse JD. US Government Printing Office: Washington DC. 1977.

⁴ Bay Ridge in a 99.5% white district of New York with some middle-income neighbourhoods.

⁵ Bedford-Stuyvesant in a district with a 84.4% black population, 32.4% of the households being headed by females. Both it and Fort Green would colloquially be described as black ghettos.

⁶ Fort Greene has a 56.4% black population, 29.2% of the households being headed by females. It contains some of the older white ethnic and middle-class communities.

⁷ Combined figures for the 15-24 age group not available for the New York Districts.

Note: Prevalences are given to the second decimal place because that is the way in which the New York figures were presented. Whatever about the New York figures, the Mountjoy A data probably do not justify the use of anything more than a first decimal place, if that.

Heroin Abuser Profile

This will be provided in the form of the answers given by the 88 known 'ever abused' heroin abusers into Mountjoy A Ward to a majority of the 57 interviewee questions into the questionnaire. The answers to a few of the questions are omitted as in the event they added little to the profile obtained.

If the summated figures for all the answers to any one question do not total 88 (or whatever lesser figure may be appropriate, depending on the question), the reason is that some interviewees either did not answer the question or else gave an indeterminate answer.

The key words in each question are stressed. The numbering of the questions corresponds with the numbering in the questionnaire.

1. Age at last birthday? – Males, fifteen to nineteen: 17; twenty to twenty-four: 27; more than twenty-four: 9. Female, fifteen to nineteen: 18; twenty to twenty-four: 13; more than twenty – four: 4.
2. Sex? – Male: 53. Female: 35.
3. How many friends whom you see at least once a week have you got? – 12 of the 88 subjects said they had no such friends at all.
4. Ever belonged to a club you attended every week? – Yes: 53. No: 29.
5. Ever had a hobby practised every week? – Yes: 30. No: 51.
6. School aside, have you ever taken apart in any sport/game at least once a week over a period? Yes: 9. No: 73.
7. The strongest influence in you life today? – Parents: 13. Drugs: 47. Girls friend/Boy friends: 13. Other friend: 2. Religion, TV, priest, pop/sports star: Nil each.
8. A great leaving school? Eleven years: 1. Twelve: 4. Thirteen: 26. Fourteen: 28. Fifteen: 25. Sixteen, seventeen, eighteen: 1 each.
9. Type of school last at? – Primary: 40. Secondary: 6. Vocational: 18. Other (mainly 'special'): 24.
10. Certificate/qualification/skill gained? – Yes: 4. No: 84.
11. Can you read? – No: 10.

12. Can you write? – No: 10.
13. Are you working now? – Yes: 4. No: 84.
15. Are you? – Compulsorily unemployed: 64. Voluntarily unemployed: 9.
Disabled/sick/retired: 2. Housewife or equivalent: 9.
16. Longest period in any job? – Less than a year: 55. More: 26.
17. Longest period of unemployment? – Less than a year: 7. More: 75.
18. Religion? – Catholic: 88.
19. Smoke cigarettes? – Yes: 82. No: 3.
20. How many cigarettes a day? – Five to nine: 3. Ten to nineteen: 13. Twenty or more: 64.
21. Do you drink? – Yes: 38. No: 45
23. What do you drink? – Beer/ale/stout/cider: 36. Wine: 1. Spirits: 1.
24. Number of drinks on each drinking occasion? – One: 3. Two: 0. Three: 10. Four: 9. More than four: 16.
25. Drink ever a problem for you or your family? – Yes: 30.
26. Heroin aside, have you ever over a period taken at least one drug once a week that was not prescribed for you? – Yes: 83.
28. What is your favourite none-prescribed drug, heroin aside? – Disconal: 65.
Cannabis: Palfium: 3. Morphine: 2. ‘Anything’ (sic): 1. Cocaine: 1.
Tuinal: 1. (Note: multiple drug abuse was apparently the norm.)
30. How old were you when you first took heroin? – Less than fifteen: 13. Fifteen to nineteen: 53 (fifteen: 11; sixteen: 12; seventeen: 7; eighteen: 9; nineteen: 14).
Twenty to twenty-four : 18 (twenty: 9; twenty-one: 2; twenty-two: 2; twenty-three: 4; twenty-four: 1). More than twenty-four: 4.
- (From the answers to this question the number of years that had elapsed since the introduction was calculated. It was as follow. Less than a year: 2. One year: 15. Two years: 33. Three years: 18. Four years: 9. More than four years: 11.)
31. Who offered it to you? – Dealer/pusher: 6. Friend: 62. Relative: 6. Other: 8.
32. Ever regularly taken heroin at least once a day? – Yes: 82. No: 6.

33. Have you done so within the past year? – Yes: 73. No: 8.
34. Taking it at least once a day now? – Yes: 34. No: 48. (Note: 20 interviewees were in prison, which precluded heroin use or at least an admission of it.)
35. When taking it daily, how many times a day do you take it? – Once: 10. Two to four times: 37. Five to eight times: 23. More than eight times: 5.
36. When did you last take it? – Within 4 hours: 20. Within 4-12 hours: 8. Within 12-24 hours: 6. Within 1-7 days: 5. Within a week to a month: 10. More than a month: 32.
37. How do you mostly take it? – Snort: 7. By mouth: 0. Smoking: 0. Skin popping: 16. Mainlining: 65.
38. Why do you take it? – ‘like it/nice/feel better’: 15. ‘For kicks/high’: 9. ‘Hooked/addicted/habit’: 10. ‘Relaxing/pressure off’: 5. ‘Everyone else takes it’: 3. ‘Nothing to do’: 1. ‘Avoid withdrawal’: 1. ‘Keeps pain away’: 1. No reason given: 32.
39. How do you know what you take is heroin? – Almost invariable answer: ‘the taste’. One answer: ‘Took rat poison once’. Another answer: ‘The colour’. Another: ‘I look at it’.
40. Ever taken another drug with heroin? – Yes: 61. No: 25.
41. What was the usual other drug? – Diconal: 44. Cocaine: 8. Palfium: 4. Morphine: 3. Cannabis: 2.
42. Ever had detoxification? – Yes: 48. No: 39.
43. Ever had long-term Physeptone treatment? – Yes: 18. No: 69.
44. Ever had rehabilitation (Coolemine-types)? – Yes: 3. No: 82.
45. Ever been through ‘cold turkey’? – Yes: 64. No: 19.
46. What usually made you go through ‘cold turkey’? – In prison/custody: 38. Other involvement with the law: 0. Pregnancy: 1. Family pressure: 3. Own decision: 6. Only course open: 1. Other: 15 (most commonly lack of money).
47. Ever gone back to heroin, having given it up? – Yes: 68. No: 17.

48. Reason for going back? – Friends/relatives/peer pressure: 17. ‘Addicted/missed it/habit/available/withdrawals’: 13. ‘Depression/boredom’: 6. ‘Physeptone cut off by Jervis St.’: 1. ‘Day after detoxification’: 1. ‘Not enough treatment’: 1. ‘Physeptone unsatisfactory’: 1. ‘Don’t know’: 12.
49. Longest period without heroin? – Less than a week: 15. A week to a month: 15. One to three month: 14. More than three month: 37. (But note effect of incarceration: 56 had been in prison at some time. See Note 3, Questions 51, 52.)
50. Who takes heroin? – Friends, most: 55. Friends, a few: 24. Friends, nil: 4. One or more relatives: 44. No relative: 39.

51. and 52.

<u>Ever arrested for? –</u>	<u>In connection wit heroin</u>	<u>Not in connection with</u>
Theft from vehicle	27	40
Theft from shop	49	55
Theft from house	16	26
Theft of vehicle	22	43
Assault	20	29
Other Offence*	55	37

*For example: drug pushing, bank robbery, armed robbery, security van snatch, handbag snatch.

(Note 1: A large number of interviewees had been arrested for a particular types of offence on a number of occasion. Note 2: It was discovered in the Phase I double line study, and was confirmed repeatedly in the present study that the daily requirement of heroin for a full-blown heroin abuser coast £100-200. Note 3: Twenty subjects were interviewed while in prison; but it was estimated in the course of the present study that 56 of the 88 heroin ‘ever abusers’ had been in prison at some time.)

53. Parents alive, living together? – 49. Separated? – 7. Separated in past? – 2.
54. One or both parents dead, separated while alive? – Yes: 9. No: 20.
56. What do you thing should be done to fight heroin abuse? – ‘Up to the individual.’ ‘Nothing can be done.’ ‘Nobody will stop you if you want to.’

‘Going to prison helps.’ ‘Heroin is available in prison.’

‘Local people should help to fight problem.’ ‘Lectures in school early on.’

‘Get jobs.’ ‘Boredom leads to drugs.’ ‘Too much time to ourselves.’

‘More clinics.’ ‘Physeptone treatment inadequate – should be like in England.’ ‘More clinics and counsellors.’ ‘Centre for treatment.’ ‘Money from government.’

‘A place in the country.’ ‘Take them away from the area – to a farm.’

‘Coolemine is pure punishment.’ ‘Coolemine-type place for inner city.’

‘Coolemine not fit for anyone.’ ‘Most Coolemine people go back to heroin.’ ‘Residential care.’

‘Open up a centre.’ ‘Something in the area.’ ‘Club to go to after coming off drugs.’

‘Crack big-time pushers.’ ‘Stop suppliers.’ ‘Get dealers out’ ‘More police.’

‘Pushers getting off in court.’

57., 58., 59., 60. A large number of comments favourable to the interview were made by the interviewees. The interviewers felt in the vast majority of cases that the interviewees understood the question and were on the whole honest.

Galway, Sligo, and Cork – Phase I

Galway

I talked with two specialist gardai, one psychiatrist, and the professor of pharmacology in the University College. At present there is only one person, a girl, in Galway known to abuse heroin, and she gets supplies from Dublin. Only three other heroin users have been known in Galway over the years.

The major drug problem was variously identified as to do with psychedelic mushrooms, benzodiazepine tranquillisers, and solvent sniffing; though cannabis and LSD use is also fairly common, Ennis being the source of supply. General practitioners over-prescribe tranquillisers, leading to dependence in the middle-aged; but there is practically no prescribing of opiates though one doctor is known to be an ‘easy touch’ as

regard prescribing. Barbiturates, amphetamines, and cocaine are not abused in Galway. There is little drug abuse by second-level student. But there is some by third-level student, particularly at the university college.

Abuse of alcohol is much more important in Galway than abuse of any drugs. Professor Leonard said he believe there was no abuse of 'hard' drugs at all along the west coast up to and including Sligo.

Sligo

I talked with a specialist garda, a psychiatrist, a hospital chief pharmacist, and health educational officer. A striking feature of all those interviewed was that they seemed more relaxed about the drug problem than the people seen in Galway, and much more relaxed than corresponding people in Dublin.

There is no abuse of heroin or other opiates. There were two separate vague reports of a man and woman, opiate users, who had moved from England to Sligo; and one of them suggested that the woman had said she could get Diconal illicitly in Sligo.

There is no abuse of barbiturates, amphetamines, LSD, or cocaine, and there is no solvent sniffing. Cannabis is quite widely available and used, and there is a good deal of abuse of benzodiazepine tranquillisers, prescribed by both, general practitioners and psychiatrists. There is also some abuse of cough medicines. I was given two contradictory reports as to whether third-level students in Sligo abuse drugs.

As in Galway, abuse of alcohol is worse in Sligo than abuse of drugs.

Cork

I talked with a specialist garda and with three psychiatrists. There are perhaps three or four persons in Cork who abuse heroin, but they get any supplies from Dublin. However, the same person plus another thirty-odd in Cork abuse synthetic opiates: Diconal, Palfium, and pethidine. These are prescribed for them by Cork general practitioners out of soft heartedness, venality, ignorance, weakness, or carelessness; or else are obtained as a result of pharmacy break-ins. The garda said the abusers mainline these substances; one psychiatrist said they did not. Two psychiatrists told me separately

from one another that abuse of Diconal is Ireland's peculiar contribution to the drug problems.

There is some abuse of benzodiazepene tranquillisers, mostly by middle-aged people for whom they are prescribed to excess, and there is some solvent sniffing, particularly by itinerants' children. Cannabis is used a good deal, and LSD a little; but there is little or not abuse of barbiturates, amphetamines, or cocaine.

DISCUSSION

Mountjoy A – Heroin Abuse Prevalence

There can be no doubt of the ‘heroin abuse’ authenticity of 81 of the 82 questionnaires completed on the basis of the master list. Of the 82 persons named on it 81 admitted to having abused heroin, though two of them said they had not done so in the past year. For reason already given in the ‘results’ section this could not be accepted in the case of one of the two.

In addition, the individual completed questionnaires rang true, and the analysis of answers provided in the ‘Results’ section suggests strongly that there was consistency as between any one completed questionnaire and other.

The answers to Questions 19, 21, 25, 26, 28, 31, 32, 33, 37, 39, 40, 41, 46, 47, 50, 51, and 52 are regarded as particularly convincing in this regard: there is a consistent extreme element to the answers for which neither collusion nor chance provides a satisfactory explanation.

Furthermore, contrary to expectation, of the 82 names on the master list 61 were confirmed by Jervis St. as belonging to persons known there as heroin abusers. And finally, all twelve validation interviewees were regarded as authentic ‘with a year’ heroin abusers.

The seven extra questionnaires provided by Jervis St. are by definition from heroin abusers, though two of the interviewees had not used heroin within the past year.

It is of interest to note that, despite the prognostications from various sources that the young people concerned would never co-operate in the completion of such a long and intimate questionnaire, the co-operation given was exemplary – thanks to the interviewers in large part, but also to a pathetic desire to help in tackling the problem that was shown by most of the interviewees.

The definitive Mountjoy A prevalence figures provided are disturbingly high, particularly in the 15-9 age group as a whole and especially in the females in that age group, though the figure for females aged 20-24 is also high.

It is surely matter for great concern that the Mountjoy A figures are in various respects worse than the available figures for certain New York black ghetto area;

especially as, for reasons indicated in footnote 1 and 2 to the comparative prevalence table, the New York figures probably represent an overstatement of the prevalence of heroin abuse in recent years.

Mountjoy A – Heroin Abuser Profile

The most striking feature is the concentration of abuse in teenagers and young adults. In that connection it is of interest that, while he was interviewing an adult abuser, one interviewer, who is himself a teacher, came across four boys aged 10 to 12 who said: all of them had skin-popped heroin on at least four occasions, had distributed or sold heroin for an older person, knew lots of abusers, thought everyone 'did it', saw no danger in their activities, and were approaching teenagers in order to buy heroin. They were encountered by the interviewer some distance from their homes.

This is, of course, anecdotal evidence; but not therefore to be dismissed; and in fact, no fewer than 13 interviewees in the formal study stated that their first introduction to heroin came when they were less than 15 years old, while a further 53 were introduced to it at age 15-19.

It is clear from the figures for the number of years that had elapsed from the time of introduction to heroin that, while an 'epidemic' of introductions to heroin had started two years ago, the problem was substantial before that. No fewer than 39 of the 88 heroin abusers were first introduced to the drug three or more years previously.

Salient features of the rest of profile will now be considered. It is said that as many as 12 interviewees claimed to have no friends, and that only 9 had ever taken part in sport or game at least once a week over a period. The strongest influence in their lives was named as drugs by more than a half the sample: none mentioned television, religion, or a priest though all 88 were Catholics.

The educational record is dismal: early school leaving, only 6 going to a secondary school, almost four times as many going to a special school; and only 4 out of 88 emerging from the educational process with any kind of certificate qualification, or skill. Equally shocking in 1983 is that 10 of these young people could neither read nor write.

Even more dismal is the work record: only 4 out of 88 were employed at the time of interview, and 64 were 'compulsorily unemployed'. It is difficult to think that a 73% compulsory employment rate is explicable solely on the ground that their drug usage made these young people disinclined for work or incapable of it. Some at least of their drug usage must have stemmed from unemployment, as indeed some of them indicated at interview. The longest time in a job was less than a year for 55, the longest period out of a job was more than a year for 75. At best this is surely at least as much an indictment of society as of the individual concerned.

Heavy cigarette smoking was the almost invariable rule, but less than half of the interviewees drank. However, those who did drink appeared to drink rather heavily: 25 of the 38 drinkers would take four or more drinks at each drinking session. No less than 30 interviewees stated that drink had at some time been a problem for them or their families; and it is tempting to speculate that some of the heroin abusers of today are the children of the alcohol abuses of yesterday.

No fewer than 83 of the 88 had regularly taken a non-prescribed drug other than heroin, Diconal being the favourites such drug with 65 of them. Diconal is a proprietary preparation containing an opiate drug (dipipanone) plus an anti-emetic. It is controlled under the Misuse of Drugs Act 1977. (There was evidence from the phase I study of improper prescribing of it some Dublin doctor.)

As concerned heroin usage: 62 subjects stated they had first been offered it by a friend, though some of them many conceivable have been trying to shield a dealer or pusher, if only out of fear. No fewer than 82 of the 88 had regularly taken heroin at least once daily, and 73 had done so within the previous year. The answers as regards frequency of administration are probably not altogether reliable since most of the interviewees clearly thought, not in terms of that frequency, but in terms of the number of pack of heroin taken per day.

Mainlining (intravenous injection) was much the most popular mode of administration, and most of those who skin-popped (injected beneath the skin) did so only because their veins had been rendered inaccessible by scar tissue resulting from

previous intravenous injection. Sixty-one had taken another drug along with heroin, Diconal again being the most popular.

Sixty-four subjects had under gone 'cold turkey' (sudden withdrawal) of heroin, not medically managed), mostly due to lack of money or to their being in prison; though at least once subject stated that heroin could be obtained in prison. (Quite separately from the present study, such 'in prison' availability has been mentioned also by non-abusers.) Sixty-eight subjects, having given up heroin, had gone back to it; and the number might well be higher if the remaining subjects were interviewed again in a few month' time.

Nearly all the interviewees had friends who took heroin. That is readily comprehensible. Less comprehensible is the starting figure of 44 for the number who had one or more relatives taking heroin.

The figures for arrests indicate that there were more of these for crimes not connected with heroin abuse than for those that were so connected; and the crime picture is in reality even worse than the figures might suggest since many interviewees had been arrested more than once for the same type of offence, and some had been arrested many times. Fifty-six, it was estimated, had been in prison at some time.

Two final sad notes are, first, that in the case of 29 interviewees one or both parents were dead, and that parents were or had been separated in 18 cases; and second, that in their answers to the question about what they thought should be done to fight heroin abuse a number of interviewees, themselves only teenagers, made such remarks as, 'So-and-so should be done so that young people don't get like me.' Their own youth, they seemed to feel, had been left behind when they first picked up a syringe, a needle, and some heroin.

In conclusion: it is difficult not to think that these young people in North Central Dublin are the victims of society. They live in a dirty, squalid. Architecturally dispiriting area; education seems to provide no mode of escape unemployment is to be their almost inevitable lot; their parents are quite often separated or else dead; abuse of alcohol is a common problem; crime the societal norm; imprisonment more likely than not; heroin

taking is regarded as commonplace by quite young children; current treatment and rehabilitation facilities seem to hold little in the way of answers to their heroin abuse.

The one source of some deeper philosophy of life than to live from hand to mouth, evading reality with drugs and crime and drinks, is the Catholic Church; but despite the presence of some excellent priests in the area religion appears to have little or no influence on these young people.

Galway, Sligo, and Cork

There is no drug misuse problem in these cities comparable in gravity with that was found in North Central Dublin, though there is some limited abuse of synthetic opiates in Cork.

There is, however, no room for complacency. All but five of the 88 Mountjoy A heroin abusers started their abuse within the past six years, and all but 11 within the past four years: the position in these provincial cities could alter quite rapidly.

Moreover, in each of these cities today there is abuse of a number of drugs, especially tranquillisers, as well as solvent abuse in the case of Galway and Cork, and abuse of cough medicines in Sligo. The ground, in other work, is well prepared for a more serious and more widespread abuse, and this fact has doubtless not escaped the attention of those responsible for the supply of heroin to Dublin and perhaps that of any existing criminal element in those three provincial cities.

It may, indeed, be that there already is some heroin abuse in provincial centres other than those so far investigated. There is certainly one unconfirmed report, carried by a doctor from London, of serious drug abuse in Drogheda; and there are similar anecdotal reports of substantial drug abuse in Limerick, Waterford, and Wexford.

Ireland

It would be very rash indeed, in view of the apparently reliable reports gathered in the Phase I Dublin study of heroin abuse in parts of Dublin city and country other than the North Central Dublin area, to assume that there is not such problem in these areas or

simply a minor problem. It is only nine months since the statement that there was in the age group 15-24 about a 9% prevalence of heroin abuse in the North Central Dublin area. This was greeted with incredulity by a number of doctors and others. The true prevalence turns out to be not 9% but 10% and indeed 13% in female aged 15-19.

It would be, if not rash, at least unwise to assume that heroin abuse will not spread out side Dublin if it has not already done so; or to assume that, aside from heroin, abuse generally of drugs and other substances will not in any case increase in both Dublin and the provinces before it begins to be contained.

Ireland, in fact, is faced with a drug misuse problem that seems to be uncommonly close to crisis point. The word of a priest from the North Central Dublin area about heroin abuse there may have a wider connotation. He said; "This community has managed to cope with drink problems, with crime, with unemployment, and so on, but I don't think it is going to be able to cope with this one (drug abuse). I think it is perhaps going to be destroyed by drugs".

It is with this grave prognosis in mind that recommendations for action are presented.

RECOMMENDATIONS

The recommendation given below are, first, geared to the current Irish drug scene but take account of UK experience; second, necessarily personal and provisional; third, not given their justification solely by the present limited study; and fourth, are based upon the belief that drug abuse is best tackled as a complete entity rather than abuse of particular drugs being tackled piecemeal.

Heroin abuse is merely one end of a total spectrum of drug misuse, of which there are various other varieties in Ireland at present; a spectrum that can sometimes usefully be taken to include abuse of alcohol, solvents, and tobacco, as well as of drugs.

Recommendations are made under the two main heads of primary ('firm') and secondary ('tentative'). This reflects the fact that the exact nature of the final second recommendations will be determined by action taken under the primary head.

Primary Recommendation

(1) Drug Misuse Symposium to last 2 days, to be held under the auspices of the Medico-Social Research Board (and perhaps of such bodies as the Health Education Bureau), and to have as attenders as many as possible of those involved in the drug misuse problem anywhere in the Republic, and of those interested in it. The total attendance is envisaged as perhaps 100-150, with expert speakers from both the Republic and the UK.

This may seem a pedestrian first proposal; but one of the most surprising facts to emerge in the course of the present study is that people involved in the problem of drug abuse in one area of Dublin are either ignorant of the existence of similar persons in another area., or else know them only name. The symposium would serve, in other words, as a means of getting such people acquainted with one another as well as of making known the latest thinking and practice as regards drug misuse in the Republic and the UK.

(2) Establishment of Information Centre, probably in the Medico-Social Research Board offices, at which up-to-date and comprehensive information on drug misuse, both here and internationally, would be held; the information to include medical, pharmaceutical, sociological, and penal data, together with all relevant addresses. A small library of books and journals is envisaged too.

In the course of the present study the acquisition of individual relevant items of information sometimes took laborious hours. Such a centre, to be initiated by a full-time, and maintained by a part-time, sociologist with secretarial help, could issue a regular newsletter as well as acting as a reliable repository for information, and could help to dispel the many myths surrounding drug abuse that were encountered in the course of the present study. (Such a centre was first suggested by Dr. Dermot Walsh of the Medico-Social Research Board staff.)

(3) Visit to Other Countries, by a small team (Say, Psychiatrist, specialist nurse, social work, informed lay person) to discover in the field the current thinking and practice in all drug-abuse fields in those countries.

Certainly the UK should be visited, perhaps one or two continental countries (say, Holland, and West Germany where Hamburg is reported as particularly successful in the drug misuse fields), and possibly the USA. The team members would probably be drawn from the bodies indicated in (4) and (5) below; the total visit to last 4-8 weeks. Books and journals, though useful, can never provide the depth of information, especially up-to-the-minute information, that can be secured from a visit. Ireland might as well benefit from others' experience of tribulation.

(4) Central Drug-Misuse Policy Board Of perhaps 15-20 members, representing all the interested professional persons (medical, nursing, social, workers, psychologist, police, Lawyers), and all other interest persons (voluntary agency personnel, priests and other clergy, parents, teachers, and representative of the Departments of Health and Justice); the remit being to propound initial national drug-misuse policy and the broad lines of appropriate action, and then to maintain a watching

brief on the drug-misuse field with the issue of reports on topics thought appropriate by its members or suggested to it by Ministers, etc. It would be essentially a national, advisory, policy-formulating, non-executive body.

A small permanent secretariat is envisaged, its head perhaps to have the task of overseeing and co-ordinating all efforts in the fields of drug misuse, and of querying their efficacy, and of acting as general stimulator and trouble shooter. He/she would also be charged with co-ordination of the policies and efforts of different government departments. This would probably be a task for a senior professional civil servant.

(5) Central Drug-Misuse Expert-Advice Unit Composed of perhaps eight or ten person professionally engaged in the drug-misuse fields (psychiatrist(s) nurses, social workers, health educator, voluntary agency worker, probation officer, etc.).

Its remit would be act as specialist consultant advisory body to the Central Policy Board, Government Ministers, and regional bodies (see below), but it would also be available to give ad hoc specialist advice to individual, usually professional, and organisation active in the drug-misuse field.

Like the Central Policy Board, it would have national interests, but it would have both a day-to-day executive advisory role and longer-term consultant one. It is envisaged as having a small secretariat of one or two persons who would be in telephonic contract as needed with Unit members for ad hoc advice; the Unit meeting as any entity as such only when it was called upon to pronounce on major issues. It would obviously have ties with the Information Centre.

(6) Research While the scope, type, location, and perhaps executants of future drug-misuse research would fall within the remit of the Central Drug-Misuse Policy Board, advised by the Expert-Advice Unit, some further research seems obviously to be required, and needs to be performed so urgently that its initiation cannot wait upon the establishment of the Board and the Unit.

This research would be: first, study of a control population in the Dublin Mountjoy A Ward to see to what extent the characteristics identified in heroin abusers in

the present study are, in fact, peculiar to them; second, Phase II study of misuse of heroin (and of other drugs) in certain Dublin areas where it is suspected to be prevalent (Dublin 8, Dun Laoghaire), and in certain Dublin area where it is thought not to be (say, Donnybrook, Howth); and third, an extension of the Phase I study to further Irish provincial centres, chosen on the basis that drug misuse is known or suspected by gardai or other knowledgeable person (psychiatrist, pharmacists, etc.) to be substantial.

The present study provides a model, to be suitably modified, for such Phase I studies, and for the Dublin Phase II studies of the areas where heroin misuse is supposedly prevalent. In the areas where it is believed not to be prevalent the Phase II study could be conducted on the basis of interviewing a random sample of young adult/adolescents or, more likely, of those young adults/adolescents thought by informed community leaders most likely to be involved in any misuse of drugs. (Difficulties are foreseen for both types of Phase II studies, and have been indicated earlier in the present reports.)

The Medico-Social Research Board would seem the appropriate body to conduct this research. The more extensive, definitive delineation of drug misuse. Particularly misuse of heroin, in Dublin, and the rough epidemiological surveying of the whole country provided by these studies would seem the essential minimum for the initial working of the Central Drug-Misuse Policy Board; and that is one reason why this research must be regarded as urgent.

In relation to the choice of further Dublin areas for Phase II study, it would probably be helpful if the Dublin districts of residence of all those attending the Jervis St. Clinic in, say, the past four years could be indicated on a map. (This need not involve any breach of confidentiality as regards the identity of patients).

Similarly, in relation to the choice of further provincial centres for Phase I study, it would probably be helpful if Garda drug seizures and/or convictions for drug offences during the past four years could be similarly mapped for the whole country. The forensic laboratory at the Garda Síochána HQ in Phoenix Park might well prove helpful in this regard: liaison already exists between its personnel and the Director of the Medico-Social

Research Board (Such a map may well, of course, already be in existence at the Garda HQ.)

Secondary Recommendations

It may already be apparent why these have been described as tentative: the Central Drug-Misuse Policy Board would obviously be the body to make firm recommendations on the topics here covered. This is not to say that some of the measures suggested (for instance, some control of irresponsible prescribing by doctors, and some educational measures) should not be initiated in the near future; but such measures are included here since their ultimate pattern will be largely determined by the advice tendered by the Board to the Minister, and to bodies such as the Health Education Bureau, or, say, the medical or teaching professions.

(1) Area Drug-Misuse Policy Boards One to be formed in each Health Board area, though in the Eastern Health Board area four would probably be needed (two in Dublin, north and south, and two in the Board's rural districts). These Boards would follow the same pattern as regards membership as the Central Board, though they would have fewer members (say, 10-12).

Their remit would be to advise the Boards and other interested local bodies on drug-misuse policy and appropriate action in their area, taking account of the Central Board's pronouncements and of local condition. It is very likely that in some Health Board areas drug misuse is minimal, and correspondingly the work of the Area Policy Board would be; but even in such circumstances it would be as well to have such a body, even if only to maintain a watching brief.

(2) Area Drug-Misuse Expert-Advice Unit One to be formed in each Health Board area (two or three in the Eastern Health Board area), their membership to be similar in composition to but probably less in numbers than the central Expert-Advice Unit; the remit to be an area one. In particular, it is envisaged that the Units would take a very active role, though still only an advisory and guiding one, in relation to all those involved in the day-to-day management of drug abusers, especially to the non-expert among them: for example, general practitioners, voluntary or parents' organisations,

teachers, gardai (the last, of course, seeking advice on, say medical or pharmaceutical matter).

(3) Education

(a) Health Education. This whole topic will call for urgent study by the Central Policy Board; but it can be said that the present study revealed no educational material of a type likely to be effective in the North Central Dublin districts; that the research recommended earlier will indicate the spheres and geographical area in which education is most urgently needed; the consideration should perhaps be given to the possibility of education being conducted, not on the basis of experts proceeding laboriously through a succession of audiences, but of each chosen person, once taught, going out to teach a few others plus regular monitoring to ensure the message was not being distorted in transit. The emphasis must certainly be on the urgent need for education.

(b) Specialist education (of certain doctors, nurses, social workers, etc. in the field of drug misuse will probably need to be conducted. Establishment of guideline for it would par excellence be a matter for the Central policy Board, very much itself guided by the central Expert-Advice Unit; with the Area Board advised by the Area Units, participating in the implementation of policy. Specialist functioning might have to be assumed in this regard by the Western and Southern bodies concerned in respect of the Galway and Cork medical schools.

(4) Treatment Although prevention, treatment, counselling, and rehabilitation are here considered separately, up-to-date thinking on these matters favours a unified approach: that is, all these matters should be overseen and co-ordinated by the Area Boards and Units subject to the policy recommendations of the Central Board.

At present there is only one specialised drug-misuse treatment centre – the Jervis St. Drug Advisory and Treatment Centre. The position in the UK is not strictly comparable with that in Ireland, but the UK does have just over 100 such centres; so on a population basis, and if the prevalence and nature of drug misuse were similar in the Republic, it should have about 6 or 7 such centres. Certainly the Jervis St. centres is

grossly overloaded; and it would seem a matter of great urgency to set up at least one extra such centre in Dublin, probably under the general direction of the present Jervis St. Medical Director.

The Central Board will doubtless wish to consider the establishment of specialist centres in provincial cities. Certainly the impression was gained from the present study that the current treatment arrangements in Cork might profitably be reviewed: they appeared to have grown up somewhat haphazardly in response to immediate pressures.

(5) Community Centres Although in the course of this study a number of suggestions for Day Centres as encountered, they seem almost to have disappeared in the UK in favour of counselling and 'detached work' centres, most of them established by voluntary organisations; and certainly a strong case could be made for the establishment of such a centre in Mountjoy A Ward and perhaps in other areas of Dublin, as well as in provincial centres identified by research.

(6) Rehabilitation Centres There are some 15 such centres in the UK. In the Republic there is one – at Coolemine – though accommodation, I believe, has been offered in Navan for the establishment of a second Coolemine-type centre there. The impression was gained in the Dublin Phase I part of the present study that the Coolemine regimen was not particularly successful, and this was strongly reinforced by the unsolicited comments of the Dublin Mountjoy A interviewees. However, a detailed comparison of alternatives (of which probably none is very successful) will doubtless emerge from the proposed visit to the UK of an expert team; and it would seem there might be scope here in Ireland for a comparison of three or four different rehabilitatory approaches used in different centres.

(7) Law Enforcement This is not an area to which normal medical expertise is pertinent; but a few words on three matters may be in order.

(a) Improper Prescribing Power exists now under the Misuse of Drugs Act 1977 to deal with improper prescribing by doctors, and indeed the machinery has already been invoked. The essence of that approach, however, is that action is taken only when an offence has apparently been committed. A preventive approach might be worth

consideration as an alternative: that is, that the prescribing of all opiate drugs to drug addicts should be permissible only by doctors specially licensed for that purpose by the Minister of Health and Social Welfare.

This need not mean restricting such licences to hospital doctors. There may well be instances, as in the UK, where such prescribing may properly be carried out by non-hospital doctors, though their number would almost certainly be small.

Consideration might also be given, as in the UK at the moment, to a ban on all prescribing of Diconal. Previous experience, however, would lead one to expect this simply to result in abuse of another opiate drug: for example, Palfium.

(b) Law Enforcement It is perhaps worth repeating, though with no claim to special knowledge, that the Phase I Dublin study – and it is now supported to some extent by the Phase I provincial study – revealed that the gardai believe they are understaffed in relation to their duties in the drug field; that the courts are too lenient to major suppliers; and that cast-iron evidence, of a kind difficult to secure, is essential to secure a conviction.

The writer of this report has no relevant expertise or special knowledge; but it is worthy of note that, among concerned and well-meaning middle-aged lay people in the Dublin North Central area, there is doubt about the earnestness of the gardai in relation to drug offences, and even a belief that the motivation of the gardai in this field is suspect. This unfortunate state of affairs may well be merely a lay reflection of the concern about their role and their effectiveness felt by the gardai themselves.

(c) Major Heroin Suppliers The suggestion has recently been made by the UK Association of Chief Constables that, in relation to major suppliers of heroin, the same system should obtain there as in the USA: viz., that, if such a person is convicted, the presumption is made that all his property of whatever kind has been obtained by drug trafficking and is therefore forfeit. This might be thought too draconian for the Republic, but desperate diseases call for desperate remedies.

(8) Local Initiatives In different parts of the world there is a good deal of work by voluntary agencies, often on a purely local level, in the field of drug misuse: for

examples, parents' associations for education of themselves and their children, and early detection of drug misuse; a variety of rehabilitation houses and methods; counselling units. This is, of course, some work of that kind in Ireland also.

It need hardly be said that such initiatives should continue to be encouraged; and where they are deemed to be effective should attract public funds. The emphasis in this report on national and area planning in relation to drug misuse was not meant to discourage these other most valuable initiatives.

Local initiatives should, however, conform to such planning if they are to attract public funds; though on the other hand planning should be flexible enough to accommodate all but the most outré of such initiatives, and even for them it should, so long as they are hopeful, be able to discover some niche.

In fact, the secret of success in combating drug misuse, as in many other fields, lies in a creative tension between central planning and peripheral initiative. Neither can dispense with the other: a dialectic should exist.

(9) Role of Catholic Church It seems to the present writer that the Catholic Church could well play a unique part in relation to the containment of drug misuse in Ireland, and perhaps to its diminishment; and for the following reasons.

(a) Depth of Problem The malaise affecting the heroin abusers of North Central Dublin, affecting the society that permits squalor, illiteracy, anomie, and unemployment on the scale revealed in this report, and affecting those who import heroin and sell it for profit is grave and deep-seated. It is a sickness in the souls of men. Correspondingly a solution of depth and vigour is needed; of the kind that the Church has shown in certain parts of the world in recent years, and has often shown in Ireland in the past. Secular answers, however necessary, cannot heal a sickness of the soul. The answer must au fond be religious: that is, in the Irish context, Christian and of the Christian kind most familiar and organised here – the Catholic one.

(b) Drug Abusers as Outcasts The drug abuser is often despised and shunned by his peers, his neighbours, his own relatives, and even by his doctor. He is therefore par excellence a candidate for the exhibition of the charity (more strictly, agape) that has in

the past enabled Christians to tend the leprous, the grossly handicapped, the lunatic when others looked away. The heroin abuser, with his formidable tendency to relapse, to crime, and to self-destruction, demands almost inexhaustible virtue in his keeper.

(c) Parish possibilities Having an already existing network of parishes with schools and churches, a captive audience every Sunday, and a tradition of teaching the people what they should do, the Catholic Church would seem well suited on a purely pragmatic level to undertake education on drugs, and to establish counselling services, clubs, and day centres. All these could quickly arise or be extended in response to need as a natural part of its parochial functions.

(d) Religious communities There is a variety of communities here in Ireland, some of them with substantial rural demesnes. It should surely not be beyond the wit of, say, the Jesuits, Franciscans, and Cistercians among the orders for men to set up rehabilitation centres in rural locations for male drug abusers from Dublin (and perhaps other centres). Orders of nuns could similarly cater for the girl abusers. As no rehabilitation system is now generally accepted as satisfactory, such an arrangement would allow for a number of systems, based on differing concepts, to be tried out to see which of them worked best in the Irish context.

(e) Seminaries, etc. Training establishments with their complements of young men dedicated to service and to a high calling already exist: the Church would find it comparatively easy, therefore, to arrange for the rapid training in the drug abuse field of postulants shortly to be ordained, or else of priests and nuns already working in parishes.

It should indeed be possible for such young men and women, having been quite quickly trained, to go out to parishes where drug abuse is a particular problem, and devote themselves to that problem in those parishes and in their neighbouring areas; and to achieve success.

If young priests and nuns cannot effectively deploy the empathy, the patience, the expertise, the love that young drug abusers clearly need, it will surely be a grave reflection on the relevance of the Catholic Church in Ireland to the present-day world.

Conclusion

Scientific reports do not commonly quote poetry; but the topic of this report is unusual, and the abomination it delineates in North Central Dublin, and the lesser evils of the provinces, both affecting largely the young, do put one in mind of some lines of A.E. Housman. They might have come from one of the Dublin teenagers encountered in this study, unemployed, living in a slum, child of a broken home, unloved, without hope or vision, desperately seeking escape by indulgence in a habit that is prone to kill and that demands for its satisfaction regular criminal activity likely to lead to gaol. Housman wrote, giving such a child the words to speak:

‘And how am I to face the odds
Of man’s bedevilment and God’s?
I, a stranger and afraid
In a world I never made.’

Those who devised and carried out the present study and wrote this report on it, and those who may read the report are, in fact, the makers of that child’s world; and of course, the production and the perusal of reports is a part of the making, a part that might be thought merely to add to the bedevilment if it is not certainly to be followed by such remedial action as a clear understanding may dictate and a Christianly love of neighbour inform and sustain.

And lastly, the report may be considered unduly sad in part. Housman wrote also:

‘Into my heart an air that kills
From you for country blows:
What are those blue remembered hills,
What spires, what farms are those?
That is the land of lost content,
I see it shining plain,
The happy highways where I went
And cannot come again.’

For the young of North Central Dublin there is an air that kills, blowing from a far country; but it is not the land of their lost content. They have had none: no blue hills to remember, no spires, no farms, no happy highways; no Connemaras, no Books of Kells. What they have lost instead is simply all of real value on the temporal plane they ever truly possessed – their youth. The sadness is in the loss, and there can be no excess of it.

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JSB

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