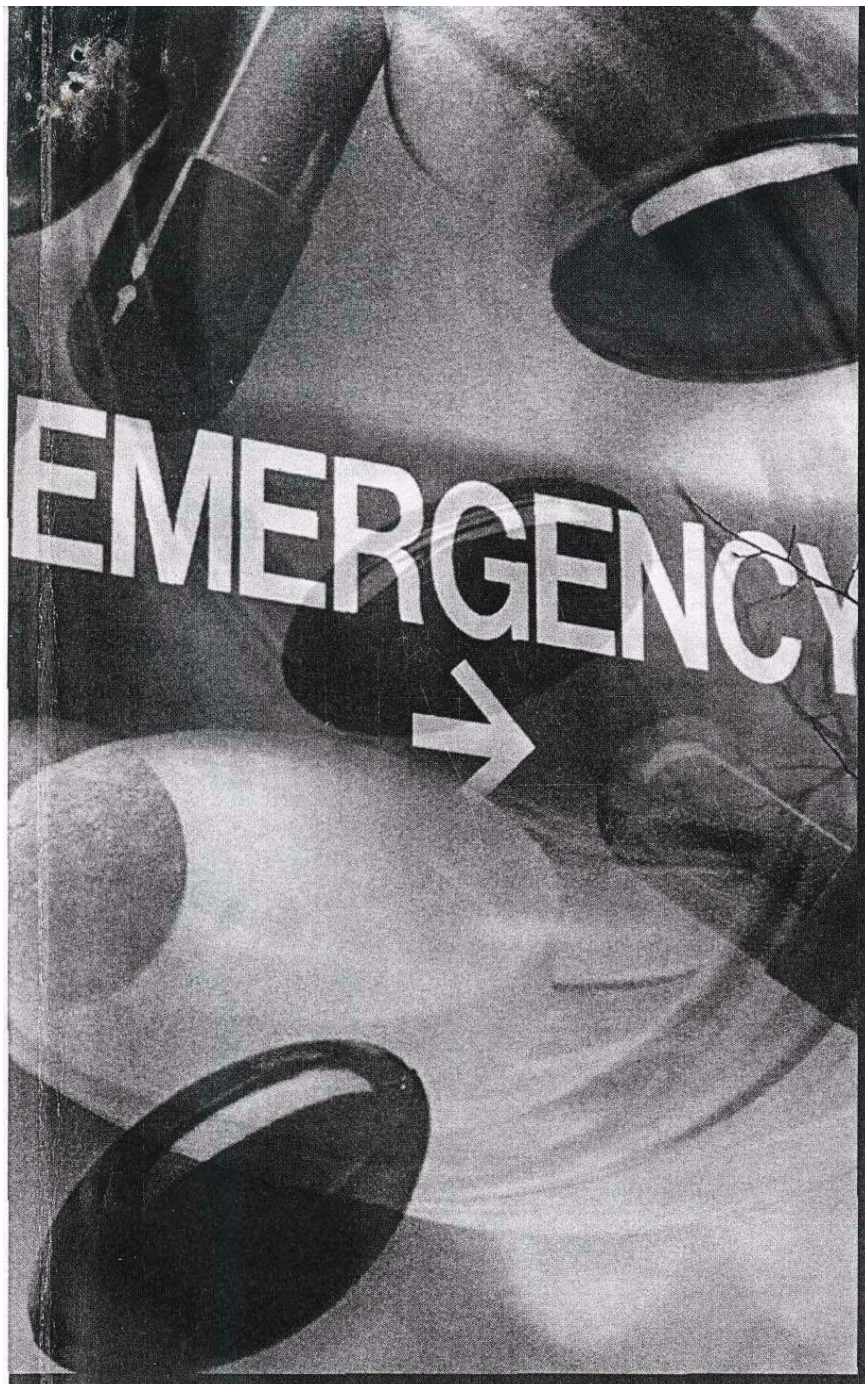

Drugs & Community

An Exploration of the Nature & Extent of Drug Use in the Greater Blanchardstown Area

GBRD

Greater Blanchardstown Response to Drugs

Jennifer D'Arcy

March 2000

Research Funded by the Blanchardstown Drugs Task Force

Drugs & Community

An Exploration of the Nature & Extent of Drug Use in the Greater Blanchardstown Area

A Report prepared on behalf of the

Greater Blanchardstown Response to Drugs

&

Funded by the Blanchardstown Drugs Task Force

By

Jennifer D'Arcy

March 2000

Designed & Printed by
Oak Print & Design
01 2867377

Greater Blanchardstown Response to Drugs
10 Dromheath Avenue
Ladyswell
Mulhuddart
Dublin 15
Tel/Fax: 8208064

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FOREWARD

In 1996, the Ministerial Drugs Task Force on Measures to Reduce the Demand for Drugs reported their findings concerning strategies to deal with drug misuse. One of the key recommendations of that report was

"The Task Force has concluded that the lack of valid, concrete information on the nature and extent of drug misuse in this country needs to be addressed. Notwithstanding the difficulties involved in compiling such information, there is a need for accurate research to assist in the longer term targeting of the drugs services and to ensure that an appropriate mix of services is provided, based on the evidence for their need and effectiveness."

It was with the above need in mind that the Blanchardstown Drugs Task Force allocated funding to the Greater Blanchardstown Response to Drugs to undertake the following research. This research is the first empirical piece of research concerning the prevalence of drug use in the Greater Blanchardstown area.

The research commenced in August 1998 with a consultative process involving agencies involved with the drug issue. It was quickly found that although there was a great concern in estimating the numbers involved in problematic drug misuse in the area, there was also a concern in investigating the nature of that drug misuse in order to enhance service delivery.

The research investigates the prevalence and profiles of drug misusers in the six designated Task Force areas of Corduff, Mulhuddart, Blakestown, Mountview, Huntstown and Hartstown. There is often a fear in opening up debates concerning the level of drug use in any particular area. Given the covert nature of illegal drug use, it is often easier to ignore what we do not see. This following report is one of several projects undertaken by the GBRD to engage communities in the realisation of a drug problem in their area.

The following report with its analysis of a local drug problem and the emphasis which the research places on the implications for social policy in all aspects of the findings can be seen as a valuable step in facilitating discourse in the area of drugs policy.

I look forward to the positive contribution of this report in acting as a guide to the services, agencies, families, individuals and communities in the Greater Blanchardstown area.

Seamus Mc Donagh
Chairperson
GBRD

ACKNOWLEDGEMENTS

This report has benefited greatly from the assistance of many people and I would like to thank them. I would like to take this opportunity to thank the management committee of the Greater Blanchardstown Response to Drugs for their enthusiasm and support in completing this research project. A very special thank you must go to the research steering committee, consisting of Seamus McDonagh and Phillip Keegan for their hard work and guidance in bringing this report to fruition. In deciding on the research methodology to be used in the report, I would like to thank Declan Reddy for his advice and experience throughout the course of this research. My sheerest and warmest thanks to my research assistant Lyndsey Jones for the time, effort and interest invested in this research and for her invaluable contribution to the interviews.

Many thanks to those organisations and agencies, too numerous to mention, for the time that they took with me to discuss the following research. I would also like to recognise the support received from the Blanchardstown Area Based Partnership throughout the course of this research and particularly for the demographic profile used in this research. Thank you to the many doctors, nurses, general assistants and counsellors who co-operated with me in my invasion of treatment centres. A research project of this proportion cannot become a reality without strong administrative support, I would like to express my gratitude to Patricia Caffrey for her administrative support, patience, enthusiasm in reading draft copies of this report and for her friendship throughout the course of this project.

Finally, I would like to thank all those respondents who participated in the interviews providing confidential and often incriminating information for the purpose of this research. I would also like to express my sincerest thanks to you for the tea and coffee that we shared, often in your own homes, and for offering an enlightened perspective on the drugs issue which evaded me prior to meeting you. I hope that both the findings and recommendations of this report will go along way to changing your situation for the better.

In acknowledging the assistance that I have received, I would also like to follow the time - honoured tradition of retaining full responsibility for the report and for any errors that it may contain.

Jennifer D'Arcy
Research Officer
GBRD

CHAPTER ONE

Introduction

"How came any reasonable being to subject himself to such a yoke of misery, voluntarily to incur a captivity so servile, and knowingly to fetter himself with such a sevenfold chain?"

(Thomas De Quincey, 1966:26)[1]

The above quotation describing De Quincey's experience of opiate dependency is a question that remains on the lips of many people living in contemporary society. Research in the area of substance abuse has frequently looked at contributing factors to substance abuse (O'Higgins & Duff, 1997). The following research will offer an account of both the extent of drug misuse in the Greater Blanchardstown area and the nature and profiles of both the drugs being used and the people using them.

The Blanchardstown Drugs Task Force through the Greater Blanchardstown Response to Drugs (hereafter known as the BDTF and the GBRD) funds the research.[2] The research commenced in August 1998 and conducted interviews over an eleven month period. The research took as its remit the six designated Task Force Areas (TFA) of Corduff, Mulhuddart, Huntstown, Hartstown, Blakestown and Mountview.

Initially the research was designed to offer an overview of both the extent and nature of drug use in the area, however as the research progressed and an epidemiological profile emerged, the research adopted a holistic approach to understanding the drug problem in these areas. Therefore, before offering an analysis of the data collected through both quantitative and

[1] De Quincey, T. (1966) *Confessions of an English Opium Eater and Other Writings* New York: Signet Press

[2] *The Funding Agents:*
The Greater Blanchardstown Response to Drugs is a networking organisation consisting of community, voluntary and statutory organisations which campaigns locally and nationally on issues relating to drugs, substance abuse and prevention education issues in the Greater Blanchardstown area. Through research and education we aim to raise awareness and develop responses to drug related problems. Through facilitating a community development process we support individuals and groups who wish or who are providing services for substance abusers and their families. This allows community ownership for services being provided locally. Greater Blanchardstown Response to Drugs is a non-sectarian organisation. From the GBRDs inception in 1992, the organisation was the first community based initiative around education, training and information to be delivered in the Greater Blanchardstown area. Currently, the GBRD are responsible for organising and delivering Information Evenings and Education Programmes in the Greater Blanchardstown area.
The Blanchardstown Area Partnership nominated community representatives to the Blanchardstown Task Force which was established on the 7th February 1997 in such a way as to acknowledge existing communities and organisations and thus ensured a cross section of community interests. The Task Force has a major impact on the drug problem locally by suggesting measures that can effectively address the drug abuse situation in the community. As part of its role in the community, the Task Force has developed plans aimed at dealing with not only the immediate needs of active chronic drug users in the Blanchardstown area in the short term, but to compliment and integrate existing services in the community. It is hoped that this will ultimately alleviate the hardship caused by drug users and those at risk of becoming involved in drug taking.

qualitative research methods (see Chapter 3), this report will synthesise the demographic profile of the area and the historical factors influencing drugs policy both at a national and local level. The final section of the report attempts to identify and propose recommendations for tackling the drug problem in the Task Force areas. *Drugs and Community* aims to reflect the paradigms affecting drugs policy in the 1990s. Perhaps the most important development in this area is the recognition of the impact of drugs at both the individual and social level (Cullen, 1996).

The following report is aimed as at an exploration of the nature and extent of drug use in the Greater Blanchardstown area, it is therefore useful to offer a definition of what we mean by drug use or rather drug misuse. Drugs are often defined by how our judicial system views the drug, i.e. legal or illegal. This can often hold damaging consequences resulting in the use of legal substances such as prescribed drugs and alcohol being interpreted as relatively harmless. Loughran (1999) claims that the health, social and economic costs of both legal and illegal drugs are cause for major concern in our society today. This research has taken illegal drug users as a criteria for selection. The report of the Advisory Council on the Misuse of Drugs (1982) provides a working definition for problem drug users which is adopted in this report.

"A Problem drug taker would be any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)."[3]

Cullen (1998:12) goes on to expand this definition to include:

"when a person's use of drugs has serious consequences for their capacity to work, their involvement with serious crime, their ability to partake in society at a level that most others rightly take for granted, and their capacity to avoid premature death. Drug problems also have serious and often catastrophic consequences for the immediate families and communities of those who are most directly affected including extraordinary levels of crime and lawlessness, community disintegration, and widespread social and emotional traumas."[4]

The distinction between drug use and drug misuse is drawn within this report. O'Higgins (1998) also distinguishes between the two in a bid for a greater understanding of policy in Ireland.[5] The definition of drug use adopted by O'Higgins offers a broader dimension to the drugs issue. Within this definition, drug use can be defined as the taking legal drugs, excluding alcohol and tobacco, without any problem occurring for that person with that drug. This includes taking 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.

[3] Report of the Advisory Council on the Misuse of Drugs (1982) UK
[4] Cullen, B. (1998) *Young People & Drugs: Critical Issues for Policy.* Dublin: Children's Research Centre, TCD

While the report has adopted the definition of drug misuse, the questionnaires used in interviews address the use of legal drugs. However, the problem of alcohol, tobacco and prescribed medications pose a research problem in their own right. Given the damaging consequences of legal drugs such as the above, it is imperative that research into the prevalence of such drug use is conducted in the Blanchardstown area.

[5] O'Higgins, K.(1998) *Review of Literature and Policy on the Links Between Poverty and Drug Abuse.* Dublin: ESRI &

CHAPTER TWO

Demographic Profile of the Blanchardstown Area

For the purpose of comprising a demographic profile for the Blanchardstown area, the report will move beyong the six designates Task Force areas to the Blanchardstown electoral wards of Abbotstown, Blakestown, Coolmine, Corduff, Delwood, Mulhuddart, Roselawn and Tyrrelstown.[1] The demographic profile for the Blanchardstown area illustrates a large town, which is still growing with pockets of disadvantaged communities within its parameters. The population of Blanchardstown has now reached 70,000 from 3,000 in the early 1970s. The 1999 county development plan states that the ultimate target population is 100,00.

One of the past development features of Blanchardstown has been the construction of large numbers of local authority houses. Due to the housing shortages in recent times, the first tenants of new public housing are usually unemployed or otherwise not working. Inevitably, most of these new tenants who are residents of Blanchardstown are surviving on low incomes. Most of the residential areas indicate substantial evidence of social and economic disadvantage. The entire wards of Tyrelstown, Mulhuddart, Coolmine and Corduff are entirely or mostly comprised of housing estates with very high levels of social and economic disadvantage. The majority of the housing is local authority owned.

The population has continued to grow rapidly mainly due to further new house building, both in the private and local authority sectors. The number of private houses being built has accelerated although there are plans for only a small number of local authority housing in the next two years. The data from the electoral register indicate the current trend in population growth of the area. The population of Blanchardstown has grown by over 15% since 1996. Population growth has accelerated substantially in this same period to a rate of growth of between 3.5% and 4% per annum. This rate of growth is equivalent to 2,500 per annum for the total Blanchardstown/Castleknock population and 1,500 to 2,000 for the Blanchardstown wards.

The Blanchardstown wards are growing significantly faster than the Castleknock wards because there is more development land available to build private housing in the Blanchardstown ward. In the early part of the 1990s, the relatively week economy reduced

Combat Poverty Agency

[1] The demographic profile presented here is comprised from information received from the Blanchardstown Partnership and research conducted by Brendan Lynch, Economic Consultant on their behalf.

the demand for private housing, whereas at present the demand for new private houses is unprecedented. The rate of local authority house building may be lower than it has been in the past. However, there is uncertainty as regards where Dublin Corporation intends to build houses for the people on its waiting list for housing. (Dublin Corporation has very little land left for house building within its own functional area).

Age Profile:

Blanchardstown has a significantly younger age profile compared to the rest of the state with relatively few senior citizens. This would be expected of a new town. The proportion of young adults is also slightly higher than the state average, although its is similar to Dublin. Clearly, the young age profile skews the demand for different social services compared to the average profile of demand in urban Ireland. Schools are the most obvious requirement although this has been met. The low numbers of senior citizens is even more noticeable from the statistics and obviously implies quite a low demand for social services for the elderly.

Ward	Under 15	15-24	Over 65
Abbotstown	19%	17%	24%
Blakestown	34%	13%	2%
Coolmine	33%	23%	2%
Corduff	32%	24%	2%
Delwood	22%	27%	4%
Mulhuddart	50%	18%	.1%
Roselawn	22%	24%	8%
Tyrrelstown	51%	12%	2%

Source: GAMMA and Small Area Statistics from 1996 Census

The table for the wards shows major variations between them. The relatively high senior citizen figure for Roselawn and the relatively low under 15 figure is evidence of the relative maturity of the estates in this ward. Roselawn is almost entirely comprised of private housing that was built in the 1970s. The Delwood ward is also comprised primarily of private housing.

The Mulhuddart and Tyrrelstown wards have large concentrations of local authority housing. A lone parent heads many of these houses as subsequent data shows. Much of the local authority housing in these wards is of recent vintage, 1980's and even 1990s.

The unusually high senior citizen figure for Abbotstown is probably due to Cappagh hospital. Without the presence of the hospital, the overall Blanchardstown figure for senior citizens would be even lower at 2%.

The profile offered above represents a general overview of the both the Blanchardstown area and the age profiles of the residents. The information offered represents only a small part of the demographic profile currently being compiled by the Blanchardstown Partnership.

The population and age profile of the Blancharstown area holds interesting consequences for the overall level of drug use in the area. The Ministerial Task Forces on Measures to Reduce the Demand for Drugs (1996,1997) acknowledge the existence of a direct link between social and economic disadvantage and drug use.[2] Blanchardstown reflects a large and developing town characterised by high levels of disadvantage in specifically socially segregated areas. The following report highlights both the need to develop strategies to deal with the problem and the importance of social policies such as employment, education and housing policy in dealing with both the treatment and prevention of the problem.

[2] Department of An Taoiseach (1996) *The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Official Publications
Department of An Taoiseach (1997) *The Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Official Publications

CHAPTER THREE

Methodology

"The ultimate goal of the social and other sciences is to produce a cumulative body of verifiable knowledge. Such knowledge enables us to explain, predict and understand the ...phenomena that interest us. Furthermore, a reliable body of knowledge could be used to improve the human condition"[1]

The following report is deigned not only as an epidemiological piece of research on the nature and extent of drug use in the six designated Task Force areas but also aims to offer an understanding of the drugs problem within the context of Irish social policy. With this in mind, the following research can be understood as an empirical effort designed at estimating the prevalence of drug use in an area and the nature and profile of the respondents. The ultimate goal of this research is to provide information aimed at influencing the construction of plans that set priorities and allocate resources to achieve specific goals. Albrecht (1985:277) looks at the very nature of research, which he sees as shaping social policies.

"The values and ideologies of investigators operating in tandem with their favourite theories and research methods predetermine the questions selected for investigation and the types of evidence admissible."[2]

In commencing this research, one must always be aware of the influence of methodology in research findings. Control over the formulation of the research problem i.e. the nature and extent of drug use in the six Task Force areas, execution of the research and the interpretation of the results, can often become more important than the actual data itself. The research is aware of the cautious note, which must be taken in analysing any data set, and tries to support the findings with in-depth qualitative interviews conducted with a representative sample. In the course of this research project, attempts have been made to control the risks to validity. The close relationship between epidemiological research and social policy is consistently highlighted within the report and the data often leads one to reflect upon one of the basic aspects of social policy; the values which characterise a society and shape the relationships between its members.

The research has taken the form of a hypothesis testing study. When the research was first commissioned both the GBRD and the BDTF recognised the fact that there is a drug problem in the area, therefore the research aimed to test this hypothesis and quantify the extent of the problem. Hypothesis can be described as a tentative answer as it can be verified only after it has been tested empirically. It is insufficient to quantify this data to a large area such as Blanchardstown, therefore the research determines the nature and extent of drug use in each of the six designated Task Force areas mentioned previously. Thus making it possible for

[1] Nachmias, C. & Nachmias, D. (1992) *Research Methods in the Social Sciences 4th Edition.* London: Edward Arnold
[2] Albrecht, G. & Jackson, D. (1985) "The Social Context of Policy Research" in *Sociological Methods and Research* Vol13(3)p275-287

service providers to determine the needs of these areas and make adequate provision in meeting these needs.

The research commenced with a variety of research questions hoping to ascertain causal relationships between a variety of factors such as education, unemployment, family etc. And drug use. The research set out to look at some areas of concern amongst professionals and individuals working in the area.

- The relationship between socio-demographic factors and substance abuse.
- The risks involved in administering heroin i.e. intravenous drug use.
- The role of harm minimisation in the lives of the user.
- Effectiveness of different treatment models
- Level of treatment and choice available to drug users in the area.
- Drug use and criminal activity.

Highly structured interviews were conducted with respondents presenting for treatment from the Blanchardstown area. The prescribed research instrument used to carry out this research was the Opiate Treatment Index (see Appendix B for the applied OTI). The instrument was chosen on the basis of its reliability and validity as a research tool in measuring the extent of drug use. Reddy (1997:33) addresses the reliability of this index identifying the attractive feature of the Opiate Treatment Index (OTI) being based on objective data rather than subjective impressions of interviewers.[3] Therefore, ensuring that the instrument is measuring what it intends to measure (validity) and enabling the instrument to create consistent results (reliability).

Limitations in Data Collection

As with any research conducted in the covert activity of illegal drug use, the research project experienced difficulties in data collection on the extent of drug use. The following difficulties are not unique to the Blanchardstown area and have been experienced and reported by several researchers conducting drugs prevalence studies (O'Higgins & Duff, 1997, O'Sullivan and Roche, 1998, Murphy Lawless et al; 1999, Saris & Bartley, 1999).[4] Definitive information on the prevalence and nature of drug misuse in this country is not available. (European

[3] Reddy, D. (1997) *Methadone Maintenance Reduces Criminality. A Research Study on the Links Between Methadone Maintenance and Reduction in Criminal Activity in the Greater Dublin Area* Unpublished thesis, University College Dublin

[4] O'Higgins, K. & Duff, P. (1997) *Treated drug Misuse in Ireland. First National Report, 1995* Dublin: Health Research Board
O'Sullivan & Roche (1998) *The Level & Extent of Treated Drug Misuse in the Bray Area* Bray Partnership
Murphy Lawless, J. Coveney, E. Redmond, E. & Sheridan, S. (1999) *Prevalence, Profiles and Policy* Dublin: North Inner City Drug Task Force
Saris & Bartley, (1999) Soc<a/ *Exclusion and Local Responses* Dublin: Ballyfermot Drugs Task Force.

Monitoring Centre for Drugs and Drug Addiction, 1993)[5] The Department of An Taoiseach (1996) identified the difficulties of obtaining valid information on a phenomena such as drug use, an activity which is illegal, stigmatised and hidden. The following points summarise the difficulties encountered in the research:

1. The current system of data collection identifies heroin users presenting for treatment, therefore users who are not accessing treatment will not feature in this data.
2. The Drug Reporting System does not include waiting lists for these agencies.
3. Not all agencies take part in the drug reporting system.
4. Information obtained concerning illegal drug use is difficult to obtain and may be distorted and inaccurate.
5. Confidentiality creates a barrier for agencies that would otherwise engage in information sharing. Therefore, multiple counting may exist e.g. individuals may be presenting for treatment in more than one agency.
6. Drug users may be presenting to private GPs, which makes it difficult to estimate the numbers in treatment.
7. There is a criterion for acceptance to a methadone maintenance treatment clinic. Clients must be above 18yrs, been injecting heroin for at least a year. This policy acts as an exclusionary agent for users below the age limit and who have been using for a shorter period of time.
8. The report focuses upon dependent drug users, it is worth noting other categories of drug use such as recreational and experimental drug use. This is an important issue particularly in the area of preventative drug policy. As with any research, the closer we come to a topic the more areas we discover which beg further research.
9. The research focuses on heroin use, however decisions concerning the legal status of drugs are made at a governmental level. I feel that it would be negligent not to recognise the detrimental impact that 'legal' drugs such as alcohol and tobacco can have on the individual.
10. This report focuses on drug users in treatment as an indicator of the nature and extent of drug use in the Greater Blanchardstown area. However, individuals who are not presenting for treatment and are not stabilising in treatment may have very different experiences to recount and hence will have very different needs.
11. The 1990s have been a time of admission and recognition of a drug epidemic concentrated mainly in the Greater Dublin area. Given this recent acknowledgement of a drug epidemic, very little research has taken place in specific issues such as gender dimensions, parenting, fears of presenting for treatment etc.

[5] EIVICDDA (1993) *Inventory of E.C. (Legal) Texts on Drugs* Luxembourg: Office of Official Publications of the European Communities.

[6] Department of An Taoiseach (1996) *The First Report of the Ministerial Drugs Task Force on measures to Reduce the Demand for Drugs* Dublin: Official Publications

12. There are currently no longitudinal studies conducted examining why people initialise drug use in the first place, how attitudes changes, what factors influence a persons decision to take drugs.
13. The issue of homelessness acts as an impediment to data collection in this area as many drug users find themselves homeless at certain times in their lives. These individuals often remain unaccounted for in the drug using population.

The research (encountering the limitations of data collection) relies heavily on data collected in response to the administration of the OTI index. As mentioned earlier, the research took the approach of survey research through personal interviewing. In conducting the personal interview, the research adopted a compromising position between both schedule-structured and focussed interview form. In order to understand this compromise, it is necessary to look at the attributes of both interview styles. In scheduled interviews, the number of questions and the wording of the questions are identical for all of the respondents. In this style of interview, the interviewer should not reword questions or provide explanations of the questions if asked by respondent for clarification. In this way, the interviewer attempts to reduce the chances of the different wording in questions eliciting different responses. The schedule-structured interview is based on three critical assumptions:

1. In conducting research, the sample group has a common vocabulary, and therefore the composition of questions which are readily understandable to them should not pose a problem.
2. It should be possible to phrase all questions in a manner which is equally meaningful to each respondent.
3. The final assumption is based on the concept of identical meanings. Merton & Kendal et al (1946:541) clarify this assumption as being based in whether or not the "meaning of each question is to be identical for each respondent, its context must be identical and, since all preceding questions constitute part of the contexts, the sequence of questions must be identical."[7]

While the scheduled-structured interviews formed the basis of the interviews (see Appendix B). The research also employed certain aspects of the focussed interview, e.g. respondents were given considerable liberty in expressing their definition of a situation that is presented to them. The interviews focussed on the respondent's experience regarding the situations under study.

The ultimate aim of the research was the compilation of an overview of the numbers of drug users in treatment in the six Task Force areas. Therefore, survey research was seen as the most appropriate method for quantifying these figures. However given the nature of the

[7] Merton, R. & Kendal, P. (1946) "The Focussed Interview" in *American Journal of Sociology* 51 p541-557

problem under research, qualitative methods were seen as useful in investigating and exploring in depth the nature of the problem. In order to explore pathways into drug use, the research employed qualitative research through the use of topic guide. The interviews were held with six individuals from the Task Force areas. Hammersley believes that qualitative research may be one of the only ways to study 'deviant groups' (Hammersley, 1990:6).[8] Such groups are typically found on the margins of society. Jones (1985:48-9) identifies the merits of qualitative interviewing, claiming that in qualitative research "the notion of some kind of impersonal, machine like investigator is recognised as a chimera."[9]

Due to the confidential nature of the subject matter to be explored in these interviews we believe it was important to ensure all participants that absolute confidentiality was guaranteed. No participants' names or other identifying information will be available to anyone outside the study. Each participant was asked to sign a research consent form (see Appendix A) which was given to the interviewee and the interviewer kept a copy. It was felt that by actually formalising the confidentiality agreement on paper, the interviewees would feel more relaxed in disclosing information.

The research is based on a combination of both quantitative and qualitative research methods. However, once again, a note of caution must be exercised in that 'treated drug users' are not representative of the general drug using population. However the research does focus upon present activity and previous activity establishing causal relationships between factors which may be useful for service providers working in the field. Difficulties which participants have in coming off heroin are discussed in greater detail in the qualitative interviewing, pathways into substance use are also discussed. The role of friendship networks, criminal activity and demographic backgrounds in the lives of the respondents are discussed in great detail in the data analysis section.

[8] Hammersley, M. (1990) *Reading Ethnographic Research* London: Longman

CHAPTER FOUR

National Drugs Policy

"We seem lately to have entered a more enlightened time in that we have finally recognised that to be an addict is not necessarily a crime. We seem to handle the treatment and rehabilitation of the addict with a more positive medically oriented approach" (Julien,1975:120)[1]

Twenty years after Robert Julien identified these changes in attitude toward heroin addiction, Ireland is in the process of adopting a similar regulation. In response to an increase in awareness of the extent of problem drug use there has been an expansion of services and a range of new approaches to treatment largely influenced by the Department of Health (1991) *Government Strategy for the Prevention of Drug Misuse*[2] Loughran (1999:309) describes the 1990s as being "one of the most active phases in the Irish government's attempts to tackle the drugs issue. This is in contrast to the early years where political responses to the problem were at best reactive and at worst restrictive."[3]

Prior to 1979, serious drug abuse was little known in Irish society, it was confined to a small group of addicts whose supply of drugs was unorganised and constantly changing (O'Kelly and Bury et al 1988:35).[4] The problem of drug abuse in Ireland and particularly in Dublin, first became apparent in the mid 1960's with the emergence of sporadic instances of amphetamine abuse. The problem developed and intensified in the 1970's with a change to cannabis and lysergic acid diethylemide (LSD) as the most commonly misused drugs. Organised drug pushing did not exist. However in the seventies there was an increase in the non-medical use of synthetic opiates. Following the increase in availability in the United Kingdom and Europe, the drug scene in Ireland changed dramatically. The Department of Health (1991) note that the sudden movement towards heroin abuse in the early 1980's was matched by a steady increase in the numbers of persons, particularly young people known to be involved in drug taking. The report of the Task Force on Drug Abuse in the Eastern Health Board area (1982) included evidence from sources such as the National Drug Advisory and Treatment Centre, the Garda Drug Squad and General Practitioners. From this evidence, the Board concluded that there was a dramatic rise in the numbers of young people misusing drugs and that heroin was the predominant drug of misuse.

Research involving the analysis of the extent of the heroin epidemic in Ireland has been limited. Collection of statistical epidemiological data on treated drug misuse in Ireland

[1] Julien, R. (1975) *A Primer of Drug Action* San Francisco: W.H. Freeman & Company
[2] Department of Health (1991) *Government Strategy for the Prevention of Drug Misuse* Dublin; Official Publications
[3] Loughran, H.(1999) "Drugs Policy in the 1990s" in Quinn et al *Contemporary Irish Social Policy* Dublin: UCD Press

commenced with the participation of the Health Research Board in the multi-city study of the Pompidou group of the Council of Europe in 1984. For the past ten years, Ireland has participated in the epidemiological programme of the Pompidou group in the development, with other European countries, of a range of indications of drug abuse. Examples of this would include first treatment demand, hospital admissions, drug-related deaths, police arrests and seizures of illicit drugs.

Up to 1993, there had been no institutionalised monitoring of drugs and drug misuse within the European Union. Before that date the Pompidou group of the Council of Europe was the reference point outside of Ireland. In order to address this, the European Commission established the European Monitoring Centre on Drugs and Drug addiction which is based in Lisbon to provide member states with objective comparable information on drugs and drug addiction throughout the European Union. The EMCDDA (1993) recognises that the different rehabilitation programmes for drug users is essential to allow exchanges on the most effective forms of drug treatment between experts working within therapeutic communities.[5]

The mid to late 1980's saw a stabilisation in the heroin epidemic in Ireland. Indications of an increase in drug activity both in the country as a whole and in Dublin in particular have surfaced. The evidence can be seen in the increase of seizures for illicit drugs in the early 1990's. With the 1990 figure up by 48% on the previous year. Likewise statistics for the number of persons charged for drug offences in Ireland, (and most of these relate to Dublin) show a similar increase with a dramatic gain of 54% between 1989 and 1990. (EMCDDA, 1993:259) The Department of An Taoiseach (1996) was advised that there are serious levels of heroin abuse in the greater Dublin area, and in particular, in the inner city area. The best estimates available to the health service suggest that there are up to 8,000 heroin addicts in the greater Dublin area, 2,500 of whom need and are willing to go on methadone maintenance programmes. The Task Force feels however, that this figure would rise as services are developed. (Department of An Taoiseach, 1996:25) O'Higgins and O'Brien (1994) found that the proportion of clients presenting for treatment in 1993 had increased over the 1992 figure by 14%. Opiates remained the drug for which most of the clients sought treatment. O'Higgins and O'Brien found the number of teenagers using opium a cause for concern. They also found that 51% of all teenagers coming for treatment for the first time in 1993 had been misusing opiates.[6] O'Higgins and Duff (1997) in a first report on drug abuse in Ireland found that opiates continued to be the drug group for which clients in the Greater Dublin area sought treatment. When reference is made to opiates, the data showed that heroin was the most likely opiate to have been used. (O'Higgins and Duff,1997:82)[8]

[4] O'Kelly.F., Bury, G., Cullen, B. & dean, G. (1988) "The Rise and Fall of heroin Use in an Inner City Area of Dublin" in *Irish Journal of Medical Science* Vol 157 (2)

[5] EMCDDA (1993) *Inventory of E.C. (Legal) Texts on Drugs* Luxembourg: Office of Official Publications of the European Communities

[6] O'Higgins,K. & O'Brien, M. (1994) *Treated Drug Misuse in the Greater Dublin Area* Dublin: Health Research Board

[8] O'Higgins, K. & Duff, P.(1997) *Treated drug Misuse in Ireland. First National Report, 1995* Dublin: Health Research Board

Farrell (1996) looks at the incidence of AIDS as an indicator of the heroin epidemic in Ireland. Up until 1993, there had been 158 deaths from AIDS, 66 of whom had been injecting drug users, accounting for 42% of deaths from AIDS. By 1993, out of 1,375 who have tested positive, 712 were intravenous drug users, which amounts to 52%.

"It is clear that the problem of HIV and AIDS among the injecting drug using population has become the priority in responding to drug problems within the Irish and in particular within the Dublin setting"

(Farrell.M. 1996:72)[9]

In the late 1980's the National Drug Advice and Treatment Centre moved to Trinity court into purpose built facilities and expanded it's range of activities. The increased numbers of HIV intravenous drug users placed a strain on the centre which led to the establishment of a separate community based drug service. This service started as a low dose, harm reduction and methadone dispensing service but subsequently became established as a methadone maintenance service. The expansion of the service with satellite clinics followed off from ^the important 'National Aids Strategy Committee' report of 1992. The severity of the heroin epidemic and the ever increasing numbers of HIV intravenous drug users has forced methadone maintenance to the forefront of a social policy agenda dealing with drug abuse.

"Local community groups throughout the island of Ireland have identified local needs, taken the initiative and harnessed energies in a very vibrant way, but have then come up against a blockage in the established power structure. In essence, it is a question of attitude. If only those with power, and who wish to exercise it well, would listen and incorporate the experience of those who have first hand knowledge of the reality of the situation on the ground. The result would transform ideas of leadership and of decision making"

(Mary Robinson,1996)[10]

Cullen (1989,1994) looks at community responses to the treatment of drugs in Dublin. Cullen argues that the context in which the community drug problems are experienced in Dublin is one of increasing isolation whereby the community feel a very strong sense of powerlessness and 'institutional failure'. Cullen examines the role of the community forms of drug treatment and argues that because the emphasis was placed on 'abstinence' forms of treatment up to the late 1980's, this led to the view among community workers that there was only one form of treatment. Cullen claims that because this form of treatment became accepted as the predominant response to drug misuse, many community based workers became redundant in responding to drug problems.[11]

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[9] Farrell, M. (1996) *A Review of the Legislation, Regulation and Delivery of Methadone in Twelve Member States of the European Union, Final Report* Luxembourg Office for Official Publications of the European Communities

[10] Mary Robinson (1996) "Empowerment Through Partnership" Foreword in Harbor, B. Morris, P. & Mc Cormac, I. (eds) *Learning to Disagree - Peace and Economic Development in Ireland* Dublin: Unison & Impact

[11] Cullen, B. (1989) *Poverty, community & Development: A Report on the Issues of Social Policy* Dublin: Combat Poverty Agency

Cullen, B. (1994) *A Programme in the Making: A Review of the Community Development Programme* Dublin: Combat Poverty Agency

The 1990s however has seen a revitalisation in community response to drug addiction paralleled by a national interest in partnership approaches with the community, voluntary and statutory sectors. The representation of local people in the development of their community has permeated throughout Irish social policy and finds its basis in the concept of active citizenship which refers to the active role of people, communities and voluntary organisations in decision making which directly affects them (Department of Social Welfare 1997).

"We either address the major economic and social issues that underpin the problems of crime and drug abuse or we go the route of other countries and attempt to build a ring of steel around areas - keep a lid on it - contain it."

Fergus Me Cabe quoted in Loughran (1996:13)[12]

The establishment of Local Drugs Task Forces aimed at dealing with the implications and growth of drug use in an area is possibly one of the most exciting adventures in the area of Irish drug policy. The local Task Forces come within the parameters of the National Drug Strategy Initiative and are funded under the auspices of Mr Eoin Ryan, T.D. Minister for State for Local Development and with special responsibility for the National Drug Strategy. The Task Forces provide an opportunity for a partnership approach between the community, voluntary and statutory sector. The Local Drugs Task Forces represent a pragmatic and strategic response to drug use.

Apart from the key government departments and the influence of political parties, various interest groups attempt to have a voice in policy. The most significant of these has been the various attempts by local communities - specifically Community Action Against Drugs and inner city organisations – to draw attention to the plight of their communities. Communities are now finally being recognised as having a key role both in the provision of services at community level and also in the development of policies and anti-drug strategies. The Task Force response to drugs issues adopted in 1996 represents an innovative move towards an integrated multi-agency response.

[12] Loughran, H. (1996) "Interview with Fergus Mc Cabe" in *Irish Social Worker* 14 (3/4)

CHAPTER FIVE

Interview Analysis and Findings

Difficulties with data collection have been addressed in chapter three of this report. It is however imperative to draw attention to the factors which can prohibit prevalence on drug abuse. O'Higgins and Duff (1996:5) highlight the number of factors, which can lead to the underestimation of drug use; the report however has also identified the opportunities for double/multiple counting in the reporting system.[1] The non-inclusion of GPs, treatment within the prison service and resource issues in treatment centres has contributed to this situation. Given these factors, in its initial stages the research designed a method of counteracting this problem. When the data was returned the information was pooled in the database and cross tabs were run to try and avoid double counting. In interpreting the following data, a note of caution must be raised concerning the drug reporting system.

I

Social Factors Influencing Heroin Use in Ireland:

In assessing the Irish experience of heroin use, research studies have assumed a link between social conditions and the use of heroin and inevitably the effectiveness of methadone as a treatment option. The influence of socio-environmental conditions can act as a powerful influence in promoting the use of heroin and the treatment process i.e. peer relations, economic disadvantage, gender, age, sex, community responsiveness etc. Walters (1994:9) describes conditions as "features of the person, situation or person and situation that influence the probability of a future or concurrent behavioural outcome or event"[2]

Between the years 1979 and 1985, a study on the extent of heroin use in a Dublin south inner city electoral ward was conducted.[3] A total of 82 questionnaires were completed. Each respondent had a settled address in the ward during 1979 and 1985. All gave a history of heroin use which was validated for all respondents through medical records (see table 1)

[1] O'Higgins, K. & Duff, P. (1996) *Treated Drug Misuse in Ireland - 1st National Report* Dublin: Health Research Board
[2] Walters, G.D. (1994) *Drugs & Crime in Lifestyle Perspective.* California: Sage
[3] O'Kelly, F.D., Bury, G. Cullen, B. & Dean, G. (19880 "The Rise and Fall of Heroin Use In an Inner City Area of Dublin" in *Irish Journal of Medical Science* Vol 157 (2)

Table 1:

Current use of heroin by age and sex (for those living in the ward)

	10-14	15-24	25-29	30-34	Total
Male	4(4.4%)	32(10,7%)	3(1.9%)	0	39
Female	1 (1.0%)	5(1.6%)	0	0	6 **1979**
Total	5(2.7%)	37(6.1%)	3(1.1%	0	4
Male	1(1.1%)	41(13.7%)	8(5.2%)	1(1.0%)	51
Female	0	16(5.1%)	1(0.8%)	0	17 **1981**
Total	1 (0.5%)	57(9.3%)	9 (3.2%)	1(0.5%)	68
Male	0	27(9.0%)	14(9.1%)	2(2.1%)	43
Female	0	6(1.9%)	3(2.3%)	0	9 **1983**
Total	0	33(5.4%)	17(6.0%)	2(1.1%)	52
Male	0	8(2.7%)	5(3.2%)	4(4.2%)	17
Female	0	1(0.3%)	0	1(1.1%)	2 **1985**
Total	0	9(1.5%)	5(1.8%)	5(2.7%) 19	

The figures above represent the % of the population in that age group using heroin.

(Source: O'Kelly & Burry et al, 1988:37)

The extent of heroin use in the area was greatest in the 1979 to 1981 period and during this time it was concentrated in the under 25 age group, particularly males in the 15 to 19 year old age group (O'Kelly and Bury et al,1988). The Medico Social Research Board (1984) reported in the same period as the above studies that the most disturbing discovery to emerge from this study was the extraordinarily high incidence of heroin use among young people aged 15 to 24 living in local authority flat blocks as compared with that among those of the same age groups living in other types of housing in the same area.

Research conducted by Comiskey (1999) using the capture-recapture method of research would also suggest that the 15-24 year-old males are the group with the highest known and estimated prevalence [see table 2]. These finding were also supported in the findings of this research.[4]

[4] Comiskey, C.M. (1999) *Estimating the Prevalence of Opiate Drug Use in Dublin, Ireland During 1996*. Dublin: Department of Health & Children

Bradshaw et al (1984) conducted a study in response to previous research, which was carried out in the North-Central Dublin area. (Dean et al, 1983) In assessing the characteristics of heroin misusers, Bradshaw et al undertook a control group of persons who had never taken heroin, resident in the same area and matched for age and sex. The study claimed striking differences between the control group and the heroin misusers who took part in the 1983 study.[5] The results of the Bradshaw et al study have established a corresponding link between social disadvantage and drug misuse. Waiters (1994:15) claims that "few people would take issue with the inference that impoverished urban areas suffer much higher rates of crime and drug abuse than most suburban middle class areas."

[5] Compared with the control group, the heroin users socialised much less, were markedly less influenced by family and more by drugs, had a much poorer education and employment record, were more likely to be unemployed, were more likely to smoke and smoke heavily, less likely to drink but more liable to have a drinking problem in their families; were much more likely to have been arrested for a variety of offences and were more likely to have lost one or both parents through death. (Dean et al, 1983;2)

Table 2:

Minimum Prevalence estimates of opiate use among males ages 15-24 by location of residence

Postal Code	Cases Identified	Population Census	Minimum Prevalence – Multisource Enumeration	Estimated Prevalence- Capture Recapture**
Dublin 1	**183**	**2,880**	**63.5/1000**	**148.6/1000**
Dublin 2	**52**	**1,941**	**26.8/1000**	
Dublin 3	**24**	**2,479**	**9.7/1000**	
Dublin 4	**34**	**2,612**	**13/1000**	
Dublin 5	**77**	**4,379**	**17.6/1000**	
Dublin 6	**15**	**6,603**	**2.3/1000**	
Dublin 7	**177**	**3,557**	**49.8/1000**	**175.7/1000**
Dublin 8	**293**	**2,738**	**107/1000 '**	
Dublin 9	**20**	**5,823**	**3.5/1000**	
Dublin 10	**92**	**1,964**	**33.6/1000**	
Dublin 11	**151**	**1,335**	**25.9/1000**	**48.4/1000**
Dublin 12	**98**	**3,909**	**49.9/1000**	
Dublin 13	**10**	**4,804**	**7.5/1000**	
Dublin 14	**44**	**5,145**	**11.3/1000**	
Dublin 15	**115**	**1,712**	**23.9/1000**	
Dublin 16	**19**	**2,132**	**3.7/1000**	
Dublin 17	**37**	**1,293**	**21.6/1000**	
Dublin 18	**1**	**3,885**	**0.5/1000**	
Dublin 20	**3**	**8,241**	**2.3/1000**	
Dublin 22	**195**	**75,879**	**50.2/1000**	
Dublin 24	**217**		**26.3/1000**	
Total	**1,857**		**24.5/1000**	

****Estimates where overlaps are sufficient**

(Commiskey, 1999:17)

The influence of family and peer relations has been identified as a causal factor in the use of drugs by young adolescents. Walters (1994:17) has argued that families of substance abusers are often the recipients of minimal amounts of state support and are beset with

frequent interpersonal conflict.[6] This research claims that the pressures associated with social disadvantage is a primary influence of heroin misuse. The research also contends that the way in which a family and community respond to drug addiction is an integral part of the recovery process. This is supported by Murphy Lawless et al (1999:81) who argues that the prevention of heroin use will be achieved by providing a sense of empowerment and self esteem for young people and their community.

Peer relations have been seen as a powerful predictor of adolescent drug use.(Walters, 1994, McGrath & Scarpitti,1970)[7] this relationship is based on the premise that "If one has sufficient reason for behaving in a certain way, reasons which he receives from and has re-enforced by the people with whom he interacts and identifies, then he will probably move in that direction" (McGrath & Scarpitti, 1970:8). It is important in delivering a treatment response to drug addiction that sufficient counselling treatments are provided to assist the addict in dealing with peer and family pressures.

[6] Research conducted by 'Murphy lawless et al (1999:81) concludes that the large numbers of heroin users from the prevalence study from Dublin 1 is directly related to how a heroin sub culture has flourished in an area which has been gutted by economic restructuring.

[7] Walters, G.D. (1994) Drugs & *Crime in Lifestyle Perspective.* California: Sage Me Grath, J. H. & Scarpatti, F.R. (1970) *Youth & drugs: Perspectives on Social Problems.* USA: Scott, Foresman & Co.

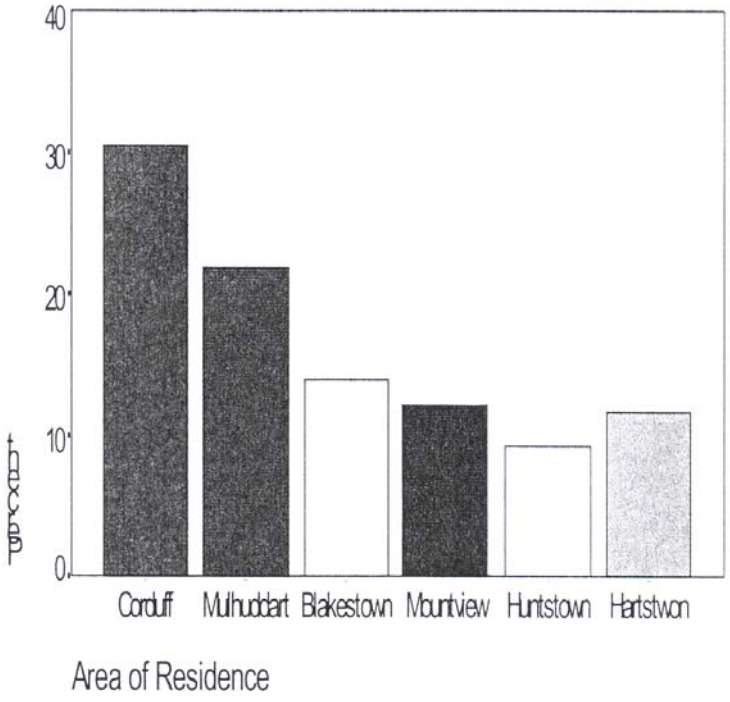
II

Blanchardstown - Socio-Demographic Profile:

The table below details the area of residence of the respondents. From the table, it can be seen that a little over 30.5% of the respondents came from the Corduff area with almost 22% coming from Mulhuddart. 14.1% and 12.5% came from the Blakestown and Mountview areas respectively. 9.4% came from Huntstown and 11.7% came from the Hartstown area. When analysing the data, it must be remembered that both the Corduff and Mulhuddart areas both have satellite clinics which makes it possible to make contact with the clients.

Table 3:

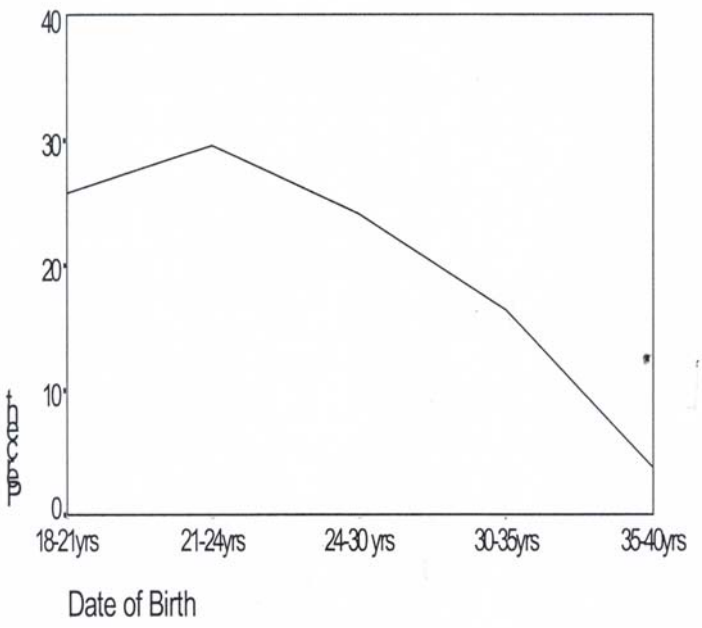
Respondent's Area of Residence



The Following table illustrates the age of the respondents interviewed in this study. From the table it can be seen that just over 25% of the sample are coming from the 18-21yrs age group and the majority of the sample came from the 21-24 yrs age group. The figures for the Greater Blanchardstown area support the results reported by Comiskey in 1999. A surprising figure however is the numbers of drug users in the 30-35 yrs age band (16.4%) this profile would be quiet unique to the Greater Blanchardstown area. Several of this category of users came from the Corduff area which is one of the earlier Local Authority estates developed in the area.

Table 4:

Age Profile



Studies by the Health Research Board have consistently pointed to the age profile of 15-24yrs and the Department of An Taoiseach (1996) concluded that:

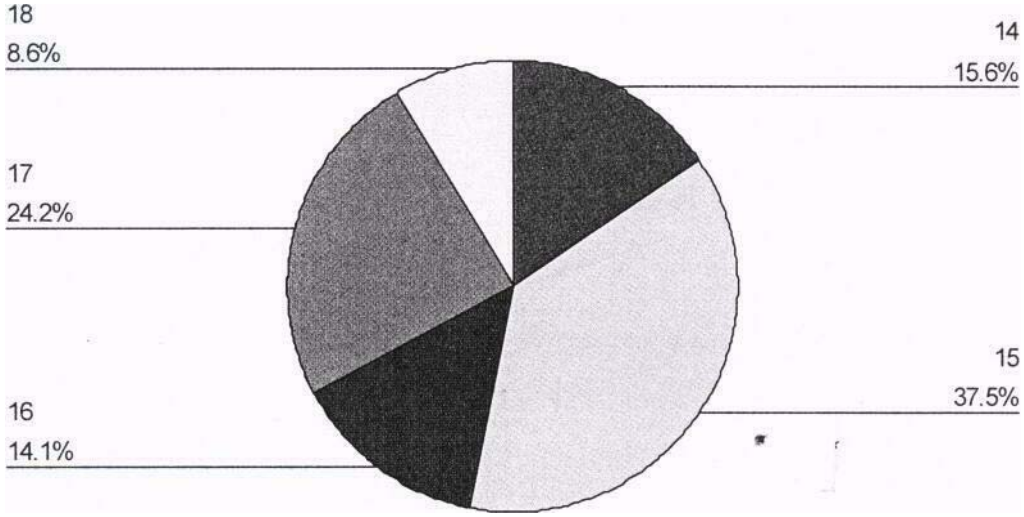
"the typical heroin addict presenting for treatment is male, in his mid-twenties and living at home with some level of secondary education. He is out of work and first used heroin at age around 15 to 19 and was taking heroin at least once a day"

In terms of the age profile, the six Task Force areas confirmed the profile given for the Greater Dublin area. Interestingly however we can find that the individuals interviewed reported having remained in secondary school for a long period of time {see table 4]

The pie chart (Table 5) illustrates the age at which respondents left the educational system at. It can be seen from the data that a large proportion (almost 37.5%) left the education system at the age of fifteen. This does not necessarily mean that they completed their Inter/Junior certificate exams (see table 6).

Table 5:

Age Respondents Left School



The chart above shows a high number of respondents left the education system at the age of 15yrs and just over 24% left school at 17 yrs of age. These findings have direct implications both in terms of educational policy and preventative education strategies in schools.

Presently, the Irish educational system has no guidelines for teaching staff in relation to discovery of drug use amongst students. Throughout the course of the research, there has been several questions posed surrounding the role of teachers and what to do when one discovers a student is using drugs. Not all schools have full time counsellors present in the event of a discovery and technically it is illegal for teachers to take drugs off students as they will be deemed as 'in possession' of drugs.

Drug users are by nature manipulative and resourceful people. They can continue on for years without disclosing their drug habit. This is the case in both schools and the family home. While the Department of Education has made steps toward implementing drug awareness programmes in schools, it is imperative that teachers are given the training and support to deal with situations concerning drugs as they arise.

Table six displays the percentage of respondents who received qualifications. The table shows that 4.7% of those interviewed went on to third level (6 respondents). However none of those interviewed remained to complete their qualification.

Educational Qualifications of Respondents

	Frequency	Percent
Inter/Junior Cert	**46**	**35.9**
Leaving Cert	**14**	**10.9**
Third Level	**6**	**4.7**
FAS	**4**	**3.1**
PLC	**19**	**14.8**
No Qualification	**23**	**18.0**
Youthreach	**16**	**12.5**
Total	**128**	**100.0**

The high educational standard of the respondents documented in the above table recreates hope for individuals working in the area of drug prevention. One of the single "greatest problems facing drug prevention was accessing individuals at risk as they tended to leave the educational system early.

Table seven shows the respondent's rating of their attendence at school. The majority of the sample 54.7% described their attendance as 'fair', 20.3% described their attendance as good and 19.5% saw their attendance as being poor.

Table 7:

Rating of Attendance at School

	Frequency	Percent
Poor	**25**	**19.5**
Fair	**70**	**54.7**
Good	**26**	**20.3**
Very Good	**7**	**5.5**
Total	**128**	**100.0**

The table raises two issues in terms of drug prevention. Firstly, how do we attract the 19.5% to attend school. Secondly, the optimistic figures of 54.7% and 20.3% who described their attendance as poor. Education prevention must be specifically geared towards young people on the basis of age and experience. In the early stages of the research, while conducting an interview with a cohabiting couple who were both using drugs, the following emerged;[2]

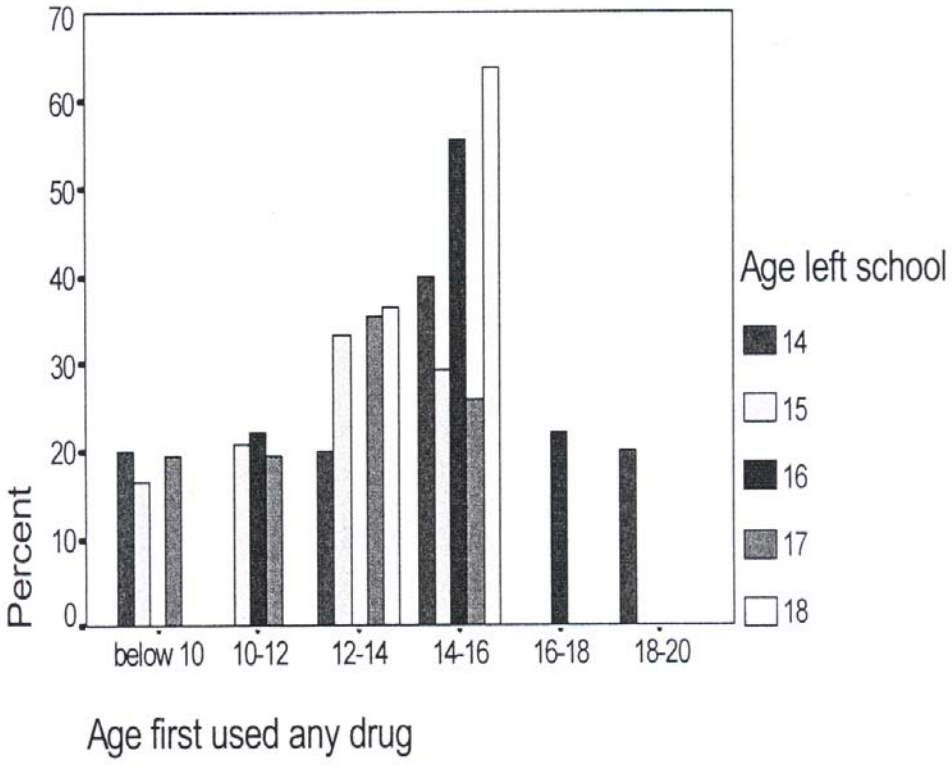
[2] Name is changed to protect identity of the family.

"One day two years ago when Mikey was only five [I was clean at the time], he came running into the T.V. room and shouted at me to come quick that 'Daddy had the tin foil out again'. He knew exactly what that meant and that really shocked me cause when I was using gear, I thought that he hadn't a clue what was going on. It really surprised us and made us feel guilty"

In designing preventative education measures, professionals must be aware that even a five year-old may actually know as much or more than them about drugs through their personal experiences. While professional are constantly aware of respecting the age and the innocence of young people and children, the reality is that they may be living the experience of drugs every day vis a vis themselves, their family or their community.

Table 8:

Age Respondents Left school and the Aye they First Used Drugs



The above table draws the corresponding relationship between the age people left the education system and the age that they first used any drug. The most striking aspect of this data is the age that respondents started drugs and their ability to remain in the education system. The data does not represent the age that individuals developed problematic drug use.

Table 9:

Level of Understanding of the Effects of Drug Use

Variable	Frequency	Percent
Understood some effects	21	16.4
Poor understanding	45	35.2
Understood almost nothing	62	48.4
Understood everything	128	100.0
Total		

The table above re-endorses the need for further drug awareness programmes as 35.2% claim to have had a poor understanding of drugs while 48.4% claim to have understood almost nothing. In looking at the above data, it must be remembered that the research focussed upon dependent drug use. Therefore, gives the many innovative drug awareness education programmes which have been introduced in the 1990s, many of the' individuals interviewed may not have been exposed to these programmes.

Domestic Circumstances:

The following tables offer an overview of the domestic and living arrangements of the respondents. The data raises interesting questions for the area both in terms of housing policy and support services for families in the communities.

Tablel0:

Marital Status of Respondents:

Variable	Frequency	Percent
Married	12	9.4
Single	76	59.4
Co-habiting	40	31.3
Total	128	100.0

A large proportion of the respondents are cohabiting with their partner (31.3%). The majority of respondents are single (59.4%) and 9.4% are married, the data cannot make firm conclusions around the number of lives affected by substance abuse.

Table 11:

Domestic Arrangements

Variable	Frequency	Percent
Living with parents	60	46.9
Living with spouse/partner	52	40.6
Living alone	11	8.6
Living with other	5	3.9
Total	128	100.0

If nearly 50% are living with their parents, there is a likelihood that there are siblings in the home also. Given this information and the stress that drug use evokes on the family, the need for support services for families becomes very apparent. Currently there are three parents support groups in the area - Corduff, Mulhuddart and Blakestown. A siblings group is currently being developed in the Blakestown/Mountview areas. These findings dictate the need for more service provision in this area. The family forms an important part of the socialisation and development process for children and they often take their older Brothers/Sisters as a role model. Alternatively, as parents become consumed with the needs of their drug-using child, often the needs of the siblings are neglected.

The research did not question users about the numbers of siblings in their family. It did however address the numbers of dependent children they have (i.e. the numbers of children that they are supporting and are actively involved in parenting). Table 10 illustrates the findings from the interviews.

Table 12:

Number of Dependants

Variable	Frequency	Percent
None	56	43.8
Adult &one child dependent	12	9.4
Adult & two/more child dependants	6	4.7
One child dependant only	32	25.0
Two or more child dependants	22	17.2
Total	128	100.0

Of those interviewed, 25% had one child dependant, 9.4% were supporting an adult and one child, 4.7% had both an adult and two or more child dependants and over 17% had two or more child dependants. Dorman and Jones (1999) in a survey of 94 drug users presenting for treatment found that having babies could improve people's opportunity of leaving the drug career.[8]

The Ana Liffey Drug Project (Annual Report 1997:18) identifies the need for support for drug using parents. The report focuses specifically on gaps in Irish drug policy.

"Child care services which have developed out of the provisions of the Child Care Act (1991) tend towards dealing with cases of reported sexual abuse or non-accidental injury. Children not at risk in these categories or who do not display outward signs of neglect through physical health; dress or demeanour may not come into contact with mainstream social work services. Moreover, as these services are biased towards crisis intervention, they are not in a position to engage in preventative action, which offset the need for care interventions downstream. The Child Care Act places a statutory obligation on health boards under section 3.1 to identify children at risk and to promote the welfare of those children in its geographical area who are not in receipt of adequate care and protection. While the physical needs of the children are not necessarily immediate, their emotional and developmental needs in the face of adversity may not be met without adequate intervention"

The Ana Liffey Project points to factors, which may lead to neglect of children:

- Being exposed to drug use of their parents
- Having a parent who is a member of a HIV high-risk group and the possibility of parental bereavement.
- Having a parent whom while being able to provide for basic needs (food, shelter, and clothing) may not themselves be in a position to provide for the emotional and developmental needs. This places a serious disadvantage on the children in social and educational terms.

Irish Child care policy recognises the importance of children remaining in the family home. While this is an aspiration, it is important to ensure that parents are equipped with the appropriate support and skills to maintain the child safely (both emotionally and physically).

Recent research conducted by Moran (1999) also points to the need for childcare facilities in the area of drug treatment. Moran identifies the need for childcare relating to the following issues.

- equality of access for treatment for parents
- quality of treatment
- quality of working life for staff in treatment centres
- emotional and educational development of children of drug misusers.

[8] Dorman, P. & Jones, L. (1999) quoted in Irish Times 13th September 1999

Moran goes on to recommend the need for both drop-in creches and full day centres which would enable drug misusers to access more intensive treatment, training and participation in the work force.[9]

Housing:

Table 13:

Housing Type

Variable	Frequency	Percent
Owner Occupier	30	23.4
Private Rented	19	14.8
Local Authority	79	61.7
Total	128	100.0

Table 13 categorises the respondents by the their housing type. The majority of those interviewed were living in Local Authority housing (61.7%). Drugs policy in the 1990s has moved towards the recognition of the drug problem as being both individual and social in nature. The Housing (Miscellaneous Provision) Act 1997, reflects this move. The Task Force reports of 1996 and 1997 affirm the need for estate management. Communities had identified that the presence of drug users and more particularly, drug dealers in their areas was aggravating the situation. The initiatives introduced included:

- Tenant Participation in managing estates.
- Information to tenants on the responsibilities and duties of both local authorities and tenants.
- Legislative proposals to combat anti-social behaviour in local Authority housing.

This legislation could be seen as a rushed measure to stem drug related anti-social behaviour in the wake of the Veronica Guerin murder with very little detail given to the definition of antisocial behaviour. When respondents were questioned, some recounted stories of intimidation they had experienced empowered by the introduction of this legislation. Loughran (1999:325) warns of the detrimental impact of such legislation on the lives of drug users:

"The impact of these developments on some drug users should be considered. In a conference held in June 1998, professionals working in the field of drug use claimed that the most difficult problem now being experienced by drug users attempting to come off drugs or to stabilise their life styles was homelessness (Conference on Pilot Drug Project, Community Care Area 5, Dublin 1998) This escalation in their housing problems was reiterated at the launch of the Merchants Quay Annual Report in July 1998. Removing drug users from

[9] Moran, R. (1999) *The Availability and Evauation of the Provision of Creche Facilities in Association with Drug Treatment.* Dublin: Health Research Board

communities is an attractive measure, but in the overall resolution of the problem, it will in fact create serious difficulties for users attempting to address their problems and also for services trying to attract current users. If users become homeless it exacerbates the chaos in their lives and at a fundamental level makes it even more difficult to keep track of, or to estimate, the numbers involved".[10]

Estate management is a simple answer to a complex problem and can lead to the further social exclusion of individuals from both families and the community.

Peer Pressure:

Research has consistently pointed to the important role of peer relationships in drug use. The following table offers details of the friends of respondents who were drug users.

Table 14:

***Numbers of Friends Using* Drugs**

Variable	Frequency	Percent
None	58	45.3
One	13	10.2
Two	16	12.5
Three	10	7.8
Four/more	31	24.2
Total	128	100.0

Research has consistently pointed to the importance of peer relations in the lives of the adolescent. Glassner and Loughlin (1987:146) point to the tendency of adolescents to use the "notion of peer pressure to explain their behaviour and that their friends, and they alter their behaviour in recognition of their understanding of how peer pressure operates." The data illustrates 45.3% of the respondents are not friends with other drug users. Most of those interviewed (all are in treatment) expressed the desire to abandon the drug culture. One respondent who had recently completed a detoxification programme claimed that;

"When you decide to give up gear, it's really lonely because I don't have any friends any more. The last time I came out, I thought that I could still be mates with them but it didn't take me long to start back on the gear. This time it's different, I know that they just want me to score with. It's really hard, I don't know why I came back."

[10] Loughran, H. (1999) "Drugs Policy" in the 1990s" in Kiely et al *Contemporary Irish Social Policy.* Dublin: UCD Press

In looking at paths into drug use, the peer relationship came out as an influential factor in first experimenting with drugs.

One respondent describes his first experience of trying heroin when he was fourteen. His first experimentation with the drug was with other people and he:

"Hadn't got a clue about it and, to be honest with you, I first skin popped it. Most people smoke it first -1 started skin-popping because I hadn't got a clue. All my friends started doing it too. We would meet regularly with a 'bag of works' and then cook it up."

Another respondent describes how she was led into heroin use through her boyfriend at the time.

We would head off to raves all the time and we'd just use 'E', then Jimmy started using 'gear' to come down off the 'E' . He started injecting, I never did! But I started smoking gear. People don't think that you can really get addicted if you smoke it but you can. I wanted to go into treatment a few years ago but I found it hard to get in to places [there was no local clinics at the time]. I had just finished with Jimmy but he had got onto a programme in town, so I started 'shooting up' to get into a detox quicker and I did!"

The above respondent has been on two detoxification programmes and one methadone programme. She has now successfully detoxified off both heroin and methadone. From her experience, it is clear that the influence of her boyfriend [Jimmy] was paramount both in commencing heroin smoking and making the transition to injecting. Peer education plays an important role in the respondents decisions to use drugs, many respondents reported the important role of their friends as both a pathway into drug use and in determining the way in which they use drugs. There is currently one peer education programme running in the Corduff area of Blanchardstown with the aim of using peer influence as a tool in drug prevention.

Table 15:

Reason for First Using Drugs

Variable	Frequency	Percent
Feeling stressed	8	6.3
Had a lot of problems	13	10.2
Curious	44	34.4
Wanted to feel high	11	8.6
Peer pressure	52	40.6
Total	128	100.0

Table 15 looks at the paths into substance abuse. Over 40% claimed to have tried drugs as a result of peer pressure. Only 6.3% admitted to trying drugs as result of problems. In any

survey research, it is important to exercise caution when reporting data. While the majority of respondents identified peer pressure and curiosity as the reason for their first experimental drug use. This is not necessarily the reason why they continue to use drugs and progress towards more harmful and addictive substances. Many teenagers experiment with drugs but do not progress beyond recreational or experimental drug use.

Employment:

From the following table, you will see that a significant proportion of those interviewed, 18% are currently employed with 18.8% working part-time. This is quite unique to the stereotypical drug user. However, a report conducted by Doorman and Jones (1999) supports the view that drug users in treatment returning to work have greater chances of rehabilitation.

Table 16:

Working Conditions

Variable	Frequency	Percent
Working full-time	23	18.0
Working part-time	24	18.8
Currently unemployed	81	63.3
Total	128	100.0

However, as the above table suggests 63.3% remain unemployed. If we take this figure in light of recent labour force statistics for 1999, we can see the stark contrast between the unemployment rate for drug users and the average unemployment rate for Dublin. If we look at the international Labour Office (ILO) statistics for June - August 1998, the unemployment rate for Dublin is 4.5%. This rate refers to those who are unemployed and actively seeking work. If we refer to the Principle Economic Status (PES) rate for March - June 1999, the unemployment rate for Dublin is 6.9%. The Principle Economic Status refers to how people define themselves, i.e. unemployed; they may not necessarily be seeking employment. The PES is possibly the most likely rate to contrast our figures with, as many drug users are not actively seeking work due to their addiction. Whatever figure we choose to employ in contrast to our 63.3% unemployed, unemployed becomes an indisputable element of drug use.

Table 17:

Working Conditions in the Last Six Months

Variable	Frequency	Percent
All of the time	34	26.6
Most of the time	33	25.8
Half of the time	15	11.7
Some of the time	22	17.2
None of the time	24	18.8
Total	128	100.0

The above table which asks people how much of the last six months they were unemployed shows that only 26.6% spent all of the last six months unemployed which is considerably less than the 63.3% unemployed in table 16. These figures would suggest that while drug users are more likely to experience unemployment, the main difficulty experienced is not actually acquiring a job but acquiring sustainable long-term employment. While the research did not investigate the nature of this unemployment, i.e. is it short-term contract employment, the likelihood is that drug users are finding long term employment an increasing difficulty in a challenging meritocracy.

An interesting question arises when looking at unemployment and drugs. The 1990s have witnessed a time of recognition of the link between poverty and drugs. Therefore identifying the multi-dimensional nature of the factors influencing drugs, however the relationship between unemployment and drugs can be addressed in two ways. Firstly, does unemployment lead to drug use and secondly does drug use cause unemployment. The answer to both of these questions could be 'yes'. Zinberg (1984) identifies that lack of valued life commitments such as employment that makes a stable form of recreational drug use less likely. Zinberg's findings concluded that unemployment precedes drug abuse and not the opposite.[11] While unemployment is likely to precede drug use, sustainable long-term work is difficult to achieve while misusing drugs.

[11] Zinberg, N. (1984) *Drug Set & Setting: the Basis for Controlled Intoxicant Use*. New Haven; Yale University

III
Treatment History

The following information is concerned with the respondent's treatment history. From the table below, it can be seen that data presented in this report is compiled from clients who are presenting for treatment.

Table 18:

Respondents Currently Attending Treatment

Variable	Frequency	Percent
Yes	128	100.0

The treatments named include methadone maintenance, detoxification, counselling, therapeutic communities and Narcotics Anonymous. When asked how they were referred to treatment, a large number of respondents claimed to have referred themselves (37.5%) [See Table 19]

Table 19:

Referral to Treatment

Variable	Frequency	Percent
Self	48	37.5
Family	31	24.2
Partner	12	9.4
Courts	4	3.1
Friends	12	9.4
GP	21	16.4
Total	128	100.0

Table 20:

Variable	Frequency	Percent
Less than a year	26	20.3
Over a one year	56	43.8
Over two years	29	22.7
Over five years	17	13.3
Total	128	100.0

From the above table it can be seen that the majority of those interviewed (43.8%) have been in their current treatment for over one-year. 13.3% have been in treatment for over five years. The data above represents the type of treatment respondents have been receiving, which may not necessarily be in the same treatment, centre. For example, people may have changed from a treatment centre in town to local satellite centres.

Table 21:

Previous Treatment History

Variable	Frequency	Percent
Not in treatment	41	32.0
Methadone	11	8.6
Detoxification	70	54.7
Therapeutic Community	6	4,7
Total	128	100.0

The majority of those interviewed had undergone previous detoxification programmes (54.7%) while 32% had never been in treatment prior to the treatment they are undertaking. Regardless of the type of treatment previously undertaken, respondents expressed concern at the big challenge they felt faced them leaving any treatment programme both in the past and presently. A respondent summarises this anguish as she describes her experience of leaving detoxification programme three years previously:

"When I came out of the short-term detox, I felt OK, I really thought that it was the end of the 'drugs-me' relationship. When I came home I didn't know what to be doing with myself. A friend suggested going to a support group. I went once and it was great, but a few days later, I was back on the stuff and I felt too guilty to go back near them. I wish I had."

Another respondent describes their experience of a methadone maintenance programme:

"I left the programme nearly a year ago. My script was being reduced cause I was giving dirties [urine] so then I just left and said that I didn't need it anymore. After that I tried to give up but I went straight back on gear, I ended up back on methadone but I haven't given any dirties in over three months. I'm going to try and cut down on my doses and look to being clean in a few months. I'm working now so I think this is a good time cause it's becoming harder to get to the clinic each week.

The interviews identified the challenge of not only giving up the drug of dependence but also the difficulty in maintaining a drug free lifestyle regardless of the treatment history. While the data in figure 21 suggests that the majority of those interviewed had been in detoxification programmes rather than methadone maintenance, this does not hold any meaningful suggestion concerning the success rate of detoxification as a treatment. It does however reflect the short-term nature of detoxification programmes as opposed to methadone maintenance.

IV

Current Patterns of Drug Use

The Following tables from 22 - 32 illustrate the respondent's answers to the question of whether or not they had been using any of the following drugs in the last month. The research was concerned with the following drugs - heroin, opiates, alcohol, hash, speed, cocaine, benzodiazepine, barbiturates, hallucinogens, inhalants, tobacco.

The following questions on drug use can be described as a sensitive area in the interview process. However each respondent received a contract of confidentiality from the interviewer, which may have acted towards alleviating this problem. It should also be noted that all respondents were met at least once before the interview, where the aims of the research were explained. This process while time consuming, led to a greater depth and honesty in the answers received.

Table 22:

Use of Heroin in Last Month

Variable	Frequency	Percent
Yes	40	31.2
No	88	68.8
Total	128	100.0

From the above table, it can be seen that 31.3% of the respondents in treatment were using heroin in the last month. When asked about the pattern of this use, the majority of respondents were using occasionally rather than on a regular basis.

Table 23:

Use of Other Opiates in Last Month

Variable	Frequency	Percent
Yes	40	31.2
No	88	68.8
Total	128	100.0

The above table illustrates the percentage of those using other opiates. Only 7.8% reported using other opiates. When asked about other opiates, respondents were reminded that this did not include legally prescribed methadone.

Table 24:

Alcohol Consumption

Variable	Frequency	Percent
Yes	96	75.0
No	32	25.0
Total	100.0	100.0

The issue of alcohol consumption was interesting in this research. 75% of those interviewed admitted to using alcohol in the last month. Professional working in the area of addiction have expressed concerns around cross addictions. However when respondents were questioned about their patterns of alcohol use, none of the 128 people interviewed indicated any regular patterns of alcohol use. Interviewees identified an increase in their alcohol consumption since commencing on methadone maintenance treatment, however many respondents identified a change in lifestyle patterns as an explanation. An explanation commonly encountered in the course of this research is the transition for some into employment, where frequenting a local pub at least once a week after work becomes part of the working culture. Others argued that when they were using drugs heavily, they did not use alcohol.

Table 25:

Use of Hash

Variable	Frequency	Percent
Yes	102	79.7
No	26	20.3
Total	100.0	100.0

Table 25 shows the high numbers of those interviewed using hash (79.7). When looking at patterns of drug use, hash was being used regularly, often daily. In looking at the respondent's perception of drug use, hash was seen almost within the same parameters as

tobacco. It was used regularly for enjoyment and was not seen as problematic to the user despite the fact that it is an illegal substance.

Table 26:

Use of Speed

Variable	Frequency	Percent
Yes	8	6.3
No	120	93.8
Total	128	100.0

From the interviews carried out speed did not feature as a popular drug of use. Only 6.3% reported the use of speed.

Table 27:

Use of Cocaine

Variable	Frequency	Percent
Yes	12	9.4
No	116	90.6
Total	128	100.0

Table 27 documents the use of cocaine in the last month. Only 9.4% reported to have used cocaine. Contradictory reports concerning the popularity of cocaine were reported in the course of the interviews. Many said that it would not be a favoured drug but that they would use it if they could not get heroin.

This is interesting in that cocaine produces very different effects to heroin. Cocaine can produce a surge in energy, a feeling of intense pleasure, and increased confidence. The effect of powder cocaine lasts about twenty minutes, while the effects of 'crack' last about twelve minutes. Heavy use of cocaine may produce hallucinations, paranoia, aggression, insomnia and depression. Regular users may appear nervous, excitable, paranoid and exhausted due to lack of sleep.

The figures in table 27 illustrate a small number using cocaine or crack. The interesting thing about crack cocaine is that it may appear in an area for a short period of time and then disappear which may explain the low levels of reported crack addiction. However from the

above statistics it can be seen that 12 respondents out of 128 reported use of crack/cocaine in the last month. This is important as service provision for cocaine and crack users must be prompt.

If crack hits a community, there tends to be a parallel effect of an increase in heroin use. Clients will use heroin to come back down from crack. An example of this can be seen amongst the Black community in England, who are generally not attracted to heroin. Presently, there is a significant increase in the number of Black people using heroin to counteract the effect of crashing from crack. When crack hits a community there is a corresponding increase in criminal activity. It is very difficult to pinpoint an area or house where crack is dealt due to the quick manner in which crack is dealt. This makes it very difficult for communities and authorities to gather evidence against a dealer.

It is important that continued research into the prevalence of any particular drug use is conducted on a regular basis in order to monitor the situation and employ prompt intervention.

Table 28:

Use of Benzodiazepine

Variable	Frequency	Percent
Yes	86	67.2
No	42	32.8
Total	128	100.0

An alarming finding from the research is the use of benzodiazepines and prescribed medications. From the above table, it can be seen that 67.2% reported benzodiazepine use in that last month. In tables 32 and 36, benzodiazepine use features in respondent's description of both primary and secondary drugs of use. When asked about their patterns of use, this category of drug was being used daily on a regular basis. Clients in treatment are often prescribed benzodiazepines as part of their treatment. However given that respondents were using anything from three to thirteen tablets per day and reported the purchasing of many of these through the black market, this drug features strongly when looking at problematic use. This research would recommend the introduction of a protocol on benzodiazepine prescribing. Referring to this issue, Dr Ide Delargy (National GP co-ordinator) is quoted in the Irish Times as saying that one of the most important steps which had to be taken now was to stop benzodiazepine prescribing, the prescribing of sleeping pills and other tranquillisers. Delargy goes on to urge extreme caution in this area arguing that "they should not be given without proper medical assessment from a person experienced in addiction.

This is because the potential for abuse with them and the potential for destabilising a patient who is on methadone is enormous."[12]

Table 29:

Use of Barbiturates

Variable	Frequency	Percent
Yes	8	6.2
No	120	93.8
Total	128	100.0

Table 29 refers to the use of arbiturates, which did not feature very strongly in interviews. 6.3% claimed to have used barbiturates in the last month.

Table 30:

Use of Hallucinociens

Variable	Frequency	Percent
Yes	0	0.0
No	128	128.0
Total	128	100.0

Only 3.9% of respondents claimed to have used hallucinogens in the previous month. While this is a small percentage. When looking at pathways into drug use, hallucinogens would have featured quiet strongly. Many respondents described their transition from ecstasy to heroin, using heroin to come down off 'E'. While these figures would suggest that hallucinogens are not problematic in Blanchardstown, it must be noted that they are not popular amongst this client group. If research was conducted in to recreational and experimental phases of drug use, the results may be very different.

Table 31:

Use of Inhalants

Variable	Frequency	Percent
Yes	8	6.2
No	120	93.8
Total	128	100.0

The report has included the above table although no respondents admitted use of inhalants in the last month prior to interview. Once again, as in the case of hallucinogens, it should be

[12] "Time to Declare War on Over Prescribing" in Irish Times, September 13th 1999

noted that although respondents may not be using inhalants at this point, they would have played an important role in their early phases of experimental drug use. When respondents were asked about inhalants, they tended to laugh or scoff at the fact that they were being asked. Responses such as "you must be joking", "haven't used them in years" or "years ago but definitely not in the last month" were common in the interviews. The subject of inhalants highlighted a theme, which emerged within the course of this research - the hierarchy of drugs. After interviewing 128 individuals presenting for treatment, it became very apparent that within this drug culture there exists a hierarchy of drugs. Once respondents had reached intravenous drug use, they had reached the pinnacle of this hierarchy. Inhalants and hallucinogens, often seen as the 'norm' in early drug use become unacceptable in this hierarchy. Once again, this research urges caution in the interpretation of these findings, while inhalents do not feature strongly in the patterns of drug use of the respondents, they are often the first step for young people into drugs and must therefore remain a priority in preventative drug strategies.

Table 32:

Use of Tobacco

Variable	Frequency	Percent
Yes	93	72.7
No	35	27.3
Total	128	100.0

Tobacco featured very strongly amongst the 128 persons interviewed with 72.7% smoking in the previous month. When looking at patterns of smoking, respondents were smoking on a regular basis but did not view tobacco as a drug.

V

Patterns of Behaviour & Risk

The following data refers to respondent's primary drug of use and secondary drug f use. The tables will illustrate the route of administration involved both presently and prior to treatment. It is hoped that this data will illustrate the need for further harm reduction policies in the area of intravenous drug use and health risk. When discussing primary drug use, the research has adopted the definition employed by the Health Research Board - the drug, which at the time of current treatment contact, the client alleges is causing most problems and for which he/she has sought treatment. Secondary drug of use can be defined as the drug identified by the client as contributing significantly to the drug misuse problem.

Table 33:

Primary Drug of Use

Variable	Frequency	Percent
Heroin	100	78.2
Methadone	14	10.9
Benzodiazepines	14	10.9
Total	128	100.0

From the above table it can be seen that the majority of respondents described heroin as the primary drug of use (78.2%) while 10.9% identified benzodiazepines and methadone respectively. It should be noted that in questioning persons on their primary drug of use. The research distinguishes between 'street' methadone and prescribed methadone and does not include prescribed methadone as a primary drug of use.

Table 34:

Route of Administration

Variable	Frequency	Percent
Inject	63	49.2
Smoke	37	28.9
Eat/Drink	28	21.9
Total	128	100.0

When asked about their route of administration respondents, a relatively small number (49.2%) claimed to engage in intravenous drug use. A large number (28.9%) used smoking **as** a method of administration and 21.9% eat or drank their primary drug.

Table 34:

Age Respondents First Used Primary Drug

Variable	Frequency	Percent
10-12 years	6	4.7
12-14 years	8	6.3
14-16 years	20	15.6
16-18 years	42	32.8
18-20 years	34	26.6
20-22 years	10	7.8
22-24 years	8	6.3
Total	128	100.0

The majority of respondents used their primary drug of use between the ages of 16 -18 years (32.8%). A surprising number commenced their primary drug of use between the ages of 18 -20 years and 6.3% claimed to use between the ages of 22 - 24 years. The 14-16 years are also shown to be a high-risk period for the respondents with 15.6% using drugs between the ages of 14 - 16 years. These figures may come as a surprise to many working in the area, however this data must be placed in the context of primary drug use, it does not refer to the age individuals commenced on their path into drug use.

Table 35:

Duration of Regular Use

Variable	Frequency	Percent
Less than a year	15	11.7
More than two years	29	22.7
More than five years	74	57.8
More than ten years	10	7.8
Total	128	100.0

The large majority of those interviewed describe themselves as using their primary drug for a period longer than five years. However given the age profile of those interviewed [see table 4] and the availability of treatment in the early 1990s, these figures are not surprising. 11.7% were using for less than a year. Given that 49.2% of the respondents inject their primary drug of use. Early intervention strategies are paramount in tackling the drug problem.

Table 36:

When asked about secondary drug of use, the most startling figures emerge in the area of benzodiazepines. As discussed earlier in this chapter, there is an urgent need to examine the role of prescribed pills and the issue of over-prescribing in the course of the respondent's treatment. Methadone and Hash also featured strongly with 29.7% and 24.2% respectively. Interestingly, none of the respondents identified alcohol as a secondary drug of use.

Secondary Drug of Use

Variable	Frequency	Percent
Heroin	18	14.1
Benzodiazepine	41	32.0
Methadone	38	29.7
Hash	31	24.2
Total	128	100.0

Table 37:

Secondary Drug – Route of Administration

Variable	Frequency	Percent
Inject	18	14.1
Smoke	31	24.2
Eat/Drink	79	61.7
Total	128	100.0

In response to questions concerning the route of administration for the respondent's secondary drug of use, a large number (14.1%) were injecting the drug. This figure is cause for concern as it refers to secondary drug of use which is not the drug causing most problems but the drug, which forms a significant part of the drug use problem.

Table 38:

Age First Used Secondary Drug Frequency

Variable	Frequency	Percent
10-12 years	12	9.4
12-14 years	4	3.1
14-16 years	21	16.4
16-18 years	42	32.8
18-20 years	27	21.1
20-22 years	22	17.2
Total	128	100.0

From the above table it can be seen that the majority of respondents commenced use of their secondary drug between the ages of 16 - 18 years (32.8%). 21.2 % commenced using their secondary drug between the ages of 18 - 20 years. However we still have'a relatively high number in the 10 -12 years age group (9.4%).

Table 39:

Age First Used Any Drug

Variable	Frequency	Percent
Below 10 years	18	14.1
10-12 years	20	15.6
12-14 years	35	27.3
14-16 years	47	36.7
16-18 years	4	3.1
18-20 years	4	3.1
Total	128	100.0

The above table holds particular implications in the area of preventative drugs policy. As can be seen, 36.7% of those interviewed first started using drugs in the 14 - 16 years age group. 27.3% commenced use in 12 - 14 years age group. 15.6% began using drugs between the ages of 10 - 12 years. A startling figure of 14.1% began using drugs before they reached the age of 10. These figures reiterate the need for early intervention strategies to prevent drug use. It must also be remembered that the above figures refer to persons who are progressed in their drug career. There is a need for further research into the new generation of young people in communities who are engaging in experimental drug use. There is no substantial

research conducted to date on the area of routes in to drug use. Currently the three Community Drug Teams for the Blanchardstown area are conducting research with young people in schools concerning drug-using behaviour.[13] If there is an identified concern for children and young teenagers engaging in drug use, it is not enough to quantify the extent of the problem. There is a need for a longitudinal research study with a controlled group which will explore over a period of years how young people's perception of drugs has changed and why. This could be carried out on an annual basis within the Community Drug Teams research. If this information is ascertained, it will contribute greatly to the enhancement of measures designed to deal with drug use at this level.

The following table illustrates the numbers who are currently injecting drugs. Of those interviewed, 25% injected drugs in the last month. It must be remembered that these figures represent the numbers in treatment and ignores persons who are not accessing treatment.

Table 40:

Currently Injecting Drugs

Variable	Frequency	Percent
Yes	32	25.0
No	96	75.0
Total	128	100.0

Therefore, the numbers intravenously using drugs is a lot greater if one includes chaotic drug users. At present there are 202 people from the Blanchardstown area accessing needle exchanges. This is an extremely high number given the fact there is no needle exchange in the Blanchardstown area.

Table 41:

Ever Injected Drugs?

Variable	Frequency	Percent
Yes	105	82.0
No	23	18.0
Total	128	100.0

[13] There are presently three Community Drug Teams (CDTs) operating in the Blanchardstown area, Mulhuddart and Corduff CDT, Hartstown and Huntstown CDT and Blakestown and Mountview CDT.

Table 41 illustrates the numbers of respondents who have ever injected drugs. 82% said that they have injected drugs at one point in their drug use history.

Table 42 goes on to detail the age at which respondents first injected drugs. Once again the majority injected between the years of 16 and 18 (39.8%). In targeting drug awareness programmes to young people it is vital that education in this area be delivered at an early age as many people leave the education system early. Therefore, they may not come into contact with information concerning the safe use of drugs until they present for treatment and are possibly injecting already.

Table 42:

Age At Which Respondents First Injected Drugs

Variable	Frequency	Percent
16-18 years	51	39.8.,
18-20 years	27	21.1
20-22 years	13	10.2
22-24 years	14	10.9
No Answer	23	18.0
Total	128	100.0

The majority of respondents have not injected in the last month (75%), although 7.8% have been injecting on a regular basis i.e. more than once a week and 17.2% once a week or less. Therefore injected drug use is still relatively common amongst those presenting for treatment.

Table 43:

Number of Times Respondent Have Injected in the Last Month

Variable	Frequency	Percent
Never	96	75.0
Once a week or less	22	17.2
More than once a week	10	7.8
Total	128	100.0

Table 44 details information concerning the number of times that respondents have visited a needle exchange in the past month. From the table it can be seen that the majority (87.5%) have not visited a needle exchange with only 9.4% accessing needle exchange services in the last month.

Table 44:

Number of Times Respondents have Visited a Needle Exchange in the Last Month

Variable	Frequency	Percent
Never	112	87.5
Once	8	6.3
Twice	4	3.1
No Answer	4	3.1
Total	128	100.0

Table 45:

Have Respondents Ever Re-used a Needle?

Variable	Frequency	Percent
Yes	95	74.2
No	21	16.4
No Answer	12	9.4
Total	128	100.0

From the table above it can be seen that 74.2% have re-used a needle at some point. If the following data in figures 46 and 47 can be relied upon the implications of re-using a needle and sharing equipment can be seen.

Tables 46 & 47:

Are Respondents Aware if they May Have Contracted HIV or Hepatitis

HIV:

Variable	Frequency	Percent
Positive	8	6.3
Negative	112	87.5
No Answer	8	6.3
Total	128	100.0

From table 46, it can be seen that 87.5% claim to have tested negative for HIV. This data is limited in that respondents were not asked details concerning how recent these results were. 6.3% of those interviewed declined to answer and 6.3% knew that they were positive.

Hepatitis:

Variable	Frequency	Percent
Yes	61	47.7
No	63	49.2
No Answer	4	3.1
Total	128	100.0

From the above table it can be seen that 47.7% have tested positive for Hepatitis while 3.1% declined to answer the question.

The data outlined in these tables suggest the importance harm minimisation policies. Drug use in Irish society has become a reality. Steps must be taken in every direction to combat this problem. However as long as there are persons actively choosing intravenous drug use, harm minimisation will remain a key element in tackling the problem.

A recent report conducted by the Merchants Quay project offers a comprehensive definition of harm minimisation. A public health approach to problem drug use views its occurrence not as a phenomenon caused by an individual's pathology, but rather as one causing extensive social problems and threatening public health. Harm reduction theory reflects this attitude and goes a step further, arguing that many of the most destructive consequences of illicit drug use are not the result of drugs per se, but rather of drug policy. Accordingly, with harm reduction there is as Strang (1999) argues, no predetermined positions on drug use being inherently good or bad. As a policy response, harm reduction strategies are determined solely by the

extent of observed and/or anticipated harm, which results from drug use. The principle feature of harm reduction is the acceptance of the fact that some drug users cannot be expected to cease their drug use at the present time. Thus the key component of harm reduction programmes which distinguishes them from any other drug programme, is whether they attempt to reduce the harmful consequences of drug use, while the user continues to use. To this end, harm reduction emphasises practical rather than idealised goals (Single, 1995) Harm reduction is neutral about the long-term goals of interventions, while according a high priority to short term goals.[14]

[14] Cox, G. & Lawless, M. (2000) *Making Contact: An Evaluation of a Syringe Exchange*. Dublin Merchants Quay Project
Single, E. (1995) "Defining Harm Reduction" in *Drug and Alcohol Review 14 pp287-90*
Strang, J. (1999) "Drug Use and Harm Reduction: Responding to the Challenge" in Heather, N., Wodak, A., Nadelmann, E. and P. O'Hare (Eds) *Psychoactive Drugs and Harm Reduction: From Faith to Science.* London: Whurr Publisher

VI

Criminal Activity:

The following section of the research focuses upon the criminal activity of the respondents. For the purpose of explaining the relationship between accessing treatment and a reduction in criminal activity, it is necessary to compare current patterns in criminal activity with previous criminal history. The following tables will show a sharp decline in criminal activity from the time respondents commenced treatment.

Current Patterns of Criminal Activity & Previous Criminal History

[Tables 49 - 52 - Property Crime]

Table 48:

Have Respondents Committed Property Crime Offences in the Lest Month?

Variable	Frequency	Percent
Yes	34	26.6
No	94	73.4
Total	128	100.0

Table 49:

Have Respondents Ever Committed Property Crime

Variable	Frequency	Percent
Yes	85	66.4
No	43	33.6
Total	128	100.0

Table 48 illustrates the numbers of respondents who have committed a property crime in the last month. In looking at property crime, respondents were given the following list; breaking and entering, receiving stolen goods, stolen prescription pads, stolen car robbery, shoplifting and a general category 'other' property crimes. It can be seen that 26.6% said that they had committed a property crime in the last month while 33.6% said that they had not. This is in sharp contrast to the 66.4% figure given for committing property crime prior to entering treatment [see table 49].

The following tables represent the types of property crime committed both prior to entering treatment and while currently participating in treatment [i.e. in the last month].

Table 50:

Types of Property Crime Committed in Last Month

Variable	Frequency	Percent
Receiving stolen goods	8	6.3
Stolen prescription pad	4	3.1
Shoplifting	22	17.2
No Property Crime	94	73.4
Total	128	100.0

From the above table it can be seen that of the 26.6% that had committed property crimes in the last month, the most common type of property crime was shoplifting (17.2%). Of those interviewed, 6.3% claimed to have received stolen goods in the last month and 3.f% said that they had stolen a prescription pad.

Table 51:

Types of Property Crime Ever Committed

Variable	Frequency	Percent
Breaking & entering	15	11.7
Receiving stolen goods	16	12.5
Stolen prescription pad	4	3.1
Stolen car robbery	27	21.1
Shoplifting	23	18.0
No Property Crime	43	33.6
Total	128	100.0

Table 51 illustrates the types of property crime committed by the 66.4% figure in table 49. Prior to entering treatment, stolen car robberies were the most popular amongst this group with 21.1% admitting to having stolen cars. Following this, 18% confessed to shoplifting while 12.5% of this group had been involved in receiving stolen goods and 11.6% said that they engaged in breaking and entering criminal activity.

[Tables 53 - 56 - Crimes Against the Person]

The following tables represent data from questions concerning crimes against the person. Once again, the relationship between treatment and criminal activity can be detected. There is a sharp decline in the numbers engaging in crimes against the person while in treatment.

Table 52:

Have Respondents Committed a Crime Against the Person in the Last Month?

Variable	Frequency	Percent
Yes	6	4.7
No	122	95.3
Total	128	100.0

Table 53:

Have Respondents Ever Committed A Crime Against the Person?

Variable	Frequency	Percent
Yes	53	41.4
No	75	58.6
Total	128	100.0

The above tables represent the numbers who have committed a crime against the person both recently and prior to entering treatment. Respondents were given a list of the following; assault, mugging, armed robbery with a syringe, armed robbery with a knife and armed robbery with a gun. Tables 54 and 55 document the types of crimes committed.

From table 52 it can be seen that 4.7% confessed to committed a crime against the person as opposed to 41.4% engaging in this type of criminal activity prior to entering treatment.

Table 54:

Types of Crimes Committed Against the Person in the Last Month

Variable	Frequency	Percent
Assault	6	4.7
No crime against the person	122	95.3
Total	128	100.0

Table 54 describes the type of crimes committed against the person in the last month. Of the 4.7% who committed a crime against the person, all described this crime as ‘assault’.

Table 55:

Types of Crime Ever Committed Against the Person

Variable	Frequency	Percent
Assault	8	6.3
Mugging	28	21.9
Armed robbery with a syringe	13	10.2
Armed robbery with a knife	4	3.1
Never committed crime against person	75	58.6
Total	128	100.0

In contrast, those who had engaged in this form of criminal activity prior to entering treatment listed a variety of crimes. Mugging featured strongly at 21.9%, while 6.3% admitted to assaulting someone. Surprisingly, in the case of armed robberies, syringes have become a large feature of armed robberies, becoming more commonly used than a knife. 10.2% had committed an armed robbery with a syringe while 3.1% had committed an armed robbery with a knife. This reflects an overall national trend in drug related robberies towards an increase in the use of syringe as a method of intimidation in robberies.

[Tables 57 - 60 - Selling Drugs]

Tables 56 - 60 represent data on the numbers of respondents selling drugs and the types of drugs sold.

Table 56:

Have Respondents Sold Drugs in the Last Month?

Variable	Frequency	Percent
Yes	20	15.6
No	108	84.4
Total	128	100.0

Table 57:

Have Respondents Ever Sold Drugs?

Variable	Frequency	Percent
Yes	75	58.6
No	53	41.4
Total	128	100.0

15.6% of those interviewed had sold drugs in the last month while 58.6% had sold drugs prior to entering treatment. Once again, the relationship between crime and drug use is apparent in these tables. There is an overall reduction in crime after entering treatment. When asked about selling drugs, respondents were anxious to stress that while they may have engaged in this form of criminal activity, many of them did not view this in a criminal light. Respondents referred to selling drugs to friends who were already using and were anxious to stress that they did not see themselves as pushing drugs. If they did sell drugs, it was either to support their own addiction or alternatively they may have sold drugs in order to 'help' a friend.

Table 58:

Types of Drugs Sold in the Last Month

Variable	Frequency	Percent
Heroin	14	10.9
Methadone	6	4.7
No drugs sold	108	84.4
Total	128	100.0

Of the drugs sold in the last month, heroin comprised 10.9% of those drugs while methadone comprised 4.7%. These figures are surprising amongst a group reporting a significant benzodiazepine problem. When arriving at this section of the interviews, after hearing of benzodiazepine use, it is unusual to find that benzodiazepine does not feature as a drug being sold in the last month.

Neither do these drugs feature in the types of drugs ever sold by respondents. Once again heroin and methadone are the drugs most commonly sold with 39.1% and 13.3% of the respondents respectively having sold these drugs. Hash did not feature strongly with 63% of the respondents naming hash. However, this research has posed questions concerning the perception of hash as a 'soft' drug and in most cases, respondents found it difficult to interpret hash differently to drugs such as alcohol and tobacco.

Table 59:

Types of Drugs Ever Sold by Respondents

Variable	Frequency	Percent
Heroin	50	39.1
Hash	8	6.3
Methadone	17	13.3
No drugs sold	53	41.4
Total	128	100.0

[Tables 61 - 64 - Fraud]

The following tables are concerned with the level and nature of fraud committed by respondents prior to entering treatment and while currently in treatment.

Table 60:

Have Respondents Committed Fraud in the Last Month

Variable	Frequency	Percent
Yes	22	17.2
No	106	82.8
Total	128	100.0

Table 61:

Have Respondents Ever Committed Fraud

Variable	Frequency	Percent
Yes	43	33.6
No	85	66.4
Total	128	100.0

Tables 60 & 61 outline the numbers who have committed fraud including social security, credit cards, forging cheques, and forging prescriptions and a loose category of 'other' fraud. While there is a decline in the numbers involved in fraudulent activity while in treatment, these figures are still high. 17.2% are currently engaged in fraud while this figure almost doubles to 33.6% who were engaged in this type of activity prior to entering treatment.

Table 62:

Types of Fraud Committed in the Last Month

Variable	Frequency	Percent
Forging Cheques	8	6.3
Social Security	14	10.9
No fraud committed	106	82.8
Total	128	100.0

Table 62 explains the reason for the high percentage involved in fraud. Of the 17.2% currently engaged in the activity, 10.9% of these respondents defined this as social security fraud. An interesting theme in the interviews was the low number who actually perceived social security fraud as a criminal activity.

Table 63:

Types of Fraud Ever Committed

Variable	Frequency	Percent
Forging cheques	27	21.1
Forging prescriptions	6	4.7
Social security	10	7.8
No fraud committed	85	66.4
Total	128	100.0

When asked about previous activity, the findings vary a little. A large number of the 33.6% **of** respondents involved in criminal activity had listed forging cheques (21.1), respondents listing forging prescriptions amounted to 4.7%, while the numbers who had been engaged in social security fraud was lower at 7.8%.

Many respondents recounted experiences of periodic homelessness during their 'chaotic' drug use, while a number of respondents detailed a change in their lifestyle since commencing treatment. Of those interviewees selecting social security fraud from the categories, a sizeable proportion where now parents and cohabiting with partners in a stable relationship. The idea of a stable relationship had been elusive to many during their chaotic drug use. This may have an effect and account for the increase in the numbers involved in social security fraud (through (co-habitation)while in treatment.

[Tables 65 - 66 - Contact with Gardai & Charges]

This final section of the data on criminal activity is concerned with the numbers of respondents who have been in contact with the Gardai in the last month and with the numbers who are currently facing charges.

Table 64:

Have Respondents been in Contact with the Gardai in the Last Month

Variable	Frequency	Percent
Yes	27	21.1
No	101	78.9
Total	128	100.0

21.1% of the respondents had been in contact with the Gardai in the previous month'. The question was not posed in a manner, which suggested that they might have been in trouble in the past month. Therefore, many of the respondents may have been in contact with the Gardai in connection with any matter, not necessarily criminal.

Table 65:

Respondents Currently Facing Charges

Variable	Frequency	Percent
Yes	27	21.1
No	101	78.9
Total	128	100.0

Once again 21.1% said that they were facing charges. This does not necessarily mean that they have been in contact with the Gardai, therefore, the above tables should not be taken synonymously. However many clients who are stabilising their drug use or that are currently drug free may have charges that are outstanding. There is a role for all professional working in the area to work closely with clients who may be having legal difficulties resulting from previous drug use. It is also important for individuals returning from the prison system to have appropriate support systems in place to facilitate rehabilitation in the community.

CHAPTER 6

Conclusions & Recommendations

In conducting this research, a number of issues concerning the drugs issue have been raised. The following chapter outlines these issues and makes recommendations in an attempt to build a strong policy response to the drug problem in Blanchardstown. The following findings are based on the implications which the interview data has raised.

1. 128 drug users attending treatment consented to interview. The research account for a further 41 individuals in treatment who were either contacted and refused interview or were unable to be contacted. It is estimated that for every drug user that has sought treatment, there are many more, possibly two or three times as many, who have not yet sought treatment. If we are to take the modest estimated ration of 2:1, the figures suggested would be in the region of 338 drug misusers in the Blanchardstown area. However given the demographic profile of the area (see Chapter 2), with its high level of socio-economic disadvantage and young population, the estimated ration of 3:1 is more applicable. In taking this estimated ratio of 3:1, the Blanchardstown area has approximately 507 individuals with a dependant drug problem.

2. The research has pointed to the difficulties encountered in estimating the prevalence of drug use within an area (see Chapter 3). In order to facilitate communities in recording their drug problem, all agencies should take part in the drug reporting system.

3. There is a need for continuing research into the drug problem in the Blanchardstown area. As with any major research, areas for further research have been identified. This research has looked at the profiles of this currently attending treatment in the area. Chaotic drug users who are not accessing treatment may have very different needs and circumstances and therefore must be researched as a separate entity.

4. Experimental and Recreational drug use are areas which are virtually ignored within this research. There is a need for longitudinal research into this area. For example, it is not only necessary to know how many individuals are experimenting with drugs, but also to understand why young people first start using drugs. Under a longitudinal study, a control group could be taken from the Blanchardstown area. This control group could interviewed on an annual basis and their patterns of substance use could be monitored, but more

importantly changes in attitudes towards drugs could be evaluated. Research such as the above may have a positive impact upon preventative education strategies.

5. The issue of education raises important issues for professionals working in the area. This research has suggested an education profile of drug misusers which is not altogether pessimistic. Almost half of the group interviewed remained within the educational system beyond the legal school leaving age of 15. This presents a promising opportunity for those working in the area of drugs education and prevention.

6. There is a need for further teacher development and training in the area of drug misuse. In light of the numbers remaining within the educational system while using drugs, the need for training in the identification of symptoms of drug misuse is paramount.

7. Preventative education programmes must be specifically geared towards young people on the basis of age and experience. Many young children in schools may have first hand experience of the drugs issue and while professional are constantly aware of respecting the age and the innocence of young people and children, the reality is that they may be living the experience of drugs every day vis a vis themselves, their family or their community.

8. The drug problem has a broad impact upon society in general and more particularly communities and families who are close to the problem. There are currently family support and siblings groups operating in the Blanchardstown area. Given the numbers of people affected by drugs, these groups need to be supported and expanded.

9. The research particularly highlighted the needs and rights of children affected by drug use. Adequate support structure must be put in place in order to ensure their well-being. An initiative such as parenting programmes, creche facilities and sessional care would not only benefit the child but may also act as a support to parents who are accessing treatment.

10. Drug misuse is a community problem, therefore it is important that any response to the problems should be designed in consultation with the communities affected. The Community Drug Teams have an integral role within this process.

11. The research identifies the contributing factor of housing type in the drug problem. While there have been a variety of measures and policies designed to improve the situation in certain local authority estates, it is important that policy makers do not look for simple answers to complex problems.

12. Peer relations was seen as important in the lives of the drug user and acted as an important factor in individual's pathways into drugs. A peer education programme is currently been run through the Blanchardstown Youth Service in the Corduff area, as peer education can be seen as an important element in an individual's decision to use drugs, the above project could be described as an innovative approach to preventative education.

13. While peer relations and curiosity were the main reasons cited for individuals first trying drugs. It is important that the data is not misrepresented, while respondents may cite this as a reason for their first encounter with drugs. This is not necessarily the reason why people remain using drugs.

14. The research recognises the importance of a multi-agency response to the drug problem. The drug problem experienced by the Blanchardstown community is multi-dimensional in nature. Therefore a variety of factors including poverty, unemployment, Housing and education have a crucial role to play in alleviating the problem. A co-ordinated multi-agency approach comprising the community, voluntary and statutory bodies could prove very effective in the area.

15. Throughout the course of interviews respondents frequently referred to the difficulties that they have in accessing treatment. Respondents mentioned difficulties in terms of accessing methadone through local pharmacies. This is a difficulty which may also be expressed by health professionals. Many respondents reported having to travel into town to collect their methadone because of the limited number of pharmacies in the area dispensing methadone. This will obviously create difficulties for both people wishing to re-enter the labour market or people with childcare responsibilities.

16. 21.1% of those interviewed are currently facing charges. While these findings do not suggest that 21.1% of the respondents are facing a jail sentence, many drug misusers may find themselves in prison at certain times in their drug career. When respondents drug misusers return to the community from a prison sentence they are likely to find themselves on waiting list for treatment. It is imperative that support structures are in place for offenders returning to the community. The BOND project is currently dealing with offenders who are released from prison. While this is a very important service in the area, it must be recognised that drug misusers may have very different needs to non drug users and the resources must be put in place to deal with this issue.

17. Many respondents expressed concerns relating to aftercare and rehabilitation in the community. This concern is also felt strongly by representatives from the community, voluntary and statutory bodies. It is unrealistic to expect recovering drug misusers to

travel into town to access rehabilitation programmes. Aftercare and rehabilitation must be provided on a local basis and be responsive to the individual wishes of the participant. The lack of aftercare was the single greatest impediment to individuals remaining drug free.

18. The use of prescribed drugs featured strongly within the research findings as a problem drug of use. While benzodiazepines may be provided as part and parcel of a treatment package, the level of use reported would suggest that these drugs are readily available on the 'black market'. The research supports recommendations of the introduction of a protocol on prescribed drugs. This report also recommends the need for research investigating the level of prescribed drug misuse in the Greater Blanchardstown area.

19. There are currently a number of initiatives running in the Blanchardstown area primarily funded through the Blanchardstown Drugs Task Force. These initiatives are playing a central role in tackling the drug problem in the area and must be supported. [r]

20. Many of the respondents identified the peer pressure and curiosity as a reason for first trying drugs, the research urges caution in the interpretation of these findings. While this may have been the reason for many respondents initially using drugs, it is not necessarily the reason that they misuse drugs. These findings should not undermine the important role of counsellors as part of the overall treatment package.

21. The research has also pointed to the overall significance of a variety of drug treatment approaches in tackling the drug problem. Findings concerning patterns of injecting behaviour do cause alarm and re-iterate the important role of harm minimisation as one type of treatment response. Communities have come to see drug misuse as a reality in their area. Therefore, it is imperative that individual misusing drugs are given the choice of practising safe drug use. In order to make this a reality, the provision of needle exchanges should become a priority for the Blanchardstown area. Drug misuse is present with the Blanchardstown community, suggesting the need to pursue a policy of recognition and action.

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APPENDIX A

RESEARCH CONSENT FORM

THE FOLLOWING QUESTIONS ARE PART OF A RESEARCH STUDY THAT AIMS TO INVESTIGATE THE LEVEL AND EXTENT OF DRUG USE IN THE GREATER BLANCHARDSTOWN AREA. THE RESEARCH IS COMMISSIONED BY THE BLANCHARDSTOWN DRUGS TASK FORCE AND WILL BE CONDUCTED UNDER THE AUSPICES OF THE GREATER BLANCHARDSTOWN RESPONSE TO DRUGS.1

IT IS IMPORTANT THAT YOU UNDERSTAND FULLY THAT THE INFORMATION THAT YOU SUPPLY IS TOTALLY CONFIDENTIAL, WILL NOT BE TRACED BACK TO YOU AND IN NO WAY WILL IT INTERFERE WITH ANY TREATMENT PROGRAMME YOU MAY BE ATTENDING OR BE USED AGAINST YOU IN ANY WAY.

I _____ HEREBY CONSENT TO PROVIDE INFORMATION FOR THE PURPOSE OF THIS RESEARCH STUDY. I HAVE HAD THE CONDITIONS READ TO ME AND FULLY UNDERSTAND THEM.

SIGNED [interviewee]: _____

DATE: _____

SIGNED [interviewer]: _____

DATE: _____

[1] The Greater Blanchardstown Response to Drugs is a networking organisation consisting of community, voluntary and statutory organisations which will campaign locally and nationally on issues relating to drugs, substance abuse and prevention education issues in the Greater Blanchardstown area. Through research and education we aim to raise awareness and develop responses to drug related problems. Through facilitating a community development process we will support individuals and groups who wish to or who are providing services for substance abusers and their families. This will allow community ownership for services being provided locally. Greater Blanchardstown Response to Drugs is a non-political, non-sectarian organisation.

APPENDIX B

SECTION A: DEMOGRAPHICS

NB: Interviewer to complete questions A1 - A4 prior to or after interview

A1. Code no: ☐

A2. Sex: **Female:** ☐ **Male:** ☐

A3. Area of residence: _____
A4. Postal Code: _____
A5. Date of Interview: _____

{These next few questions concern the social aspects of your life (things like jobs/friends, etc.)}

A6. Date of Birth: _____

A7. Marital status:

Married ☐ Single ☐ Separated/Divorced ☐

Cohabiting ☐ Widowed ☐

A8. Home Circumstances :

Living with parents ☐ Living with spouse/partner ☐

Living alone ☐ Living with other/lodging ☐

No fixed abode ☐ Hostel ☐

Other, specify _____

A9. House type:

Owner Occupier ☐ Private rent ☐

Local Authority ☐

A10. Dependants:

No dependants ☐ Adult dependant(s) only ☐

Adult & one child dependant ☐ Adult & two or more child dependants ☐

One child dependant only ☐ two or more child dependants dependants ☐

Other, specify _____

A11. How many different places have you lived in over the last six months?

One ☐ Two ☐ Three ☐ Four ☐ Five/more ☐

A12. How much of the last six months have you been living with anyone who uses heroin?

All of the time ☐ Most of the time ☐

Half of the time ☐ Some of the time ☐

None of the time ☐

A13. How many of the people you hang around with now are users?

None One ☐ Two ☐ Three ☐ Four ☐ Five/more ☐

A14. Present Employment Conditions:

Working full time ☐ Working part-time/ ☐

Currently unemployed ☐ On FAS scheme ☐

At school/college ☐ Engaged in home duties ☐

Other, specify _____

A14. How much of the last six months have you been unemployed?

All of the time ☐ Most of the time ☐

Half of the time ☐ Some of the time ☐

None of the time ☐

A15. How many different full time jobs have you had in the last month?

One ☐ Two ☐ Three ☐ Four ☐ None ☐

A16. If no longer at school/college, how old were you when you left?

_____

A17. What qualification did you obtain prior to leaving school/college?

Inter/Junior Cert ☐ Leaving Cert ☐

Third level qualification ☐ PLC ☐

A18. Would you say that your attendance at school was

Poor	☐	Fair	☐
Good	☐	Very Good	☐

SECTION B: TREATMENT HISTORY

B1. Are you currently in an opiate treatment?

(If no, skip to question 6)

Yes: ☐ **No:** ☐

B2. How were you referred to treatment (e.g. family, courts, peers etc.)

_____

B3. What sort of treatment are you in?

Not in treatment:	☐	**Methadone**	☐
Detoxification	☐	**Counselling**	☐
Therapeutic Community	☐	**Narcotics Anonymous**	☐

{If in more than one treatment please evaluate each separately}

B4. How do you rate this treatment?

_____

Poor ☐ Good ☐ Very good ☐

_____

Poor ☐ Good ☐ Very good ☐

_____

Poor ☐ Good ☐ Very good ☐

B5. How long have you been in this treatment?

Treatment _____ Years _____ Months _____

Treatment _____ Years _____ Months _____

Treatment _____ Years _____ Months _____

B6. How many times have you been in opiate treatment?

_____

B7. What sort of treatment have you previously been in? (please tick one box)

Not in treatment:	☐	Methadone	☐
Detoxification	☐	Counselling	☐
Therapeutic Community	☐	Narcotics Anonymous	☐

B8. How do you rate the treatment that you received?

_____

Poor	☐	Good	☐	Very good	☐

_____

Poor	☐	Good	☐	Very good	☐

_____

Poor	☐	Good	☐	Very good	☐

SECTION C: DRUG USE

{First, I am going to ask you some questions on your use of drugs. All information offerred will be kept strictly confidential.
(N.B. For all categories, if the subject responds that their last use of the drug was more than a month ago, score zero for that category. Do not include use on day of interview}}

HEROIN:

{Now I am going to ask you some questions about heroin (smack,hammer,horse,scag}

C1. On what day did you last use heroin? _____
C2. How many hits/smokes/snorts did you have on that day? _____
C3. On which day before that did you use heroin? _____
C4. How many hits/smokes did you have on that day? _____
C5. And when was the day before that? _____

OTHER OPIATES:

{These questions are about your use of opiates other than heroin (e.g. Street methadone/done/morphine/pethidine/codeine) Do not include legally obtained methadone.)}

C6. On what day did you last use opiates other than heroin? _____

C7. How many pills, doses, etc did you have on that day? _____

C8. On which day before that did you last use opiates other than heroin? _____

C9. How many pills doses did you have on that day? _____

C10. And when was the day before that? _____

ALCOHOL: _____

{These are questions about you use of alcohol.}

C11. On what day did you last drink alcohol? _____

C12. How much alcohol did you drink on that day? _____

NO.DRINK

Wine& Cider	Spirits	Beer	Fortified Wine
wine gl. Bottles Flagons casks (lit)	**nips (30ml) doubles bottles (750ml)**	**Middies schooners(425ml) cans (375ml)**	**port gl. Bottles flagons**

No. Standard Drinks: _____
Total standard Drinks: _____

C13. On which day before that did you drink alcohol?

C14.And how much did you drink on that day?

Wine & Cider	Spirits	Beer	Fortified Wine
wine gl. bottles flagons casks (lit)	**nips (30ml) doubles bottles (750ml)**	**middies schooners(425ml) cans (375ml)**	**Port gl. bottles flagons**

No. Standard Drinks: _____
Total standard Drinks: _____

C15. And when was the day before that? _____

C16. Has your use of alcohol increased since commencing on methadone maintenance?

(If you are not receiving methadone treatment skip to question C17)

Yes: ☐ **No:** ☐

CANNABIS:

{These questions are about your use of marijuana (dope, grass, hash, pot)}

C17. On what day did you last use marijuana? _____

C18. How many joints/bongs etc. did you have on that day? _____

C19. On which day before that did you use marijuana? _____

C20. And how many joints/bongs etc. did you have on that day? _____

C21. And when was the day before that? _____

AMPHETAMINES:

{These questions are about your use of amphetamines (speed)} **C22. On what day did you last use amphetamines?** _____

C23. How many tablets/snorts/hits did you have on that day? _____

C24. On which day before that did you use amphetamines? _____

C25. And how many tablets/snorts/hits did you have on that day? _____

C26. And when was the time before that? _____

COCAINE:

{These questions are about your use of cocaine (coke,snow,crack)}

C27.0n what day did you last use cocaine? _____

C28. How many hits did you have on that day? _____

C29. On which day before that did you use cocaine? _____

C30. How many hits did you have on that day _____

C31. And when was the time before that? _____

TRANQUILLISERS:

{These questions are about your use of tranquillisers (e.g. serepax, rohypnol, mogadon, valium)}

C32. On what day did you last use tranquilisers? _____

C33. How many pills did you have on that day? _____

C34. On which day before that did you use tranquillisers? _____

C35. And how many pills did you have on that day? _____

C36. And when was the day before that? _____

BARBITURATES:

{These questions are about your use of barbiturates (e.g. sleeping pills/downers: nebutal, seconal, amytal)}

C37. On what day did you last use barbiturates _____

C38. How many pills did you have on that day _____

C39. On which day before that did you use barbiturates _____

C40. How many pills did you have on that day? _____

C41. And when was the day before that? _____

HALLUCINOGENS:

{These questions are about your use of hallucinogens (e.g. LSD, Acid, Ecstacy, magic mushrooms)}

C42. On what day did you last use hallucinogens _____

C43. How many tabs/pills did you have on that day? _____

C44. On which day before that did you use hallucinogens? _____

C45. How many tabs/pills did you have on that day? _____

C46. And when was the day before that? _____

INHALANTS:

{These questions are about you use if inhalants (e.g. amyl, nitrate, rush, glue, laughing gas, aerosols, petrol)}

C47. On what day did you last use inhalants? _____

C48. How many sniffs did you have on that day? _____

C49. On which day before that did you use inhalants? _____

C50. And how many sniffs did you have on that day? _____

C60. And when was the day before that?

TOBACCO:

{Finally, these questions are about you use of tobacco.) _____

C52. On what day did you last use tobacco? _____

C53. How many cigarettes did you have on that day? _____

C54. On which day before that did you use tobacco? _____

C55. And how many cigarettes did you have on that day? _____

C56. And when was the day before that? _____

PRIMARY DRUG OF USE:

C57. What is your primary drug of use?

C58. What was/is the route of administration? (please tick one box)

Inject ☐ **Smoke** ☐ **Eat/Drink** ☐ **Sniff** ☐ **Inhale** ☐

4. C59. At what age did you first use your primary drug? _____

C60. What is the duration of regular use? (Years) _____

SECONDARY DRUG OF USE:

C61. What is your secondary drug of use? _____

C62. What was/is the route of administration? (please tick one box)

Inject ☐ **Smoke** ☐ **Eat/Drink** ☐ **Sniff** ☐ **Inhale** ☐

C63. At what age did you first use your secondary drug? _____

C64. At what age did you first used any drug? _____

C65. How well did you understand the effects of using drugs on the first occassion?

Understood all effects ☐ **Understood some effects** ☐

Poor understanding ☐ **Understood almost nothing** ☐

C66. Why do you think that you tried drugs on that occassion?

Feeling stressed ☐ **Had a lot of problems at time** ☐

Curious about it ☐ **Simply wanted to feel high** ☐

Put under pressure to try ☐ **Other, specify** _____

C67. How much money do you typically spend on drugs?

Per day £------ **Per week** **£-------** **Per month** **£-------**

C68. How much money did you typically spend on drugs?

Per day £------ **Per** **£-------** **Per month** **£-------**

SECTION D: RISK BEHAVIOUR:

{These questions are about the way you use drugs. I emphasise again that any information that you give me is completely confidential}

D1. Are you currently injecting?

Yes: ☐ **No:** ☐

D2. Have you ever injected?

Yes: ☐ **No:** ☐

D3. If yes, at what age did you first inject? _____

D4. How many times have you hit up (i.e. injected) in the last month?

Hasn't hit up ☐ **Once a week or less** ☐

More than once a week but less than daily ☐ **Once a day** ☐

2-3 times a day ☐ **More than 3 times a day** ☐

D5. How many times in the last month have you used a needle after someone else has used it?

No times ☐ **One time** ☐

Two times ☐ **3-5 times** ☐

6-10 times ☐ **More than 10 times** ☐

06. How often in the last month have you cleaned needles before re-using them?

Doesn't re-use	☐	Every time	☐
Often	☐		☐
Rarely	☐	Never	☐

D7. Before using needles again, how often in the last month did you use bleach to clean them?

Doesn't re-use	☐	Every time	☐
Often	☐	Sometimes	☐
Rarely	☐	Never	☐

D9. How many times have you attended a needle exchange programme in the last month?

Never	☐	Once	☐
Twice	☐	3-5 times	☐
6-10 times	☐	More than 10 times	☐

D10. Have you ever re-used a needle after someone else?

Yes	☐	No	☐

D11. If the answer is yes, did you clean it?

Yes	☐	No	☐

D12. Have you been sexually active in the last month? (If not skip questions D12 and D13)

Yes	☐	No	☐

D13. How often have you used condoms when having sex with your regular partner(s) in the last month?

No reg partner/ penetrative sex	☐	Every time	☐
Often	☐	Sometimes	☐
Rarely	☐	Never	☐

D14. How often did you use condoms when you had sex with casual partners in the last month?

No cas partner/ penetrative sex	☐	Every time	☐
Often	☐	Sometimes	☐
Rarely	☐	Never	☐

D15. Have you ever been tested for HIV or hepatitis?

HIV:	Yes	☐	No	☐	Result: _____
HIV:	Yes	☐	No	☐	Result: _____

SECTION E: CRIME

{In this section I am interested in ant crimes that you have committed. Any information you may offer is completely confidential.

First I am going to ask you some questions on property crime. By property crime I mean such things as breaking and entering, robbery without violence, shoplifting, stealing a prescription pad, stealing a car or receiving stolen goods. I am interested in the number of times that you committed a property crime, not the number of times you have been caught.}

E1. How often, on average during the last month have you committed a property crime?

No property crime	☐	Less than once a week	☐
Once a week	☐	More than once a week	☐
		but less than daily	☐
Daily	☐		

E2. Tick types of crime committed.

Breaking and entering	☐	Receiving stolen goods	☐
Stolen prescription pad	☐	Stolen car robbery	☐
Shoplifting	☐	Other	☐

E3. How often in the last month have you committed a crime against the person?

No crime against person	☐	Less than once a week	☐
Once a week	☐	More than once a week but less than daily	
Daily	☐		

E4.Tick types of crime committed.

Assault	☐	Mugging	☐
Armed robbery with a syringe	☐	Armed robbery with a knife	☐
Armed robbery with a gun	☐	Armed robbery with a knife	☐

{I am now going to ask you some questions about dealing. By dealing I mean selling drugs to someone. I am interested in the number of times that you have dealt drugs. Not the number of times that you've been caught.}

E5. How often, on average during the last month have you sold drugs to someone?

No drug dealing	☐	Less than once a week	☐
Once a week	☐	More than once a week but less than daily	☐
Daily	☐		

E6. Tick type of drug dealt

Heroin	☐	Cocaine	☐	Hallucinogens	☐	Tranquillisers	☐
Hash	☐	Speed	☐	Barbiturates	☐	Other	☐

{Now I am going to ask you some questions about fraud involvement. By fraud I mean things such as forging cheques, forging prescriptions, social security scams or using somebody elses credit card. I am interested in the number of times that you have committed a crime and not the number of times you have been caught.}

E7. How often on average during the last month have you committed a fraud?

No fraud	☐	Once a week	☐
More than once a week but less than daily	☐	less than once a week	☐
Daily	☐		

E8. Types of fraud committed:

Forging cheques	☐	Forging prescriptions	☐
Credit card	☐	Social security	☐
Other	☐		

E9. Have you ever committed a property crime? If the answer is yes, how often would you have committed these crimes, (read options)

No property crime	☐	Less than once a week	☐
Once a week	☐	More than once a week but less than daily	☐
Daily	☐		

E10. Tick types of crime committed.

Breaking and entering	☐	Receiving stolen goods	☐
Stolen prescription pad	☐	Stolen car robbery	☐
Shoplifting	☐	Other	☐

E11. Have you ever committed a crime against the person? If the answer is yes, How often would you have committed these crimes?

No crime against person	☐	Less than once a week	☐
Once a week	☐	More than once a week but less than daily	☐
Daily	☐		

E12.Tick types of crime committed.

Assault	☐	Mugging	☐
Armed robbery with a syringe	☐	Armed robbery with a knife	☐
Armed robbery with a gun	☐	Armed robbery with a knife	☐

{I am now going to ask you some questions about dealing. By dealing I mean selling drugs to someone. I am interested in the number of times that you have dealt drugs. Not the number of times that you've been caught.}

E13. Have you ever sold drugs to someone. If the answer is yes, how often would you have done this.

No drug dealing	☐	Less than once a week	☐
Once a week	☐	More than once a week but less than daily	☐
Daily	☐		

E14. Tick type of drug dealt

Heroin	☐	Cocaine	☐	Hallucinogens	☐	Tranquillisers	☐
Hash	☐	Speed	☐	Barbiturates	☐	Other	☐

{Now I am going to ask you some questions about fraud involvement. By fraud I mean things such as forging cheques, forging prescriptions, social security scams or using somebody elses credit card. I am interested in the number of times that you have committed a crime and not the number of times you have been caught.}

E15. Have you ever committed fraud? If the answer is yes, how often would you have committed fraud.

No fraud Once a week	☐	Once a week	☐
More than once a week but less than daily	☐	less than once a week	☐
Daily	☐		

E16. Types of fraud committed:

Forging cheques	☐	Forging prescriptions	☐
Credit card	☐	Social security	☐
Other	☐		

E17. Are you currently facing any charges?

Yes: ☐ No: ☐

E18. Have you come into contact with the gardai or court system in the last month?

Yes: ☐ No: ☐

E19. Have you ever been referred to a Juvenile Liaison Officer?

Yes: ☐ No: ☐

E20. If the answer to question E11. is yes, how long ago was this

_____

SECTION F: HEALTH

{These questions are about your health. I am going to read out a list of health problems. Please tick √ if you have had any of these problems over the last month.}

General;

1. Fatigue/energy loss _____
2. Poor appetite _____
3. Weight loss/ underweight _____
4. Trouble sleeping _____
5. Fever _____
6. Night Sweats _____
7. Swollen glands _____
8. Jaundice _____
9. Bleeding easily _____
10. Bruising easily _____
11. Teeth _____
12. Eye/vision problems _____
13. Ear/hearing troubles _____
14. Cuts needing stitches _____

Injection related problems;

1. Overdose _____
2. Abscesses/infections _____
3. Dirty hit (made feel sick) _____
4. Prominent scarring/bruising _____
5. Difficulty Injecting _____

Gynaecological (women only - in the last few months);

1. Irregular period _____
2. Miscarriage _____
3. Pregnancy _____
4. Smear test _____

Neurological;

1. Headaches _____
2. Blackouts _____
3. Tremors
4. Numbness/tingling _____
5. Dizziness _____
6. Fits/seizures _____
7. Difficulty walking _____
8. Head injury _____
9. Forgetting things _____

SECTION G: PSYCHOLOGICAL ADJUSTMENT;

{I should like to know if you have had medical complaints, and how your health has been in general over the past few weeks. Please answer all the questions on the following pages simply by ticking √ in the box that you think most nearly applies to you. I would like to know about present and recent complaints, not those that you had in the past.}

Have you recently;

G1. Been feeling well and in good health?

Better than usual	☐	Worse than usual	☐
Same as usual	☐	Much worse than usual	☐

G2. Been feeling in need of a pick me up?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G3. Been feeling run down and out of sorts?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G4. Lost much sleep over worry?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G5. Been getting edgy and bad tempered?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G6. Been getting scared or panicky for no good reason?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G7. Found everything getting on top of you?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G8. Been thinking of yourself as a worthless person?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G9. Felt that life is entirely hopeless?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G10. Felt that life is not worth living?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G11. Thought of the possibility that you may do away with yourself

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G12. Found at times that you couldn't do anything because your nerves were so bad

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G13. Pound yourself wishing that you were dead and away from it all?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

G14. Found that the idea of taking your own life kept coming into your mind?

Not at all	☐	Rather more than usual	☐
No more than usual	☐	Much more than usual	☐

[Scores based on a positive and negative number]

SECTION H: SUPPORT NETWORKS:

{The following questions are concerned with your access to support from family, community, peer or state provided netwoks. I am concerned with the support or lack of support you received in the last six months.}

H1. What support networks have been most readily available to you in helping cope with your addiction? (e.g. community, religion schools, voluntary organisations, employers, family, friends, private treatment units, public treatment units, youth services and state organisations etc)

_____

_____

_____

H2. How would you rate the support you received from these different networks.

Community:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Religion:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Spirituality:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

School/Educational system:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Voluntary Organisations:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Employers:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Family:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Friends:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Treatment Units

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐

Youth Services:

Very Good ☐ Good ☐ Poor ☐ Very Poor ☐