



**Finglas/Cabra
Local Drug
Task Force**

AN ANALYSIS OF CURRENT LICIT AND ILLICIT DRUG USE PATTERNS IN THE FINGLAS-CABRA LOCAL DRUGS TASK FORCE AREA

**FINAL REPORT SUBMITTED TO THE
FINGLAS-CABRA LOCAL DRUGS TASK FORCE**

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CONTENTS

Acknowledgements	2
Section One: Research Aims and Methods	3
Section Two: Changing trends and shifting contexts: the risk environment	9
Section Three: Drug Trends in the Finglas and Cabra areas	21
Section Four: Drug consumption practices: set and setting	31
Section Five: Drug-related harms: polysubstance use, and engaging with the drugs economy	41
Section Six: Conclusion	51
References	54
Appendices	57

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This report is dedicated to the memory of Eugene Finane a student of the UCD/URRUS Diploma in Community Drugs Work 2010-2012 and a proud Finglas man.

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SECTION ONE

RESEARCH AIMS AND METHODS

SECTION ONE: RESEARCH AIMS AND METHODS

Background to the Research Tender

The Finglas-Cabra Local Drug Task Force (F-CLDTF) was established in 1997, one of fourteen Local Drug Task Forces which formed the bedrock of the government's area-based policy response to the epidemic levels of heroin use among young people in many of Dublin's marginalised inner-city and suburban social housing estates. Communities in which residents shared a history of social and structural exclusion, multi-generational unemployment and poverty, educational disadvantage, and a large population of young people with limited social and economic opportunities (O'Higgins, 1998; O'Gorman 1998).

The Finglas-Cabra Task Force's initial action plan was drawn up on the basis of an analysis of the causes and consequences of the heroin problem in its area. The plan resulted in the implementation of a range of community-based, collaborative responses to heroin, and other drugs such as cocaine and alcohol, by local statutory, voluntary and community sectors. However, since that time drug consumption practices in Finglas-Cabra, as in Ireland and world-wide, have changed considerably. An increasing range of licit and illicit drugs are in circulation and there are growing public health and community safety concerns about the impact of drug-related harm on individuals, families and communities.

In 2012, the F-CLDTF commissioned this research study - An analysis of current licit and illicit drug use patterns in the Finglas-Cabra Local Drug Task Force area - in order to take account of these changes and to inform its ongoing work programme.

Aim and Objectives of the Research Study

The primary aim of this study was to compile a report on the current patterns of illicit and licit drug use (including alcohol and prescribed drugs) in Finglas-Cabra, which would include:

- a) a quantitative profile of the current levels of drug use in the LDTF area based on existing official sources and data from service providers;
- b) qualitative data from a range of key professional and lay informants on the current patterns of use in the LDTF area; and
- c) an analysis of the current patterns of drug use in the LDTF area using the quantitative and qualitative data gathered.

Specifically, the research was to:

- i) Document the types of drugs currently being consumed locally;
- ii) Estimate the average quantity of these drugs being consumed by an individual per use session locally;
- iii) Document how the drugs identified are currently being consumed and the potential health consequences for the individual from this e.g. experimental, recreational, polydrug, binge, chaotic use etc.;
- iv) Describe the plasticity of the drugs identified i.e. the variability of the effects of each drug or combinations of them;
- v) Describe the social settings in which the drugs identified are consumed;
- vi) Document the significant socio-economic characteristics of the individuals associated with the drugs identified i.e. age, gender, employment, education, parental responsibilities, disabilities, race and ethnicity, etc.; and
- vii) Record any significant cultural phenomena associated with the drugs identified i.e. music, fashion, sport, dance, etc.

Methodology

The research methodology employed in this study is based on a community and participatory research methodology developed by the Principal Investigator for a module in Community Research Methods on the UCD Diploma in Community Drugs Work. The research was conducted by the Principal Investigator and a team of privileged access community researchers who are graduate students of this Diploma - a programme undertaken in partnership with the URRUS (community education) project in Ballymun, as part of the Drugs Education and Research Initiative in the UCD School of Applied Social Science.

The research methodology is a sociologically grounded mixed-method approach, based on the collection and analysis of quantitative and qualitative data drawn from a variety of information sources. The approach uses induction and triangulation¹ to validate and cross-check data in order to arrive at an in-depth understanding of local drug use patterns and to develop a typology of local drug users and their consumption practices. The approach is underpinned by a participatory research methodology, designed to minimise the power relationship between the observer and the observed, and to maximise our understanding of the lived experience of drug use from the users' perspective.

¹ A method of cross-checking data from multiple sources to enhance the credibility and validity of the findings.

The core of this community research methodology is based on three conceptual frameworks from the drugs research literature which assist in examining patterns of drug use and situating these findings within social, cultural and policy contexts as well as social theories on drug use:

- i) *Drug, Set and Setting* (Zinberg, 1984) whereby drug use and its effects are understood by three determinants: the drug (the pharmacologic action of the substance itself); the set (the mindset and attitude of the person at the time of the use); and the setting (the influence of the physical and social setting within which the use occurs);
- ii) Goldstein's (1985) understanding of drug-related violence arising from a) the psycho-pharmacological effect of the drug; b) the economic compulsion for funds to purchase drugs; and c) and the organisation of the drugs market and the settling of disputes over sales territory, drug consignments, power struggles, informants etc.; and
- iii) the concept of risk environments (Rhodes, 2002; O'Gorman, 2004) as an explanatory tool for understanding how drug use and drug-related harms are shaped by physical, social, economic and policy contexts.

Ethics

Prior to commencing fieldwork for this study, ethical approval was obtained from the Human Research Ethics Committee, University College Dublin (UCD).

Our community research approach followed a strict ethical code which sought to minimise the traditional power imbalance between the researchers and the researched and ensure that dignity and respect underpin the social relations of the research process. This was achieved by following these steps and actions:

Informed Consent – participants were provided with sufficient and appropriate information about the nature of the research being undertaken in order that they could make an informed judgement about whether they wished to participate or not; permission was sought to record interviews.

Sensitivity – time was taken to build trust and rapport between the researcher and the researched and enquiries about illegal/illicit behaviours were addressed with sensitivity.

Value free – a non-judgemental approach was adopted in our interactions with the research participants.

Confidentiality and anonymity – the details of the people participating in this research are confidential; care was taken to ensure participants and their input was anonymised if there was a risk of them being identified; interview and other data were stored in a safe and secure location and codes used to anonymise data; caution was taken to avoid (further) stigmatising vulnerable groups or places.

Data collection and fieldwork

This research study set out to examine drug use from the user's perspective - their intentions, choices, boundaries, and risks – as well as getting a sense of users' lives and the role and meaning drugs play in their lives.

Contextual quantitative data were collected and analysed on key indicators of drug use (data on drug treatment, drug arrests and seizures, drug prevalence surveys); drug prescription data; and data on socio-economic data from the Census small area population statistics.

Primary data was collected through a series of research interviews, conversations and focus groups with people living, and working in drug-related fields, in the Finglas and Cabra areas. Interview schedules were designed and pilot tested and the focus group interviews were recorded and transcribed and analysed for emerging themes on patterns of drug use and related issues in the LDTF areas. Overall, over thirteen focus groups were conducted with 120 individual participants.

Further data were collected through individual interviews and conversations during the fieldwork period. Drug users by virtue of the criminalised and stigmatised nature of their activities are a largely hidden and 'hard to reach' population. Consequently, in order to access drug using groups in their natural locations, the principal investigator and five privileged access fieldworkers conducted over 180 hours of ethnographic fieldwork in Finglas and in Cabra. Over 100 contacts were made with drug users. Fieldwork sessions took place at different times and days to try and capture a broad as possible sense of drug use in the area and each session lasted approximately 3 hours. Fieldworkers took notes both during and after each session and this information was synthesised and analysed in a series of feedback sessions with the principal investigator.

The study began in July 2012, with the bulk of the fieldwork being conducted between September and October 2012, and the findings reflect the local drugs situation at that time. The results were presented to the members of the Local Drugs task Force and its sub-committees in November and the final report submitted in January 2013.

Research Supervision

Throughout the research process the Principal Investigator liaised with the Finglas-Cabra Drug Task Force co-ordinator and the research advisory group. Meetings were held on a monthly basis to discuss progress, present preliminary findings and receive feedback.

Limitations of the study

The drug users we located during the ethnographic fieldwork were those that had a public presence in the two communities at the time of the research. All of the people we interviewed were Irish and a small number were members of the Traveller community. Two-thirds of the drug users we encountered were male, reflecting the gendered pattern of public space.

For the purposes of this study we focused on those who were actively using drugs and had a public presence in the area. We met them hanging out on the estates, by the shops, the canal, the fields - the local congregational spaces where people interact. They do not represent all drug users in Finglas and Cabra, nor do they represent the very many people, young and old, in Finglas and Cabra who do not use drugs. They do, however, represent active drug users with a public presence in the areas, a presence which is often perceived as problematic.

Layout of the Report

Section Two of this report examines key indicators of drug use to explore emerging patterns and trends at a national level, and where available at a local level; as well as identifying the nature of the risk environments for drug-related harm in the Finglas and Cabra areas. In Section Three, findings from the research interviews and ethnographic studies show drug trends over time, and current drug trends and prices which are examined on a drug by drug basis. These findings are contextualised in Section Four through an exploration of the drug consumption practices of two drug using groups – young recreational drug users, and older habitual drug users - and of the area differences between the Finglas and Cabra neighbourhoods. In Section Five two key aspects of drug-related harm are explored – polysubstance use and the users' engagement with the drugs economy. In conclusion, Section Six brings together the main issues arising during this study and presents ideas for consideration and reflection.

SECTION TWO

CHANGING TRENDS AND SHIFTING CONTEXTS: THE RISK ENVIRONMENT

SECTION TWO: CHANGING TRENDS AND SHIFTING CONTEXTS: THE RISK ENVIRONMENT

Introduction

It is difficult to assess current and emerging drug trends. Partly due to the criminalised and stigmatised nature of drug consumption activities, drug use tends to be a hidden practice and drug users a 'hard to reach' population. At best we can try to estimate the nature, extent and patterns of people's drug use using a series of 'key indicators' – mainly data from population surveys such as the National Drug Prevalence study and administrative datasets routinely collected by agencies such as the Garda Síochána (Offences against the Misuse of Drugs Acts, and drug seizures); the Revenue Commissioners (seizures of drug consignments entering the state by Customs & Excise officials); and Drug Treatment Services (data on people attending drug treatment).

Each of these indicators of drug use has its own set of limitations and they are best understood in the context in which they were produced. For example, drug seizures are an indirect indicator of the supply and availability of drugs, but the data also reflect law enforcement activities, policing priorities and resources, as well the accuracy and consistency of reporting practices. In analysing these indicators, it is best to take a holistic and interpretive approach, which cross checks the indicator data against one another and grounds them in the research literature.

In this section, data from these key indicators are presented and analysed in order to examine trends over time. Though the bulk of this data is produced at a national level, an analysis of this information helps to inform our understanding of local trends in the F-CLDTF area.

Overall Trends

In the fifteen year period since the Finglas-Cabra Local Drugs Task Force was established, the consumption of an assortment of illicit and legal drugs has become 'normalised' and embedded into the social and cultural practices of many different social groups (Parker et al., 1998; Williams and Parker, 2001; Measham, 2004). Polydrug combinations of alcohol, cannabis, cocaine, and new synthetic drugs (such as mephedrone) have become a regular feature of weekend and festive socialising.

Over one-quarter (27%) of the Irish population have reported using an illegal drug (NACD & DAIRU, 2011) – a rate that equates to around 836,000 users nationwide. Of these, cannabis is by far the main illegal drug reported with cocaine, ecstasy and magic mushrooms the next most common (NACD, 2011). Prevalence rates, particularly for cocaine, increased significantly in the 2000s, placing Ireland among the highest cocaine using counties in the EU (EMCDDA 2004, NACD 2011).

With the onset of the recession in 2007, the demand and supply of cocaine fell dramatically and users drifted towards the use of new psychoactive substances popularly known as 'legal highs' as initially they were not controlled (under the Misuse of Drugs Act) and were widely available in 'head shops' and through online websites. These substances - mainly synthetic cannabinoids marketed as herbal smoking products such as 'SPICE'; BZP (benzylpiperazine) marketed as 'party pills'; and synthetic cathinones, such as mephedrone, marketed as bath salts, plant feeders etc. - became controlled substances under The Criminal Justice (Psychoactive Substances) Act 2010. Despite the subsequent closure of head shops nationwide and restricted access to the drugs, their use remains popular, particularly among young males. In the 2010/11 Drug Prevalence Survey seven per cent of young adults aged 15-34 reported using a new psychoactive substance in the previous year, the second most commonly used illegal substances after cannabis (NACD, 2012).

The incidence (new cases) of heroin use in Dublin rapidly escalated in the 1990s peaking in 1996-1998 (Smyth et al. 2000). These rates have continued to rise gradually since, with the most significant increases occurring outside the Dublin area (Kelly et al, 2009). In the most recent report on The State of the Drugs Problem in Europe (EMCDDA, 2012), Ireland had the highest prevalence rate of problem opioid (heroin) use among nineteen EU countries.

Invariably when drugs are discussed the reference is to illegal drugs. However, rates of illegal drugs are greatly superseded by those of legal drugs. Almost nine out of ten adults (87%) report being current drinkers (NACD 2012). We consume more alcohol per capita than almost all of our European counterparts and have the highest prevalence of frequent binge drinking² among the EU27 - almost half of us (44%) binge drink at least once weekly, compared to over a quarter (29%) of Europeans (Eurobarometer, TNS 2010).

Prescription Drugs

The trend for taking prescription drugs and over the counter medications in quantities and/or for purposes other than prescribed has been increasing for some time (see O'Gorman et al. 2004). Concerns regarding the diversion and circulation of prescription drugs - mainly 'tablets' intended for the treatment of insomnia and anxiety, such as benzodiazepines³ - led to the establishment of the Benzodiazepine Committee in 2000, and the publication of guidelines for good prescribing and dispensing practices in 2002. A subsequent increase in prescribing what are known as 'Z drugs'⁴ (such as zolpidem and zopiclone), appears to be an unanticipated effect of these policy guidelines. Initially, 'Z drugs' were regarded as a safe and non-addictive substitute for benzodiazepines in the treatment of insomnia, though concerns have been raised since that they pose a high risk of dependency, particularly among clients attending methadone maintenance programmes (Bannan et al. 2005; Bannan et al. 2007).

² Frequent binge drinking is defined by the World Health Organisation (WHO) as having 5 drinks or more at least once a week.

³ Such as Alprazolam (trade name Xanax ®), Diazepam (trade name Valium ®), Temazepam (trade name Restoril ®), Flurazepam (trade name Dalmane ®).

⁴ Zopiclone (trade name Zimovane®) Zolpidem (trade name Ambien ®, Stilnox®, Sublinox®)

In seeking to estimate trends in the prescription of 'tablets', we conducted an analysis of the top 100 drugs prescribed under the GMS (i.e. to patients with a Medical card and GP visiting card) which is published in the HSE's annual reports on the Primary Care Reimbursement Service. Though this data provides some indication of prescribing practices, it does not include data on private prescriptions (which are not routinely published) and consequently underestimates overall levels of prescribing. These data also underestimate the amount of 'tablets' in circulation as the number of illegally imported and stolen tablets are not included. Nonetheless, by analysing data for 2005 and again for 2010 (the most recent data available) we get an indication of prescribing trends over time. In both 2005 and 2010, over one million benzodiazepine prescriptions were issued though the overall rate per thousand of GMS patients decreased from 951 to 808 per 1,000 (see Table 2.1). In contrast, the number of 'Z drug' prescriptions increased by almost half a million in this period to reach almost one million prescriptions in 2010, an increase from 472 to 602 per 1,000.

Table 2.1: Number of 'tablet' prescriptions per thousand of GMS population

	2005 N.	2010 N.	2005 Rate per 1,000	2010 Rate per 1,000	2010 N. Tablets
Benzodiazepines: Diazepam (Valium®); Alprazolam (Xanax®); Temazepam (Restoril®); Flurazepam (Dalmane®)	1,098,733	1,305,064	950.7	807.7	18,270,896
Z drugs: Zopiclone (Zimovane®) Zolpidem (Ambien®, Stilnox®, Sublinox®)	545,456	972,595	472.0	601.9	13,616,330
Total N. People Eligible for GMS	1,155,727	1,615,809			31,887,226

Source: HSE Primary Care Reimbursement Service: Statistical analysis of claims and payments 2005 and 2010⁵

⁵ http://www.hse.ie/eng/staff/PCRS/PCRS_Publications/claimsandpayments2010.pdf
http://www.hse.ie/eng/Staff/PCRS/PCRS_Publications/Primary_Care_Reimbursement_Service_Financial_and_Statistical_Analysis_2005.pdf
 Accessed 15 October 2012

Based on an estimated average number of 14 tablets per prescription, the usual amount contained in a blister pack, this data suggests that, at a minimum, there were over 32 million prescribed 'tablets' in circulation.

Additional data from the Revenue Commissioner (Customs Service) on the number of seizures of prescription drugs and illegal non-prescription drugs⁶ shows an almost 100 hundred-fold increase in those seized in the last six years (from 14,902 in 2005, to 1,285,340 in 2011)⁷. As a result, the Department of Health announced that it is reviewing the Misuse of Drugs Regulations with a view to introducing additional import and export controls as well as an offence of possession on certain prescription drugs being traded illicitly. According to the Minister of State, new legislation will be introduced in early 2013⁸.

Prevalence data

There is little prevalence data (the extent of drug use in the population) available at a local level in Ireland, and the smallest level of area data published from the national Drug Prevalence Survey is for Regional Drug Task Force Areas. The Finglas-Cabra LDTF area is located in the Northern Regional Drug Task Force area (encompassing the area of Dublin city and county to the north of the river Liffey – see Appendix One). Data from this area show considerably higher levels of drug use than the national average and almost all other RDTF areas (NACD, 2012). For example, almost twice as many males reported using an illegal drug in the previous year in the NRDTF area than in Ireland as a whole (18% compared to 10% - see Table 2.2).

Table 2.2: Drug Prevalence (Lifetime, Last Year and Last Month) in Ireland and Northern Regional Drug Task Force, 2010/11

	LTP		LYP		LMP	
	Ireland	NRDTF	Ireland	NRDTF	Ireland	NRDTF
All adults (15-64)	27.2%	34.6%	7.0%	10.5%	3.2%	4.6%
Young adults (15-34)	35.7%	40.4%	12.3%	16.8%	5.3%	7.3%
Males (15-64)	35.5%	45.8%	10.4%	17.9%	5.3%	8.6%
Females (15-64)	19.0%	24.9%	3.6%	4.5%	1.1%	1.3%

Source: NACD, 2012

⁶ Mainly sedatives such as benzodiazepines, sleeping tablets, erectile dysfunction medicines, steroids and slimming tablets.

⁷ Dáil Éireann Debate Vol. 767 No. 1 Wednesday, 6 June 2012. Minister for Finance (Deputy Michael Noonan, Written Answers - Drugs Seizures.

⁸ Deputy Alex White, Dáil Éireann Debates Monday, 17 December 2012.

These prevalence data also show that levels of illegal drug use have continued to increase in the Northern Regional Drugs Task Force area over time, with substantial increases in the use of cocaine powder and ecstasy. Since the first Drug Prevalence Survey was conducted in 2002/3 to the most recent in 2010/11, the rate of cocaine use in this area has more than doubled (from 5% to 12%) and the rate of ecstasy almost doubled (from 6.5% to 11% - see Table 2.3).

Table 2.3: Lifetime Drug Prevalence (LTP), 15- 64 year olds, Northern Regional Drugs Task Force Area, 2002/3, 2006/7, 2010/11

	Alcohol	Tobacco	Any Illegal Drug	Cannabis	Magic Mushrooms	Ecstasy	Amphet- amines	Cocaine	LSD	Heroin	Crack Cocaine
LTP 02/3	93.5%	62.5%	29.5%	26.9%	5.2%	6.5%	3.8%	5.0%	4.2%	0.9%	0.6%
LTP 06/7	91.0%	55.4%	32.2%	28.8%	11.4%	11.2%	5.5%	10.7%	6.3%	1.5%	0.5%
LTP 10/11	89.4%	60.3%	34.6%	30.2%	9.1%	11.3%	5.8%	11.6%	7.4%	1.5%	1.0%

Source: NACD, 2012

Treatment Indicator

A wide range of drug and alcohol treatment modalities and services (inpatient, outpatient, low-threshold services, general practitioners and prison) report on the number of cases (rather than individuals) seeking treatment to the national drug treatment reporting system (NDTRS). This data provides another indicator of trends, though numbers are shaped by the level of treatment provision and the extent to which services report to the NDTRS.

In 2010, the most recent data available, a total of 16,429 cases received treatment for a drug problem, an increase of over a quarter (26%) from 2005 (n=12,101). In this same period, new cases entering treatment (never previously treated) increased by over a third (38%) from 1,976 to 3,207. These increases are regarded as being due to the demand for treatment in the regions outside of Dublin. However, the total number of cases resident in the HSE's North West Dublin Local Health Office area⁹ (which covers Finglas and Cabra) increased by more than the national average (up by 42% from 329 to 572); while new cases more than doubled from 66 to 146 (a 55% increase) (Source: HRB Trend Series 12, Report and Appendix). This local pattern of increased treatment demand indicates a continuing upward trend for problem drug use in the Finglas-Cabra area.

⁹ North West Dublin Local Health Office covers the area North of the Liffey as far as Clonsilla, St.Margaret's, Finglas, Blanchardstown, Glasnevin, Castleknock and Cabra

In addition to the NDTRS data, the Central Treatment List¹⁰ - a complete register of all patients receiving methadone (as treatment for problem opiate use) – provides an indication of changing trends in heroin use over time. Since 1998, when the LDTFs were established, the number of patients registered has almost trebled from 3,681¹¹ to 9,539 in 2012. The increase in numbers in recent years mainly relates to the expansion of methadone treatment provision outside the Dublin area¹². Overall, there are less young people in treatment now with almost a third of current CTL patients (30%) over 40 years of age.

Over five hundred (n=548) CTL clients are resident in the Finglas-Cabra LDTF area, a figure which has remained stable over the three year period 2008 – 2010 (see Table 2.4). Nonetheless, this figure represents a high proportion of the overall number of CTL clients and the area has the 7th highest number of clients of the fourteen local DTF areas. In 2010, the most recent data available for the area, there were 2.5 times as many males in treatment than females. Two-thirds of all the clients from the area (66%) were treated in a clinical setting and less than one fifth (17%) by GPs. This proportion of clients attending GPs is far less than other areas. For example, the average proportion of clients attending GPs from HSE Dublin North East was 30%, and for HSE Dublin Mid-Leinster 37% - indicating a deficit of GPs engaged in drug treatment in the F-CLDTF area.

Table 2.4: Number and Gender of CTL clients resident in the F-CLDTF area, by treatment location (2010)

	Clinic	Trinity	GP	Prison	Total
Male (N)	258	26	59	50	393
Female (N)	105	<10	36	<10	154
Total (N)	363	26	95	50	547
Total by location (%)	66.4	4.8	17.4	9.1	100.0

Source: Central Treatment List, The Drug Treatment Centre Board.

In addition, the age pattern of clients resident in the Finglas-Cabra LDTF area is somewhat different to the national picture. Clients are younger - almost half are under 35 years of age (49%); and there are fewer (25%) patients aged over 40 (see Table 2.5). This data suggests that heroin use continued to be problematic in this area for a longer period of time compared to other areas.

¹⁰ Data sourced from the Central Treatment List, The Drug Treatment Centre Board.

¹¹ Connolly et al. 2012

¹² In 2000, only 90 of the 4,851 CTL clients (2%) had been in receipt substitution services outside the Eastern Regional Health Authority area (Source: CTL)

Table 2.5: Age of Clients receiving methadone treatment resident in FCLDTF area, 2010

Age Range	N	%
16 - 19	<10	<2%
20 – 24	28	5.1
25 – 29	77	14.1
30 – 34	156	28.5
35 – 39	147	26.9
40 – 44	80	14.6
45+	57	10.4
Total	547	100.0

Source: Central Treatment List, The Drug Treatment Centre Board.

Drug Offences and Seizures

Data on drug offences and seizures can give a further insight into changing drug trends, as can amendments to the drugs control legislation. Possession of a controlled substance is an offence under the Misuse of Drugs Acts, 1977 and 1984. In the last few years, significant amendments have been made to the list of controlled substances to capture the new psychoactive drugs appearing on the drugs market. In 2006, any kind of fungus containing psilocin (the psychoactive component of ‘magic mushrooms’) became a controlled substance after a surge of availability in retail shops. A similar trend relating to the availability of ‘legal highs’ in ‘head shops’ resulted in approximately 200 ‘legal highs’ being declared controlled drugs in the summer of 2010. Ketamine, a substance with legitimate use as a medicine but which had become popular for its psychoactive uses, was also placed on the schedule of controlled drugs at this time.

The number of recorded drug offences against the Misuse of Drugs Act in Ireland increased steadily throughout the first decade of the 2000s, almost doubling from 2004 to 2007 (from 9,686 to 18,554). This trend appears to mirror the observed increases in prevalence and treatment demand noted earlier. However, the number of offences peaked in 2008 (with approximately 23,000 offences) and since then have fallen year on year, and cumulatively by a third (32%) between 2008 and 2011 (see Table 2.6).

Table 2.6: Recorded Drug Offences Ireland, by year and offence (N)

	2004	2005	2006	2007	2008	2009	2010	2011
Importation	36	36	43	54	67	46	29	41
Cultivation or manufacture	38	50	92	161	218	273	538	580
Possession for sale or supply	2196	2659	3017	3602	4301	4029	4159	3874
Possession for personal use	7138	10037	10469	14008	18093	16817	14523	12674
Other drug offences	460	540	611	729	725	817	756	526
Total (N)	9868	13322	14232	18554	23404	21982	20005	17695

Source: Central Statistics Office

A similar trend over time is visible in the drug seizure data with the numbers of seizures rapidly increasing during the early 2000s and peaking in 2007. Since then, the overall number of drug seizures has almost halved (a 48% decrease) from their peak in 2007 to 2010 (see Table 2.7).

At first glance, the decrease in both drug offences and seizures suggests a decline in drug use. However, examining the trends for different offences and the types of drugs seized helps clarify these seemingly disparate trends to those indicated in the prevalence and treatment data.

Over time, the number of importation/drug ‘trafficking’ offences has remained low, typically under 50 per year. In contrast, there has been a significant increase (more than ten-fold from 2004 to 2011) in offences relating to the cultivation of cannabis in ‘grow houses’ throughout the country, though the overall number of these offences is relatively low compared to others (less than 600)¹³. Offences relating to the sale or supply of drugs increased steadily until 2008, and have remained fairly consistently at around a fifth (20%) of all offences since then.

The main explanation for the decrease in the number of drug offences lies with the substantial fall (by 30%, between 2008 and 2011) in the number of cases of Possession (for personal use) as this category typically accounted for the vast majority of drug offences (between 70-75%) each year. The majority of these offences relate to cannabis possession and the decrease in cannabis related offences is reflected in the sharp decline in the number of cannabis seizures in the past five years. Cannabis seizures peaked in 2008 but more than halved in the subsequent year (from 5,652 to 2,314 – a decrease of 59%) and have remained at a low level since accounting for the decrease in the overall number of seizures.

¹³ During 2011, 572 grow houses were located resulting in the seizure of 26,531 cannabis plants with an estimated monetary value of €10.5m. (An Garda Síochána, 2011:29).

This decrease in cannabis seizures and offences is not reflected in the cannabis prevalence rate which continues to increase. However, this decrease confirms information on the ground of the changing nature of the cannabis market, and the shift in demand and supply from imported resin to 'grow house' and home grown herbal cannabis which appears, by and large, to bypass interception.

Table 2.7: Drug Seizures, by year and drug

	2005	2006	2007	2008	2009	2010
Cannabis-type substances (%)	55.9	50.4	49.6	56.6	42.1	41.4
Ecstasy-type substances (%)	10.8	10.2	11.2	7.3	1.6	0.5
Heroin (%)	12.0	14.9	16.3	16.1	26.5	21.0
Cocaine (%)	16.4	17.8	16.7	13.1	11.6	10.7
Amphetamines (%)	2.0	3.3	2.3	1.3	1.3	1.6
All Seizures (N)	6,362	8,417	10,444	9,991	5,494	5,477

Source: ADRU, 2011

In addition to highlighting changes in the cannabis market, offences and seizure data indicate a change in Cocaine and Ecstasy use, both of which have fallen dramatically since their peak in 2007 (cocaine seizures by 66% and Ecstasy by 97%). The collapse of the cocaine market was seen to be due to a combination of international production factors, the economic slump in Ireland, and the increased supply and demand for 'legal highs' and new psychoactive drugs (O'Gorman, 2010). However, trend information coming from users and workers on the ground (see Chapter Three) and the 2010/11 drug prevalence study, indicate that ecstasy use is on the rise again. This trend is also reflected in the recent report from the Alcohol and Drug Research Unit (2012)¹⁴ which reports that seizures of ecstasy-type substances increased by more than 900% in 2011.

At a more local level, figures from the Dublin Metropolitan Region (DMR) West (which covers Finglas and Cabra among other areas¹⁵), reflect somewhat different trends. In this area, the total number of recorded drug offences increased by 75% between 2004 and 2011 (compared to 44% nationally). Unlike the overall national figures, the number of offences in this area began to decline at a later stage - in 2011 rather than 2007/8 elsewhere (see Table 2.8). This local trend is mainly related to the continued rise in the number of Possession (for personal use) offences, when these have fallen at national level. This trend indicates that drug use continues to increase in the DMR West area, it also suggests that policing strategies and Garda operations in the area continue to focus on prosecuting for drug possession, while there is a comparatively low rate of prosecutions for sale or supply.

¹⁴ Irish Focal Point (2011) 2011 National Report (2010 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues. Dublin: Health Research Board.

¹⁵ DMR West area Includes Ballyfermot, Blanchardstown, Cabra, Clondalkin, Finglas, Lucan, Rathcoole, Ronanstown.

Table 2.8: Recorded Drug Offences DMR West, by year and offence (N)

	2004	2005	2006	2007	2008	2009	2010	2011
Importation	0	0	0	2	0	0	0	0
Cultivation or manufacture	0	1	1	3	13	11	33	30
Possession for sale or supply	235	280	404	392	527	446	450	411
Possession for personal use	215	382	530	995	1,710	1,823	1,720	1,443
Other drug offences	16	21	63	66	60	44	60	47
Total (N)	466	684	998	1,458	2,310	2,324	2,263	1,931

Source: Central Statistics Office

Socio-economic context

The trends suggested by the indicators on drug misuse present drug use as a rather atomised and individualised undertaking and do not capture either the character or context of drug use and drug-related harms in communities, nor the clusters of drug use that are influenced by availability and the circulation of drugs within peer networks and drug markets at a local level.

Epidemiological studies of drug use illustrate a distinct socio-spatial concentration of drug-related problems in marginalised communities where residents experience an unequal burden of multiple and interconnected deprivations such as poverty, unemployment, early school leaving, homelessness, poor housing, and social exclusion (O’Gorman, 2004; Buchanan, 2006). These life experiences have been identified in the drugs research literature as risk factors for ‘problem drug use’ as distinct from ‘drug use’ (ACMD, 1998; Lloyd, 1998; Health Advisory Service, 2001; Fountain, 2006). This clustering of structural and policy ‘risk environments’ for drug-related harms (Rhodes, 2002; O’Gorman, 2005) illustrates the powerful neighbourhood effects found in the concentration and interaction of disadvantage at a local level.

The level of risk environment in the Finglas-Cabra LDTF area is clearly visible in the socio-economic data available from the Tolka Area Partnership (which covers Finglas, Cabra and surrounding areas) and which shows a high level of disadvantage across the area (See Appendix Three for 2006 data). In 2006, at a time of unprecedented economic growth, all of the 20 ED (Electoral Divisions) areas were designated as disadvantaged, bar two who were ‘marginally above average’.

An analysis of the latest data from Census 2011 shows that the eight existing most disadvantaged areas in the Finglas-Cabra LDTF area (which are designated ‘very’ and ‘extremely’ disadvantaged) experienced an even further severe decline since 2006 (see Table 2.9). These areas remain among the most disadvantaged in the country with five of them¹⁶ among the 50 most deprived areas in the state.

¹⁶ In order of rank on the Absolute Index Score: Finglas South C, Finglas North A, Finglas South D, Finglas South A, Finglas North B.

Table 2.9: Main areas of Disadvantage in FCLDTF area

ED area	Main areas in ED	AIS 2011	AIS Change 2006-11
Cabra West A	Carnlough, Fassaugh, Rathoath, Ventry	-20.1	-6.6
Cabra West B	Bannow, Carnlough, Dunmanus, Fassaugh	-22.1	-7.1
Finglas North A	Avila, Barry, Cappagh, Cardiffsbridge, Mellowes, Plunkett	-24.8	-6.2
Finglas North B	Barry, Cappagh, Casement, Kildonan, Mellowes, Plunkett	-23.1	-5.3
Finglas South A	Abbotstown, Cardiffsbridge, Deanstown, Rathoath, Welmount	-24.4	-6.5
Finglas South B	Barranamore, Carrigallen, Cloonlara, Fairlawn, Farnham, Gortbeg, Gortmore, Hazelcroft, St Helena's	-16.7	-3.6
Finglas South C	Barranamore, Berryfield, Dunsink, Kippure, Vale View, Welmount	-27.4	-7.7
Finglas South D	Glenties, Tolka Valley, Rathvilly, Virginia, Westwood, Woodbank	-24.4	-7.8

AIS = Absolute (Deprivation) Index Score.

Source: Census and The Pobal HP Deprivation Index (Haase and Pratschke, 2012)¹⁷

The particularly high levels of unemployment and educational disadvantage experienced by residents in these areas (such as significantly higher than average levels of people completing their education at primary level, and significantly lower than average levels of participation at third level) demonstrate the high level risk environment, for drug-related harm, they inhabit. The very clearly established link between educational disadvantage and problem drug use - in particular with early school-leavers who have significantly higher rates of drug use than school-attending students (see Haase and Pratschke, 2010) - indicates the high level of risk for young people from this area.

A further example of the risk environment inhabited by many residents in the F-CLDTF area is illustrated by the comparative experience of residents living in the Finglas South C ED area and those living in the most prosperous ED area in the state. In the Finglas ED area, the percentage of unemployed men and women almost doubled from 2006 to 2011 (from 22% to 43% for men, and from 14% to 27% for women); and the percentage of residents with a third level education fell from 6.3% to 4.7% - just one in twenty people. In comparison, in the most affluent area of the state in the same time period, male unemployment increased from 5.2% to 6.3%, and from 3.1% to 5.9% for women; and the proportion of people with a third level education increased from 78.1% to 84%.

This context of inequality and disadvantage are significant influences shaping the nature of community drug problems and the consumption practices of drug users; issues that are explored in the next chapter of this report.

¹⁷ The Pobal HP Deprivation Index measures the relevant affluence or disadvantage of an area using Census data (Population Change, Age Dependency Ratio, Lone Parent Ratio, Primary Education Only, Third Level Education, Unemployment Rate (male and female), and the Proportion living in Local Authority Rented Housing). The scoring is given to an area based on a national average of zero and ranging from approximately -35 (being the most disadvantaged) to +35 (being the most affluent).

SECTION THREE

DRUG TRENDS IN THE FINGLAS AND CABRA AREAS

SECTION THREE: DRUG TRENDS IN THE FINGLAS AND CABRA AREAS

Introduction

In seeking to understand drug use from the perspective of users and neighbourhoods, we first sought to ascertain the overall drug trends in the FCLDTF area, and then examine these on a drug by drug basis. This section is followed by a closer examination and analysis of the consumption patterns of two prominent drug using cultures. In presenting the material in this way, the intention is to identify specific trends in relation to each of the main drugs identified in the area and then assess how these trends are situated within the drug using practices of the two groups and the overall role and meaning drug use has in their lives.

In presenting the data on a drug by drug basis, it is opportune to recall that though people may indicate a preference for, or identify with, one drug or type of drug (such as stimulants); polydrug use is the very much the norm¹⁸. In this respect, drug consumption typically involves the use of a broad repertoire of drugs in a variety of combinations, some used simultaneously (more than one drug at the same time), others concurrently (a range of drugs used on different occasions) in different time and space settings. In addition, different user groups have different intentions and influences affecting their drug choices, as well as a range of self-imposed and externally enforced boundaries and limits regulating their behavior. These issues will be explored in more detail in the subsequent section of this report.

Shifting Trends in Drug use

Participants in the research interviews and focus groups identified a number of drug trends that had occurred in the area over time. Grouping these trends into two separate drug categories - stimulant-type substances and depressant-type substances¹⁹ - helps understand the specific intentions and settings relating to the use of each. And, as a result, three successive trend waves can be detected for each drug group from the 1990s to the present day. In the case of stimulants, these trends were marked by a shift from ecstasy in the rave days of the 1990s to cocaine powder in the early 2000s. This trend was largely replaced by 'legal highs' (such as mephedrone) from 2007 until 2010, and in turn replaced by the resurgence in ecstasy use and a range of new psychoactive drugs being used by a new generation of young people.

In the same time frame, a series of trends in the use of depressant-type drugs were noted. In the 1990s, epidemic levels of heroin use were identified along with the first signs of 'street' benzodiazepine use. The use of such 'tablets' continued to increase through the first and second decade of the 2000s along with herbal cannabis (grass) and alcohol while the use of heroin declined (see Table 3.1).

¹⁸ EMCDDA, Annual Report 2011: "Polydrug use, including the combination of illicit drugs with alcohol, and sometimes, medicines and non-controlled substances, has become the dominant pattern of drug use in Europe".

¹⁹ Stimulant type substances increase mental and/or physical function while depressants decrease mental and/or physical function slowing down the activity of the central nervous system and the messages going between the brain and the body; they do not necessarily make a person feel depressed.

Table 3.1: Key Drug Trends in the FCLDTF area

	Stimulant type drugs	Depressant type drugs
1990s	Ecstasy	Heroin Benzodiazepines
2000s	Cocaine Mephedrone	Cannabis Herb Benzodiazepines
2010s-	Ecstasy (and other stimulants and hallucinogens) New Psychoactive Drugs	Cannabis Herb Z drugs Alcohol

Like other trends, drug trends, have a natural epidemiological cycle with levels of use rising (often rapidly) to a tipping point and then stabilising or falling as saturation point is reached and a new trend emerges. Patterns of drug use evolve continually, responding to global and local shifts in drug production and supply, and in changes in demand influenced by factors such as accessibility, fashion, price, quality etc. For example, the decline in cocaine use in 2007 was influenced by a multiplicity of factors from a fall in production levels in South America, and a shift in their export market from Europe to the United States, as well as a perceived drop in quality, and the collapse of the Irish economy and ensuing reduction in many people's disposable income (O'Gorman, 2010). In the ensuing vacuum, headshop products and legal highs provided a cheap and accessible alternative. Overall, what is clear from the relatively seamless shift from one trend to the next is that the demand for psychoactive substances appears inexhaustible.

Current Trends

In addition to highlighting changing drug trends over time, findings from all our research interviews and focus groups consistently indicated the same current drug trends in the FCLDTF area, namely that:

- Alcohol is the main drug of use across all ages and gender.
- Polydrug use is the norm.
- Cannabis (grass and resin), Ecstasy, Mephedrone (snowblow), Ketamine, and cocaine powder are the most commonly used illegal drugs.
- The use of prescription 'tablets' such as 'yellies' (Diazepam 5), 'blueys' (Diazepam 10), and 'zimmos' or 'Z drugs' was widespread across age and drug user groups.
- Heroin continues to be available, though demand is low and quality poor.

- Crack cocaine and crystal methamphetamine were reported to be used and available, but these appeared to be confined to micro-areas and there was no evidence of diffusion to the wider population yet. In our field research we found no active users.
- There were no reports of young injecting drug users aside from steroid ('juice') users in a gym and body building setting.

Drug retail prices

In addition to asking respondents to identify current drug trends, we asked about the current cost of these drugs. However, prices were seen to vary depending on a range of factors. These included the buyers social relationship to the seller and if they were known to them; whether the drugs were being paid for 'up front' at the point of sale, or 'on tick' or credit; and, the level of supply and demand for that drug at that point in time. In addition, the weights of the drug were reported to be arbitrary; for example, a 'one gram bag' would not necessarily contain 1 gram of the drug. Overall, the €50 'deal' was the most common retail unit on sale with the quantity of a drug made up to sell for €50 rather than been sold by a standard weight (see Table 3.2).

Table 3.2: Current drug retail prices September 2012

Price	Drug and Quantity (approximate as variable)
€50	2 gram bag of grass/weed
€50	½ oz. cannabis resin
€50	.5g of quality cocaine powder
€50	Bag /3 pipes Crack Cocaine rocks
€50	1 gram bag of Ketamine powder
€30	100mls 'Phy' (Street Methadone)
€20	'Score bag of gear' - Heroin
€20	1 gram Snowblow/mephedrone
€20	1 gram low quality cocaine.
€20	Blister pack (14) of tablets 'Zimos' (Zimovane)
€10	10 Roche [Valium]
€5-€10	Ecstasy tablet
€2	'Bluey' - Valium/Diazepam©10mg
€1	'Yellie' - Valium/Diazepam©5mg

Individual Drug Trends

In the following section, trends and views relating to each of the drugs most commonly identified in our research are examined before the polydrug consumption practices of different user groups, and the set and setting in which they occur, are examined.

Alcohol

Alcohol was identified as the main substance used by people in the FCLDTF area, as it is in the general population. Concerns were expressed about the easy accessibility of alcohol with the increased number and range of outlets in the area such as in local shops, supermarkets, garages and pubs, as well as the clandestine home delivery services where age restrictions can be by-passed. The availability of low cost and discounted alcohol was also noted, with one interviewee commenting:

It's cheaper than a litre of milk

There were concerns about the impact of alcohol use by very young teenagers:

kids are talking about having hangovers everyday and not just after weekends

and concerns too about the effect of mixing alcohol and 'tablets' on health, on behaviour, and on the sexual activities of teenagers. There was a sense that because alcohol appeared less harmful relative to illicit drugs that not enough attention was being drawn to its misuse:

sure it's only alcohol, it's not heroin or drugs.

There were concerns about the high visibility of alcohol use in public - in the streets, car parks and alley ways - and also about the more hidden alcohol use in the home and the extent that it fuelled domestic violence, isolation and depression. The increase in alcohol use was seen not just to be related to increased availability and affordability but to be related to the risk environment and setting people inhabit. Young people were considered to be seeking an escape from boredom, and the lack of hope they had for their future. Older people were believed to be escaping from problems associated with job losses, poverty, and the recession.

Cannabis

Cannabis was identified as the most commonly used illegal drug in the area, as it is in the general population. As discussed in Section Two, a major shift in the cannabis market has seen a decrease in the availability and use of cannabis resin (hash) and a significant increase in herbal cannabis (weed, grass, skunk). The often repeated view was that:

*everybody smokes it
a joint is like a cigarette*

Its use had become so normalised and accepted that locally it was hardly classed as a drug anymore:

It's only a relaxer.

Many users couldn't understand why it was not legalised or decriminalised for possession as it had been in a number of European countries in recent years (such as Belgium, the Czech Republic, Estonia, and Portugal). Some queried its legal status, and thought perhaps it was legal, but weren't sure. Other young people jokingly remarked that the government should thank them for smoking 'weed' as it calmed people down and minimised violence. These views contrast sharply with those at policy level where the stance remains resolutely prohibitionist.

Part of the rationale for this policy stance is the public and mental health concerns about the shift from cannabis resin to herbal cannabis. Largely due to changes in the international cannabis market, there has been a shift from imported cannabis resin to an intensification of domestically cultivated herbal cannabis (in 'grow houses') with an increased level of potency. Arnold (2011) noted that samples from seizures of herbal cannabis found that the cannabis which was of Irish cultivation had very high levels of THC (Tetrahydrocannabinol - the main psychoactive component) which appears to induce psychosis in susceptible people, and low levels of CBD (cannabidiol) which appears to protect the brain from the ill effects of THC.

These concerns were mirrored locally. Such is the reputed strength and the high impulse to re-use that a number of 'urban myths' have emerged among older and younger drug users about the drug being sprayed with heroin, or amphetamines. Concerns about effects contributed to an age differentiation in the type of cannabis preferred, with older users expressing a preference for resin, and a wariness of 'weed':

*It's too heavy on the brain.
grass is worse than the gear [heroin] now*

However, price was found to be a further influential factor with older users reluctant to pay the higher cost of herbal cannabis. A bag (roughly 2 grams) of grass retailed at €50 whereas for the same price they could buy a ½ oz of cannabis resin.

Ecstasy²⁰ (XTC, E, bomboms, yokes, pills, MDMA)

After its heyday in the 1990s rave scene, ecstasy's reputation faded as both price and quality dropped in the late 1990s and cocaine became more available and affordable:

we turned our nose up at them – 'you're doing yokes?'

However, now with the decline of the quality and accessibility of mephedrone, Ecstasy has re-emerged as a stimulant or 'upper' of choice among young people for recreational and socialising purposes. It remains a young person's drug; older users are not attracted to its 'buzz'.

The users we spoke to report it being of high quality and available at a good price with the bad 'come downs' that had become associated with its use, a thing of the past:

The most popular drug at the weekend would be Es, it's the cheapest drug you can get and it's the most get out of it drug you can get

that's all we do now again is just yokes

back about 2 years ago the Es were rubbish but these are wooah!

a bag of E dust and you'd be booom - hits you straight in the eyes [all laugh]

I could get you two of the top range 'boms' [ecstasy] for 10 euro and you'd be out of your head - instead of spending 100 euro on coke, a tenner and you're swimming for the night

Ecstasy was reported to be taken in tablet form or powder. 'Green apples' were identified as a current favourite brand, though the type of pills available can be erratic as production bases and supply routes are frequently intercepted. Prices quoted varied from €5 to €10 euros per pill, depending on the quantity bought or the position of the buyer in the supply chain. Users reported taking between 2 to 10 pills per occasion depending on the nature of the session.

Some users who didn't like the sensation of taking pills reported a preference for MDMA powder, and if not available they would use the dust at the end of a bag of pills, or crush pills up to sniff or ingest them:

I'd put a few scoops into a skin and tie it up and swallow and yeah it just dissolves in the stomach and it hits you like a kick in the face it does.

Others smoked the crushed up tablets or powder, either with tobacco in a 'rollie' [hand-rolled cigarette], or a bong:

the smoke looks like its green it's a real dense looking smoke that's in it.

For all users, alcohol was an essential part of their ecstasy taking routine:

Q: would you be drinking with then as well?

A: yeah of course you would, you wouldn't do them without drink.

²⁰ Ecstasy - an amphetamine-type derivative with hallucinogenic properties.

Cocaine powder

As indicated in Chapter Two, the European cocaine market had, by and large, collapsed by 2007 and was replaced in the youth recreational settings by cheaper and more accessible 'legal highs'. Some of the young men expressed a continued preference for cocaine powder, though it too had developed a tarnished reputation with regards quality. Prices varied with €50 for a gram of good quality powder and €20 for low grade. Nonetheless, cocaine was reported to be still delivered and used in pub settings and though 'not as mad as it was before', it continued to function as a means of a 'straightner' extending people's capacity to drink alcohol.

*I'm a man for me coke, like if I'm going to the pub I need a 50 bag or something
when you get too sloppy it [coke] brings you back alive
In the pub - a few darts [lines of coke], few yokes [E], and a few games of pool.*

New Psychoactive Drugs

Mephedrone (snowblow, herbal)

The term Snowblow was used locally to describe generic mephedrone and associated new psychoactive substances, though few users seemed sure exactly what the product they took contained.

Users related nostalgic tales of when the substances were available in headshops as 'legal highs:'

*we used to love that in the headshops, aah stop, and 'wild cat' and all, we used to just buy it out of the shop without drink and all, cos it was legit – you'd be chuffed with life – you'd get your money and go straight to the head shop – we used to sit outside it and then walk down to the field and just sit there
I used to sit in me room with a bottle of water and just sit there and sniff it all day long, chillin, with the music up full blast, just out of me head*

Mephedrone remained highly popular for a number of years and was seen as being effective and good value (currently it retailed at €20 a gram bag). This had a particular appeal among the young women who were more price conscious of their drug spending habits than the young men, and who had found cocaine too expensive:

*it would have you up in no time
a cheaper version of Es and coke*

However, a number of the young people now regarded the quality as having disimproved and the after-effects were reported to have become more severe since it went underground and onto the illegal drugs market [legislation controlling its use was passed in the summer of 2010]:

you can get a bad buzz of it

Consequently, though snowblow was reported to be still available, many had drifted from using this substance to Ecstasy.

Hallucinogens

The use of Ketamine (K or Special K – a hallucinogen with medical uses as a veterinary anaesthetic, controlled under the 2010 legislation) was reported as popular, though not as available or frequently used as Ecstasy or Mephedrone. Priced at €50 a gram, we were told it wasn't hard to get 'if you know the right people'. It was used, similarly to Ecstasy powder, by swallowing the powder in 'a skin'. Users reported its effect to like being in a drunken state and it was generally not regarded as a 'party drug', but was one to be taken in a home setting or just 'hanging around':

That stuff is for in the house or just for up here on the road

The hallucinogenic effects of the drug were described as producing 'an intense buzz' with users feeling their legs turn to jelly 'like walking on water'. Users reckoned that if you were in a pub and seen by the bar staff they would consider:

that you were locked ... that you were full of drink because you are that wobbly.

Higher levels of use were reported to induce a dissociated state and a more extreme loss of co-ordination. Users described going down a 'Ket-hole' and feeling cut off from reality with out of body experiences. We were related many such drug stories about Ketamine use, one of a young man who thought he was chasing a big fish round the garden:

he was running around your man's front garden for an hour and they were all in the sitting room laughing at him, he thought he had a fish and he was 'I have the fish, I have the fish'.

There were some reports of DMT (N,N-dimethyltryptamine) being available – an expensive psychedelic drug (€200 a gram) indigenous to South America and historically smoked by tribal communities to achieve altered consciousness. Users reported that:

this DMT is an unbelievable buzz – you'll never do another drug like it – it's deadly, it's unbelievable.

Tablets

The term 'Tablets' is used to describe an assortment of medication prescribed largely for the treatment of insomnia and anxiety such as benzodiazepines²¹ and 'Z drugs'²². They are depressant drugs in that they slow down the activity of the central nervous system and the messages travelling between the brain and the body, rather than inducing depression. Both have similar long-term usage problems in that users become tolerant to the effect and can also become dependent.²³

²¹ Benzodiazepines such as alprazolam/xanax®, diazepam/valium®, flurazepam/dalmane®, temazepam/Restoril® etc.

²² 'Z drugs' such as zolpidem/stilnox®, zopiclone/zimovane®.

²³ <http://www.druginfo.adf.org.au/drug-facts/>

Z drugs were initially regarded as a safe and non-addictive substitute for benzodiazepines, though as discussed in Chapter Two increasing concerns have been raised about their misuse, and the number of diverted tablets in circulation which has grown exponentially.

Sources of both benzodiazepines and Z drugs vary, some were reported to be licit, prescribed by doctors though then diverted and passed on to family members or sold and exchanged with peers or on the street. Others are sourced illegally from robberies of pharmacies and pharmaceutical companies while more are imported or bought via the internet and from on-line pharmacies. The illicit suppliers range from one person operations (such as pensioners selling on their prescriptions) to major criminal endeavours:

someone you know, people get them, prescribed them, and don't take them – or you'd be 'I'll pay for your script and give you money for them' so they can buy weed or whatever – they'll sell them on.

Locally, they are widely available on the street, from door to door sales, or by order on phones and are often shared or traded for other drugs. Prices are low, €20 for a blister pack of Zimovane; €2 for a 'bluey' – a 10mg Diazepam tablet; and €1 for a 'yellie' – a 5mg Diazepam tablet. Generic or imported tablets cost even less than 'real' branded ones which are reputed to be more effective. Though it was reported to be getting harder to source 'real' ones, the fake ones were widely available - 'you can get them all day long'.

This level of availability and affordability, coupled with their numbing effect, make 'tablets' the ideal recession drug.

*yellies (Diazepam 5) and blueys (Diazepam 10), everybody takes them and that's an everyday drug, not just a weekend
the valium D10 - everyone takes them sitting around with drink*

The quantities consumed appear vast. We had varying reports from people taking 2 to 3 a day; popping ten at a time; using a whole card in a day (usually 14 in a blister pack); or taking between 30 to 40 tablets.

As a 'street drug', tablets were rarely taken on their own or as a primary drug. As described in the following section, their use appears to be largely functional across a variety of settings. They help users to 'come down' from a bout of Ecstasy or other stimulant use; or, as an antidote to the use of high strength cannabis 'weed'; or, to enhance the effects of alcohol. Mixed in large quantities with alcohol the effect is dramatic, leading one person to suggest:

it makes them feel like they're untouchable – bullet proof – that's how all the shootings and shit happens – when you go into a shop and you're full of Roche [Valium] you think you're invisible and every one is looking at you and you're going around out of your head

However, the pharmacological properties of a drug, or combination of drugs, are just one aspect shaping the outcome of their use. As described in Chapter One, the 'set' and 'setting' contexts of drug use are also highly influential. In the next section of this report, drug consumption practices are examined in a more holistic and situated way. As a result, a more nuanced picture emerges, revealing the complexity of drug taking and its outcomes.

SECTION FOUR

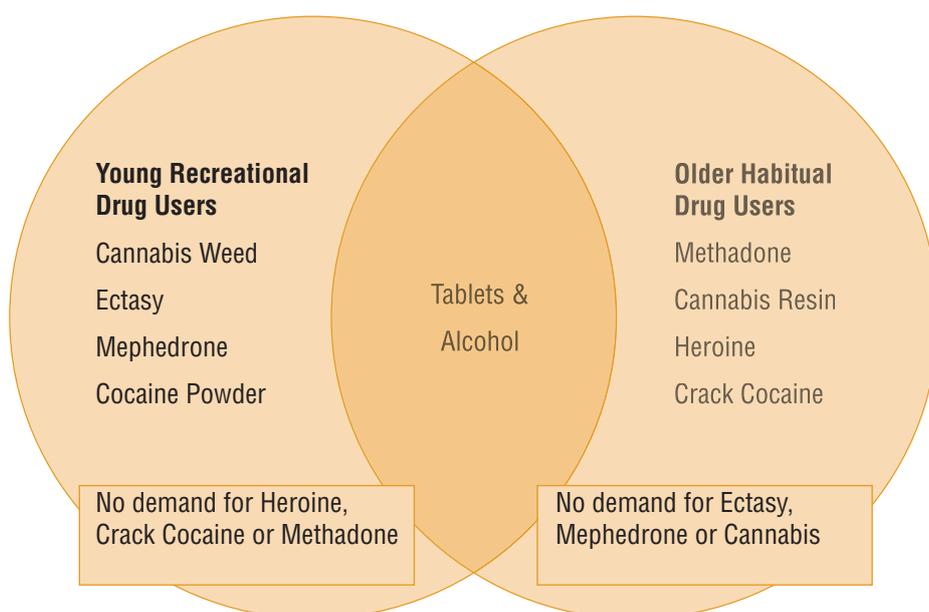
DRUG CONSUMPTION PRACTICES: SET AND SETTING

SECTION FOUR: DRUG CONSUMPTION PRACTICES: SET AND SETTING

In the previous section of this report, trends associated with the main drugs currently used in the F-CLDTF area were examined on a drug by drug basis. However, drugs and drug users do not exist in isolation from their social, economic and policy contexts, or from the influence of the demand and supply on the drugs market and the operations of the drugs economy. In this section, these contextual issues are explored through an analysis of drug consumption practices in a set and setting context (cf Zinberg, 1984). In addition, in order to understand the dynamics of polysubstance use, this study focuses on two key drug using groups - young 'recreational' drug users and older 'habitual' users – each with distinct drug preferences and drug using repertoires, though with some shared consumption patterns (see Figure 4.1 below). These descriptive labels were chosen to differentiate between the group's drug using intentions, with, by and large, the young group taking drugs in a recreational setting, and the older group taking drugs 'to feel normal'.

We met these groups - described as being 'from the street' - hanging out on the estates, by the shops, the canal, the parks and fields; the local congregational spaces where people interact. They do not represent all drug users in Finglas and Cabra, nor do they represent the very many people, young and old, in Finglas and Cabra who do not use drugs. However, they do represent active drug users who have a public presence in the area – a presence which is often perceived as problematic.

Figure 4.1: Main drug using groups and their drug preferences – individual and shared



In talking with, and interviewing, members of these two groups we sought to get a sense of them as people and a sense of their lives, though due to some constraints we had to focus most on the role drugs play in their lives. From them, we found diversity and differences, but also a core set of patterns to the meaning of drugs in their lives.

Young Recreational drug users

The young people we engaged with for this research were mostly 'lads', males aged between 18-24 into 'street drinking', taking drugs and hanging around their areas. About half were early school leavers, the rest had completed school. A small number were linked in with local training programmes, the remainder were unemployed. A few reported they intended to go to college and we learned subsequently that they had achieved this. Almost all were living at home and receiving Jobseekers Allowance, the average weekly payment was 100 euros. From that, their first deduction was 'your Ma's money', then phone and internet bills, after which there was little left.

For these young people with little money or resources and a lot of free time on their hands, hanging out in their friendship groups accounted for a significant part of their daily lives. Friendship bonds and the support they provided each other were of vital importance to them, and influential over the patterns and practices of their drug and alcohol consumption. In their descriptions of drug using occasions they referred to making choices as to what drugs they would consume and where, dependent on the mood they were in and whether they wished to enhance or dispel that mood. On a daily basis they would hang out where they live and stand at the corners having a few joints - the rest was unpredictable.

Despite having few structures and routines to their day and week, patterns emerged from their drug stories which indicated that their drug use and drug combinations were shaped by a range of factors. These included their initial mood; their intention in terms of the effect they sought (up, down or 'straightner'); the money they had; what drugs were available and how easily accessible the drug was (for example, having to travel to another area or into town to score would act as a deterrent; the quality (bad 'come downs' were actively avoided); the responsibilities they had for that day; as well as a sense of differentiating between drug use that was appropriate or functional for weekdays and weekends.

Overall, their drug using intentions could be classified into four categories which ranged from 'chillin', 'buzzin', getting 'mangled', and 'coming down'. Each intention was related to a particular repertoire of drugs: 'chillin' – a combination of one or more of weed, alcohol and tablets; 'buzzin' – alcohol to begin with then mainly ecstasy; 'getting mangled' entailed a higher level of polysubstance use mixing larger quantities of stimulants and hallucinogens; and 'coming down' was eased with combinations of herbal cannabis and tablets (see Table 4.2).

Table 4.2: Drug use intentions - young recreational drug users

	Chillin'	Buzzin'	Getting Mangled	Coming Down
Cannabis Grass (Weed, Skunk)	X			X
Tablets (Zimos, D5s, D10s)	X			X
Ecstasy (Es, Green Apples, Yips, Yokes)		X	X	
Cocaine Powder (Coke, Sniff)		X	X	
Ketamine (Special K)			X	
Alcohol	X	X		

Though many of the young people we spoke to were unemployed, the week was structured into weekdays and weekends and this influenced their drug using habits. During the week, their drug-taking intent is 'to chill' and the typical drugs of choice were 'weed and tablets' with alcohol sometimes added to the mix:

*A few 'roche' and a bit of hash, just all day have a lovely buzz
From Monday to Thursday it's just the weed and tablets*

The weekend, often 'kicked off' on a Thursday and heralded their drug consumption being ratcheted up a notch or two with an emphasis on having a good time, on 'coming up', and sometimes going for a 'lethal buzz'. Those engaged in training and work, and for whom drug use was predominantly a weekend affair, now joined in.

Different drug intentions also required different physical settings. Weekday drug use (cannabis, tablets and street drinking) was mainly at home, in a front garden, or on the street with a few mates. Moving on up to 'buzzin' and 'getting mangled' was a larger group activity and required a different setting - a house party in a free gaff (i.e. where there was no adult in a supervisory role); a derelict house; or an isolated park or field where music and dancing could enhance the experience and they could get 'completely out of it'. There were few supervised venues to hang out or party – many were too young to get into local pubs or were turned away, 'regulars only' was reported to be a frequent response to their attempts to get into pubs or clubs, in any case alcohol was more affordable as a take-out.

The quality of substances was judged on their effectiveness, on how soon they would have the user 'up', and how they would feel afterwards 'coming down'. Currently, Ecstasy was the drug of choice and the weekend

started with - Es and beer. The young users described how they would start at home with a few 'tins' – you'd have to get a few into you before you'd go out - then hang out in their garden or at the corner with a few mates until the evening starts to build up.

In the next phase of the evening, a process of virtual engagement would start with the young people texting and 'facebook-ing' each other:

are you getting a few bomboms?

People start texting: 'are you on it?', 'are you on it?', 'are you on it?' and then eventually they meet up. All agreed that they would only take Ecstasy if the mood was right and they were in good form:

the happy feeling is the time for the Es - we would do E, sniff, and speed - the three of them together – it's a lethal buzz.

Es is a love buzz so it is – you don't be fighting when you're on Es unless something really kicks off

After the first few beers, many reported cutting back on alcohol and not mixing it with the stimulants. On these occasions, alcohol use decreased as the night progressed and they described how they would carry the one bottle around with them for the night, though they would continue using coke and ecstasy right through the night.

The quantities they consumed varied, with up to 10 pills over the weekend if the night progressed into 'a bender' (more usual in the summer or at festive bank holiday weekends) moving from Saturday night into Sunday when they could be 'up' for a couple of days.

its good craic while you're doing it, it's the best craic in the world when you're doing it.

Despite the young people's narratives describing the enjoyment and excitement of these occasions:

lovely buzz - everyone chatting to you and having a laugh

stories of 'bad trips' and 'bad buzzes' were plentiful. The main concern was the immediate aftermath of a session and the inevitable and dreaded 'come down'. Young users described the intense depression, the paranoia, the cold sweats, and their tendency towards aggression during this phase 'you'd be boxing the walls' and their attempts to self-medicate with 'tablets' and cannabis to try manage these come-downs.

Most of the young people we spoke to were male. The groups we found hanging out were predominantly male as young women had much less of a public presence and the two groups rarely mixed together in public until late in the evening. The young women we talked to were into their 'valium and drinking' when they were hanging out at home, whereas for partying they preferred herbal highs such as 'snowblow'. One of the fieldworkers noted:

they don't hang around with each other on a day to day basis it's like last thing at night, before they go home.

In contrast, the women in the older habitual user group played a more central role in their group setting.

Older Habitual drug users

The older drug users we met were mainly in their mid-thirties to forties and had a long drug using history, often spanning decades, with a history of injecting and a preference for 'tablets', alcohol, methadone, heroin and crack cocaine (in preference to cocaine powder). Almost all were linked in with services, many were on 'on the clinic' attending a methadone maintenance programme either in the area or in the city centre; others were primary 'street drinkers' who topped up with prescription drugs mainly, and street methadone if available, and tended to congregate separately from the others.

In contrast to the young recreational drug users, their drug intention was to feel normal.

they are not going out to get stoned anymore, they do it now to feel normal, to be 'a part of'.

To achieve this, their daily drug use involves 'tablets' mixed with alcohol, and methadone (usually prescribed for them), and 'if we can afford it we'll treat ourselves' to heroin and cocaine.

Attending the clinic, and often the pharmacy, on a daily basis provides a structure to their lives and they congregate nearby, sitting on the wall and drinking tea [allegedly to 'bring up' the effect of their methadone], and catching up with the people coming to and fro. The group provides a support structure for each other, sharing and swapping stories and tablets for much of the day. Drug sales within the group are done for little profit, and there is an expectation that 'you sort each other out':

If one person gets their prescription on a Tuesday and the other might not get it until Thursday so the Tuesday fella will share it with the other fella - they kinda look after one or another.

The fieldworkers noted:

they are lifers really, that's the life they live and they seemed happy and content living that lifestyle. They don't go out of their way to get drugs anymore, or go out robbing for it. If someone had either heroin or cocaine they would use it but they don't go out looking for it, they appear content with what they had.

The quantities of tablets consumed by this group varied. There were drug stories of users of long-standing taking 30 or 40 a day, though most reported more cautious amounts with an expressed preference for either one or the other type of tablet - benzodiazepines or Z drugs.

I wouldn't take Roche [valium] 'cos I don't like them, I just take zimovane, just 2 a day - I get full of energy off them, get the bumble bee [buzz] off them

I wouldn't be able to do without the 2 [valium] I have everyday, I take them in the morning

The habitual users had little interest in stimulants or in 'buzzin'. Cocaine was mainly used with heroin and their preference was for depressants – opiates, methadone, tablets, and alcohol.

Alcohol was a key drug of choice among this group, in stark contrast to when they were actively using heroin and didn't drink alcohol at all. One group of users estimated that eight out of ten people on the methadone maintenance clinic were alcoholics, who had moved 'from gear to beer':

You'd see them going around to the X [local pub] they might go in and have a pint if they have an extra few quid – but mostly its Dutch Gold and cheap beers on the corner.

The potential harm of mixing alcohol, methadone and 'tablets', was an issue of concern in the two local drug treatment clinics. Clients who seemed intoxicated on arriving at the clinics were reported to be breathalysed, as one attendee related:

if they even suspect you to be a bit drunk, they make you blow into the bag [breathalyser], they won't give you your full dose if you blow over a certain amount, they'll only give you 20mls, they have their regular people that they breathalsyer every day, they know who drinks.

Cannabis smoking was part of this group's daily drug using routine, though in contrast to the young users they expressed a preference for hash [resin] rather than weed [herbal]. Many felt that 'weed' was 'too heavy on the brain':

I take 4 pulls on it [weed] and I have to go to bed, I'm gone, I'm not able for it at least you're yourself on the cannabis [resin] you know what you're doing ... you're not aggressive, you don't want to look for trouble, you just want to get on with your day to day whatever you're doing.

The combination of 'tablets' with 'weed' produced an additionally powerful effect, which was sought after by some 'it's a lovely mix':

if you're after taking valium as well and you're smoking weed you'd be out of your bickie ... but that's what you pay for, that's what I pay for.

However, in addition to the influence of perceived effects, the higher cost of herbal cannabis was an influential factor in their choice of consumption:

weed is stronger, it's a nicer buzz – weed is like a luxury to hash smokers – it's too expensive, you couldn't afford to smoke it.

Many of the drug users 'on the clinic' and 'in recovery' spoke about the demise of heroin in recent years 'heroin has taken a back seat'; and that an epidemic of crack cocaine 'rocks' had taken off in the last three years. However, none of the older habitual users we spoke to were currently using crack cocaine; neither had the trend appeared among the younger users:

I've never seen anyone under 30 under 25 smoking crack.

This is not to infer that crack cocaine is not available or being used in the area but users were not visible during the time of this research study. In any case, crack cocaine by its nature tends to be a hidden rather than a street drug as it requires an indoor setting where pipes can be lit and smoked, as one former user commented:

You couldn't go into a 'jacks' and start smoking a rock.

Many of the habitual users reported past phases of intense crack cocaine use, a period they now recalled with some dread especially regarding the effects – the sickness in their stomachs; the impact on their bowels; and the craving to re-use:

Morning noon and night 24/7, 7 days a week 52 weeks a year crack, crack, crack – it's just mental.

They recalled buying the powder and washing up the cocaine themselves:

When I started on it 3 years ago I used to get 50 bags of powder and I'd wash it up myself and I'd get 20 pipes ... It's gone harder to get the powder to wash up into the crack, it's dirt now, it's mixed to shite.

Consequently, current users were reported having to buy their rocks which was much more expensive, though from the sellers point of view a lot more money could be made from selling it this way.

All agreed that after using crack you'd need something to help you come down from the intense 'up':

A couple of roche, a few zimmos, a lump of hash, bit of grass or else your bag of gear.

The drug combinations consumed by both young recreational drug users and older habitual users indicate an additional level of risk behaviour. These will be explored in Section Five, which looks at the drug-related harms associated with polysubstance use and the operations of the drugs economy. Before doing so, the remainder of this section examines the neighbourhoods the drug users' inhabit and identifies the differences between the two main areas in the LDTF area – Finglas and Cabra.

Neighbourhood effects: Finglas and Cabra

The Finglas-Cabra Drugs Task Force area covers a broad range of diverse estates and neighbourhoods with established differences in their socio-economic and demographic composition as well as in the structure of their built environment. In assessing the patterns of drug use across the LDTF area we found substantial differences at the micro level which related to the risk environments identified earlier (see Section Two and Appendix Three). Again, it is worth re-stating that this research study dealt with the visible presence of drug and alcohol use in the LDTF area, and it was not within the scope of this study to include more hidden forms of drug use which are undoubtedly present.

The contrast between the Cabra and Finglas areas was regarded as 'massive':

across that bridge [Broombridge] you'd see some difference within a couple of minutes - it's a different world over there.

Finglas, as noted earlier, has an extremely high level of unemployment and educational disadvantage and is a high risk environment for drug-related harm. The area is largely made up of social housing built by the (now) Dublin City Council. In a number of these estates, the built environment is poorly maintained with uncollected refuse and a high proportion of boarded up houses:

We walk around and we see so many houses that are boarded up in Finglas South and that's on the increase, and we see houses that have been boarded up for well over a years and a half, two years, still boarded up, still nobody in them.

all we see is broken glass, empty tablet bottles, boxes... it has completely been forgotten about.

At the street level we found groups of teens, young and older adults (predominantly male) congregating publicly, and often in mass, at different 'hot spots' in the area - outside local shops and the post-office, pubs, church walls and car-parks, in the front gardens of gable-end houses, as well as in more secluded spaces in fields and parks nearby. Many are street drinking, mostly cans of beer, the older ones with bottles of spirits. The waft of cannabis lingers in the air as you pass by. Others can be seen making their deals, young 'gilleys' [delivery boys with hoods up] circle around on their push bikes; older boys, higher up the supply chain, squeal to a stop then rev off in flash fast cars and 4x4s, a package is exchanged, mostly subtly, but often not.

In the more remote spots in both areas by nearby railway tracks, isolated parks and alleyways, we found strewn cans and broken bottles; butts of cigarettes and joints; discarded 'skins' and torn cardboard strips from Rizla packets; empty pill bottles and blister packs of tablets, indicating the drug using scenes that congregate there. Residents in these areas expressed their fear of having to pass by or live near the public spaces the street users inhabit.

Each area is made up of different urban villages. For example, in Finglas, people differentiated between the West, the East, the South and the 'far South'. For the most part, people from the different areas mixed together, though some of the young men avoided areas they considered to have a rough reputation, reckoning it would be dodgy to go there if you weren't known.

In contrast, Cabra is largely an old settled mixed-class area, though as noted earlier, with some deep pockets of disadvantage. At a street level, there was a stark difference between the two areas. In Cabra, there are few people hanging out on the streets and there is little visible presence of drug use or an 'open' drugs²⁴ market where people deal in public, as we had witnessed in Finglas. A lot of the older heroin users were reported to have died or moved out of the area, and there were no visible signs of habitual users hanging out in the area. The local clinic is located away from the village across the bridge and people tended to come and go to that in taxis. Compared to Finglas the drugs market was 'closed' and mainly selling recreational type drugs:

they're selling grass, selling snowblow and they're selling Es.

there is harder drugs here but it's very small cliquey and they won't deal with strangers. You can't just walk up the street and give someone a nod, are you looking? ... it's a very closed shop.

Mostly, people went to 'little hide out spots' to take their drink and drugs so as to avoid being seen; street behaviour was reported to not be tolerated. Locals related tales of anti-drug marches and people being ordered out of the area for drug-related activities by community activists seeking to address anti-social behaviour and keep drugs out of the area:

the main policy is to keep drugs out and keep drug dealers out.

²⁴ An 'open' drugs market is one open to any buyer, without need for a prior introduction to the seller (Hough and Natarajan, 2000). A closed market requires an introduction from a trusted source.

In this respect, the vast majority of people we talked to referred to the activities of ‘the shiners’ – though this seems to be a generic name given to anti-drug activists and people viewed as having connections with republican movements. We were told:

you can get any drug you like in Cabra but because of this ‘community activism’ everything is kept on the low key, your try and keep it down as much as you can

if you have the phone number of someone they’ll come out and meet you but there’s no one standing on the corner saying are you looking? so if you have the numbers you can get it, but just walking up and down the street you’d be left walking up and down.

The differences in the visible drug scenes in Finglas compared to Cabra demonstrate how much trends can vary at a micro level within a Drug Task Force area. The research literature suggests that the differentiation in the level of risk environments inhabited by residents plays a significant role in this outcome. Although, as noted previously, there are a small number of pockets of extreme disadvantage in Cabra, the critical mass of disadvantage in Finglas provides a context where drug-related harms and risk behaviour were seen to flourish to a much greater extent - as will be examined in the next section of this report.

SECTION FIVE

DRUG-RELATED HARMS - POLYSUBSTANCE USE, AND THE DRUGS ECONOMY

SECTION FIVE: DRUG-RELATED HARMS - POLYSUBSTANCE USE, AND THE DRUGS ECONOMY

In addition to the drug consumption practices and the level of risk environment identified in the previous chapter, two further issues were identified as posing a high level of risk for drug related harms. Firstly, the drug-related harms brought about by polysubstance use; and secondly, the drug-related harms emanating from the users' interactions with the drugs economy.

Polysubstance use and risk behaviour

Drug interactions between substances, both illicit and licit, taken simultaneously or concurrently, are a complex pharmacological issue, and the effects, in particular between combinations of street drugs, is largely unknown. Science struggles to understand and keep up to date with drug using practices especially those involving the new psychoactive drugs appearing on the market.

Drug websites offering harm reduction advice and information advise against experimenting with various combinations of drugs as some drugs potentiate (increase the effect) of others; often with erratic effects. At a minimum, it is known that mixing street drugs, alcohol, prescription medications and over-the-counter medicines is unpredictable. The effect of drug combinations is seen to be highly individual and dependent on a number of factors. These include the previous drug experience of the user; the doses taken; the drugs used; his/her expectations; and the setting in which they take the drug (MacDermot, 2008:117). Users of 'street drugs' are particularly vulnerable in that can never be sure what they are taking – the drug may not be what the seller claims, and the quality and potential toxicity of new psychoactive drugs is unknown and often of dubious standard. Substances manufactured and packaged by illegal and uncontrolled 'underground' laboratories can contain by-products that arise from poor chemical synthesis, as well as being distributed in an unregulated fashion, such as not being stored at the correct temperature etc.

Though the National Advisory Committee on Drugs (2012) caution that the lack of knowledge about the toxicity and effects of new psychoactive substances makes it difficult to suggest specific harm-reduction advice to users; there is general agreement in the literature on some basic harm reduction guidelines. For example²⁵:

- Combining depressants – benzodiazepines, Z drugs, alcohol, cannabis and heroin - increases the risk of overdose.
- Mixing stimulants (such as Ecstasy and Cocaine) with depressants (tablets, alcohol, heroin etc.) places the body under severe stress as it attempts to deal with the competing effects of 'uppers' and 'downers'.
- Mixing Ketamine and depressants can cause nausea, vomiting, decreased breathing rate, coma and death.

²⁵ A range of harm reduction websites provides realistic information for drug users such as - <http://www.druginfo.adf.org.au/drug-facts/>; <http://www.urban75.com/Drugs>;

- The chances of an overdose are increased if ecstasy is taken with other stimulant drugs such as amphetamines or cocaine. This combination can also increase effects such as heart rate, blood pressure and anxiety.
- Using ecstasy and drinking alcohol at the same time can lead to dehydration and overheating, and can also increase the negative effects of 'coming down'.
- Taking Ecstasy with some antidepressant medication can lead to unpleasant effects such as increased heart rate, loss of coordination, nausea and vomiting.
- Using benzodiazepines to help with the symptoms of the 'comedown' of stimulants can lead to a dependence on both drugs.

Many of the young recreational drug users we spoke to were keen internet researchers using the myriad of drug information and drug discussion websites (such as erowid.com, pillwatch.com etc.) to explore drug pharmacology and the effects different drugs and combinations could achieve; such as seeking to offset the hallucinatory effects of weed with the calming effect of a 'tablet'. The more cautionary information on these websites appeared to be ignored and did little to deter many from experimenting:

I haven't a clue what's in them but I don't care.

these days we don't know what we're taking, nothing is pure anymore but we'll just take it anyway.

Though everyone seemed to have a bad drug experience to relate, the reactions to these experiences varied. For some, a negative experience changed their attitude to drug-taking:

I took 3 seizures over smoking weed and doing coke and came off everything, am off it 6 months now.

Whereas others claimed to have enjoyed the effects of having 'a mad one':

God no sure it was deadly- but I just couldn't move – but what was going on in me head was brilliant

There was, however, more than an element of bravado in these drug stories, and we suspected that these experiences were not as wonderful at the time, as they were when related retrospectively.

In seeking to understand the nature of risky drug-taking practices, it helps to consider the role and meaning drugs have in the lives of their users. The young people we interviewed related the positive effects of 'buzzin' and the confidence they felt stimulant use gave them for going out partying and going into pubs and clubs. The young women were particularly emphatic that they would not dream of going out without drugs because they needed them for a confidence boost.

On a positive note, many of the young people we met sought to move away from what they perceived as risky drug use, and they related the boundaries, limits and the personal harm minimisation strategies they set around their drug taking:

Every now and again I'd take a dart or two of coke at a party – weed I'd smoke that every day. Tablets, I wouldn't go near, they leave you like a door brain forgetting everything, so I wouldn't go near them.

Most of us have our limits – have some cop on - like I wouldn't do anything Monday to Thursday then on Friday I'd probably do something just to have a buzz but I wouldn't be smoking weed or tablets or anything.

A key finding from our interviews and fieldwork with the young recreational drug users was the absolute abhorrence they had of heroin, crack cocaine, and intravenous drug use. As a consequence, they placed a firm boundary around their drug consumption practices in respect to these:

Es, apples, weed, tablets, everything bar crack and heroin.

Gear would get you strung out and leave you like a junkie.

No [heroin use] there was very, very few maybe you could get one out of ten lads that probably had a taste for it, but it's still the older generation, crack as well.

Naah [to using needles] – couldn't tell you anyone my age who is using needles.

This phenomenon represents a positive outcome for drug education, public health and harm reduction messages, though a trend for intravenous 'juice' use (steroids) was noted in a gym setting:

'Juice needles' is the only needles you'd see around in Finglas.

Steroid use was reported to be popular with young males who wished to pump up their body weight, but the effect was reckoned to cause people to 'go off the head'. One young man reported that he had stopped using the substance as he found himself snapping at others over what he regarded as the stupidest things. He related a story about a friend who continued to use steroids:

he does be going around looking at his arms arms going 'feel that', it was rock solid the muscle and while he's doing all this he's doing 10 to 15 blueys a day and snowblow on Fridays ... you get a month's course [of steroids] he did it in 3 days, he was whacking the juice out of it, he ended up falling out with his Ma and Da and he told me he picked up his old fella by the throat saying 'I'll fucking put your head through the wall' - it was over nothing.

In addition to the risky practices that polydrug taking entails, the engagement of users in the drugs economy, either as a buyer or seller, posed a further set of risks.

Engaging with the drugs economy

Though the operations of the drugs economy was not a focus of this research, the topic of how people accessed and afforded drugs arose naturally within our conversations with users. The increased variety of licit and illicit drugs available, and the process whereby users access drugs, was seen to have changed substantially in the past decade. The drugs economy now ranged from the small deals and drug exchanges at street level; to deliveries at 'uptown' parties; to money laundering within financial institutions; and a global industry moving goods from one continent, country, city and town and using the latest technologies and telecommunications (mobile phones, Facebook, drug discussion sites, on-line pharmacies) to trade and shift product from one location to the next.

From those we interviewed, we identified two significant changes as being highly influential. Firstly, the impact of new technologies on the operations of the drugs market; and secondly, the collapse of the traditional binary opposition between user and dealer, with the boundary between the two becoming increasingly fluid.

The diffusion of new technology into people's everyday lives has also impacted on the sale and use of drugs via anonymous mobile and social media communication, and internet drug shopping. By and large, the mass open drug markets and sellers with distinct pitches on street corners are gone, though, as noted earlier, elements of this remain in parts of Finglas. Accessing drugs is now largely done through mobile phone contacts:

You don't have to walk around and say - can you get me this? can you get me that? You just ring someone and say do you know if such and such has yokes there and he'd say no I'll see if this fella has I'll ring you back in a minute - then he'd give him your number and he'll call 'are you looking for stuff?'

A: No one stands on corners now, everything is on the phone - you'll actually get a message on your phone everyday - 'phone on'. [He reads messages out] 'phones on lovely rock'; 'up and on'.

Q: What do they mean phones on?

A: I'm in business, your man's working, he sends it out in a multi message to everyone.

Q: When you ring how does it work?

A: It's dropped off, or you go and meet them, now when they deliver it to you they want a fiver extra, delivery charge. A taxi actually comes and delivers it to you and your man says an extra fiver there. You don't have to leave your door.

On-line illicit pharmacies and 'community websites' provided another source for licit and illicit drugs, and information on their effects. Some of the drug sales advertised on such websites were reported to be scams with buyers sending credit card and pay pal details which are then used fraudulently. Others, though, were reported to be a reliable source which provided the drugs as specified. After registering an email address on these sites members can send anonymous personal messages to each other to finalise deals etc. Recent messages on one such site advertised a range of drugs such as cannabis, ecstasy, mephedrone and DMT for sale:

looking 4 weed in Dublin

DMT dublin - samples available for first twenty.

Most people we spoke to, though, did not have the financial wherewithal to possess credit cards to purchase on-line and expressed a preference to buy locally, where quality was reckoned to be better, and there was the possibility of negotiating a discount or free tasters and samples, especially when a new brand of drug came on the circuit:

you're guaranteed to get at least one free 'cos if there's someone selling Es they want to give everyone 1 or 2 to get them going 'cos then they'll want more.

Local sellers used a range of marketing strategies to move their produce, advocating for its effectiveness and quality:

It's great, go out and do it, you should do it, you're missing out here, you haven't a clue what you're missing out on, this is brilliant lethal buzz.

go on just take one they're good.

Prices were not static, and varied depending on how well you knew the seller, your ability to negotiate, and whether you were paying cash up front, or 'on tick':

if you have cash you get a 3 gram bag [of snowblow] if you give 50 euro up front, but if you get it on tick you get 2 grams.

Similarly, the price of good quality cocaine varied from:

A 100 euro a gram, but if you'd 80 cash I'd take it off you.

The binary opposition between user and dealer, though a persistently popular concept in public discourse, does little to tease out the complexity of how drugs are brought, shared and exchanged among users. The phenomenon of a 'social supply' of drugs operating in peer groups, and with little profit motive, was first identified in the 'rave days' of the 1990s when quantities of ecstasy would be bought for sharing within a peer network.

The current trend for social supply was seen to be firmly grounded as an anti-austerity measure in the context of the current recession and the lack of disposable income. For both the young recreational and older habitual drug users 'social supply' and the sharing of drugs was an essential means for affording them:

If you're short, friends will sort you out [with drugs]

you would be offered a 'sniff of coke or an E. Like one E is a fiver, no one is going to - like I wouldn't go back to them and say 'have you got that fiver'.

Many of the young users we spoke to had links with higher-level dealers and did some dealing themselves, in the sense of selling drugs for profit. Research studies internationally have demonstrated how marginalised

young people with aspirations for status and financial success, but with little opportunity to achieve these through the formal economy, often provide a steady supply of labour for local drugs markets (Nightingale 1993; O’Gorman, 2005). In the context of the economic crisis, with few employment and funding opportunities open to young people from the area, working in the local drugs economy provided some scope for paying bills, and for being able to participate in social events including the cost of their drug use. One of the fieldworkers recorded that:

the lads we were talking to last night, only get a 100 euro a week [young persons jobseekers allowance], one of them was telling us he has two little kids and he gives €30 euro maintenance, he gives his Ma €20 and he has €50 euro to live on a week and he says of course I have to sell something I can’t live on €50.

Similarly, an interviewee remarked:

it’s all the recession, the recession hits everyone in different ways, it’s just a load of shite, like some people can have trades and proper qualifications and still sell drugs ‘cos they can’t get a job, so it’s either that or let their kids going round with bleedin’ holes in their runners.

To explore this issue further, we sought to estimate the drug costs of both the young recreational drug users (see Table 5.1) and the older habitual users (see Table 5.2) based on our analysis of their consumption practices.

Table 5.1: Estimated range of drug costs per week - Recreational users

Recreational Users	Weekdays	Low	High
Alcohol	2 nights x 8 cans per night (4 cans = €5)	20	20
Cannabis Herbal	Low = 1 bag (€50) once a week. High = bag every second day	50	150
Tablets	2 – 5 ‘to chill’ @€2 each	4	10
	Weekends		
Alcohol	Low = Tray of cans €20 High = Tray + Spirits €30	20	50
Ecstasy	€10 each	20	20
Mephedrone/Cocaine/Ketamine	1 bag @ €50		50
Tablet	Low = 5 @ €2 each ‘to come down’ Blister pack = €20	10	20
TOTAL		€124	€320

These calculations are based on users paying full retail prices for their drugs, though as noted earlier much of their drug use was shared, traded, and discounted. We also factored into the calculation a range, from high to low, that sought to take account of the variable quantity of drugs that would be used in a given week. The estimated range for active recreational drug users was from €124 – €320 per week; and for the older habitual drug users from €69 - €200 per week.

Table 5.2: Estimated range of drug costs per week - Habitual users

Habitual Users		Low	High
Prescribed Methadone	75-120mls	-	-
Prescribed Tablets	2 tablets x 7days	-	-
	Additional		
Alcohol	7 nights x 4-8cans per night (cans 4 for €5)	35	70
Additional Tablets	2-5 per day	4	10
Cannabis Resin	¼ oz – ½ oz.	30	50
Heroin	1 bag @€20	n/a	20
Crack Cocaine	3 rocks/pipes €50	n/a	50
WEEKLY TOTAL		69	200

The cost of these levels of drug consumption provides some additional rationale, particularly for the young drug users, to get involved in the drugs trade. However, it also increased their risk of drug-related violence, predominantly from building up drug debts.

Drug-related violence

The popular conception of drug and alcohol related violence focuses on the psycho-pharmacological effects of alcohol and drugs (particularly cocaine and other stimulants) on people's behaviour. In this respect, among the users we spoke to, the combination of alcohol and valium was regarded as having an especially negative effect:

*mixed with drink [tablets] you can go just off the wall
you don't care you have 'the pill power' in you*

However, for the most part, the young recreational users we spoke to were clear that their intention was to have a good time, and that drug-related violence stemmed from other issues:

some of the young fellas are going around off of their head and doing what they want – some people take advantage of the drugs. We don't. We go on them but we keep to ourselves and just go out for a good night.

Their attitude is bad as well, and the drugs and their attitude doesn't mix well.

The research evidence is clear that the pharmacological properties of the drugs are just one aspect of a complex web of possible effects and outcomes of drug use (see Zinberg, 1984; and Goldstein, 1985 among others). Two other factors must also be taken into consideration in assessing drug-related violence: the link between violence and acquisitive crime to fund drug purchases (though not all drug-related crimes are violent) – and the violence arising from the operation of the drugs economy and local drug markets. In this hidden economy, without recourse to a legal means to police itself, disputes over territory, suspected informants, and stolen or seized consignments of drugs are liable to be resolved by violent means (Hammersley, 2008).

A recent study, of the impact of drug use and drug markets on a number of neighbourhoods across Ireland (including Finglas), described the complexity and volatility of inter and intra-crime group relations (often kinship based, with various splinter groups of former allies, now foes) operating at the distribution end of the trade (O'Gorman, 2013). Finglas and Cabra have been the scenes of a disproportionate number of such drug-related violence and 'gangland killings'. Though, not all the victims of these disputes were involved in the drugs trade, some were innocent bystanders in the wrong place at the wrong time and mistaken for, or in the company of, the intended victim.

For many of the young people we spoke to, building up a drug-related debt was the main cause of drug-related violence. Such debts would start to build up by getting 'a lay on' from whoever was selling that day, if they had no money:

A: you don't even need money for drugs you just go out and you see the right person and you say yeah give us that until next week

Q: how much tick would you get?

A: depends on who it's off, how much they can afford and how much you know the person

Q: so would you go around to a few people?

A: nah that's the worse thing – loads of people do – they are planning on getting out with not playing – that's why people get a batter – if I get some off him, then him, then him then I'd have to watch for five people instead of just getting it off with him and watch for him.

If I owe someone money I'd pay him I don't really owe people money but if I did I'd rather just get it out of the way as soon as I could ... if you're avoiding them they just don't like it.

Unpaid debts were punished – ‘you get a box around for owing 50 euro’. There was some disagreement about whether taking the punishment struck out the debt though this seemed to depend on how well you were known to the seller, whether you sold yourself, and how strong you were in standing up to the sellers:

Like if you get hit your bill is dropped and you don't have to pay then.

Some people kill you and still want their money and then the more you don't pay them the worse the hidings you get.

If someone hit me I wouldn't pay them

Users reported harsh punishments being meted out to enforce the servicing of drug-related debts including severe beatings and murder, and described how this contributed to suicides, and attempted suicides, by those unable to cope with their situation. Overall, violence was seen to be an accepted and normalised means of resolving disputes:

Finglas is nowhere near rough, people just get turned off with all the shootings but at the end of the day that's just someone who didn't pay someone or done something wrong.

Going to the police was not an option for the young drug users as they were compromised by both committing an illegal offence by possessing drugs and by being involved in the drugs trade themselves. In any case, the young people we spoke to reported poor relations with the Garda and related how they experienced over-policing and getting:

a lot of hassle and 'hindings'

they class a crime as loitering just standing around doing nothing and we're saying 'what do you want us to do, there is nothing to do'.

Overall, the additional level of drug-related harm experienced by these young people from their engagement with the drugs economy through the buying and selling of drugs, added to and exacerbated the risk behaviour resulting from their polydrug drug use and the risk environment they inhabited.

SECTION SIX

CONCLUSIONS

SECTION SIX: CONCLUSIONS

Key Findings

This research study set out to describe and analyse the current patterns of illicit and licit drug use in the Finglas-Cabra Local Drug Task Force area. An analysis of key indicator data on drug use, accompanied by evidence from our fieldwork, highlighted a number of new and emerging trends. These included a shift in use from cannabis resin to herbal cannabis with concomitant concerns about its effects on mental health, and an increased diversity in stimulant use which included cocaine, new psychoactive drugs, and more recently ecstasy. Additional trends were noted regarding the pervasiveness of polydrug use and the widespread availability and affordability of 'tablets' which were used, along with alcohol, across drug user groups.

Data indicated that the levels of drug use within the Finglas-Cabra Drug Task Force area were higher than the national average, as well as many other drug task force areas. The prevalence of illegal drug use has continued to increase over time in the area, with substantial increases noted in the use of cocaine powder and ecstasy. Local patterns of treatment demand indicate a continuing upward trend for problem drug use with a younger than average age group in treatment. In addition, the number of drug offences in the local Garda region continued to increase when they were falling at a national level, though this is a function of local policing strategies as well as a continued increase in drug use in the area.

Evidence is clear that a high risk environment - in terms of economic disadvantage, unemployment and educational disadvantage - such as that inhabited by many residents in the Finglas-Cabra LDTF area, contributes to a high level of drug-related harm. In 2006, at a time of unprecedented economic growth, 18 out of the 20 Electoral Divisions in the Finglas-Cabra LDTF area were designated as disadvantaged. Since then, a number of these ED areas have experienced further severe decline with five neighbourhoods in the area ranking among the 50 most deprived in the state in 2011. Although, there are a small number of pockets of extreme disadvantage in Cabra, the concentration of disadvantage in the Finglas area reflected the visible differences in the drug scenes between the two areas and the critical mass of drug-related harms and risk behaviour that were identified in Finglas.

In examining drug consumption practices in detail, this study focused on those who were active drug users with a public presence in the LDTF area - a presence which is often perceived as problematic. Two key drug using groups were subsequently identified - young 'recreational' drug users, and older 'habitual' users - differentiated by distinct drug using intentions and drug using repertoires, though with some shared consumption patterns.

These drug user groups were seen to make functional choices based on the outcome they sought from a drug taking occasion; the effectiveness of a given drug to achieve this outcome; and the quality of the drug, particularly in terms of the severity of the 'come down' they experienced in the aftermath of its use. The availability of the drug; the ease of access; and the price also influenced consumption as did the day of week, and whether the users were hanging out at home, on the street, or partying.

Though, levels of risk behaviour were high among both younger and older user groups, there were positive signs of choices being made and limits being set on their drug use. In particular, the shunning of heroin, crack cocaine and injecting drug use by young drug users demonstrates the potential to influence drug using decisions through the creation of age-specific, context-specific, and gender-specific harm reduction programmes. For both the young recreational drug users and the older habitual drug users, friendship groups were a valued source of support and an important influence over the patterns and practices of their drug and alcohol consumption. Consequently, these friendship networks provide potential as a site for peer interventions.

Implications for Policy

In drug policy discussions there is tendency to focus on a particular substance – such as ‘tablets’ or ‘cocaine’ – or combinations of substances, as the key determining factor shaping drug trends. However, this substance specific focus is not hugely helpful in understanding the drug phenomenon at a neighbourhood level. The findings of this research study demonstrate that the drugs themselves are just one aspect contributing to drug-related harm in a community. As with many social phenomenon age, gender and structure matter, in that different types of drugs become normalised for different groups of people depending on the opportunities and constraints placed upon them by their structural location in society (Shindrick, 2002; MacDonald and Marsh, 2002).

The high risk environments for drug-related harm that are inhabited by residents in Finglas, and to a lesser extent Cabra, indicate the continued need for a drugs policy that addresses socio-economic marginalisation, unemployment, and educational disadvantage. However, in contrast, current drugs policy frames the increase in drug use in the general population as a universal phenomenon (DCRGA, 2009), rather than one which is predominantly space and context specific. This marks a shift in policy from area-based initiatives, such as those undertaken by the local drug task forces. By failing to make a distinction between individuals’ drug use and the dynamic of community drug problems played out in a context of social and economic exclusion, policy strategies are unlikely to provide an adequate response to the types of drug-related social problems that have been identified in this report. Though drug trends may change and new drugs emerge, evidence continues to indicate the disproportionate impact drugs have on young people with difficult lives who live in challenging neighbourhoods. In order to address such community drug problems, broader contextual social issues must also be addressed.

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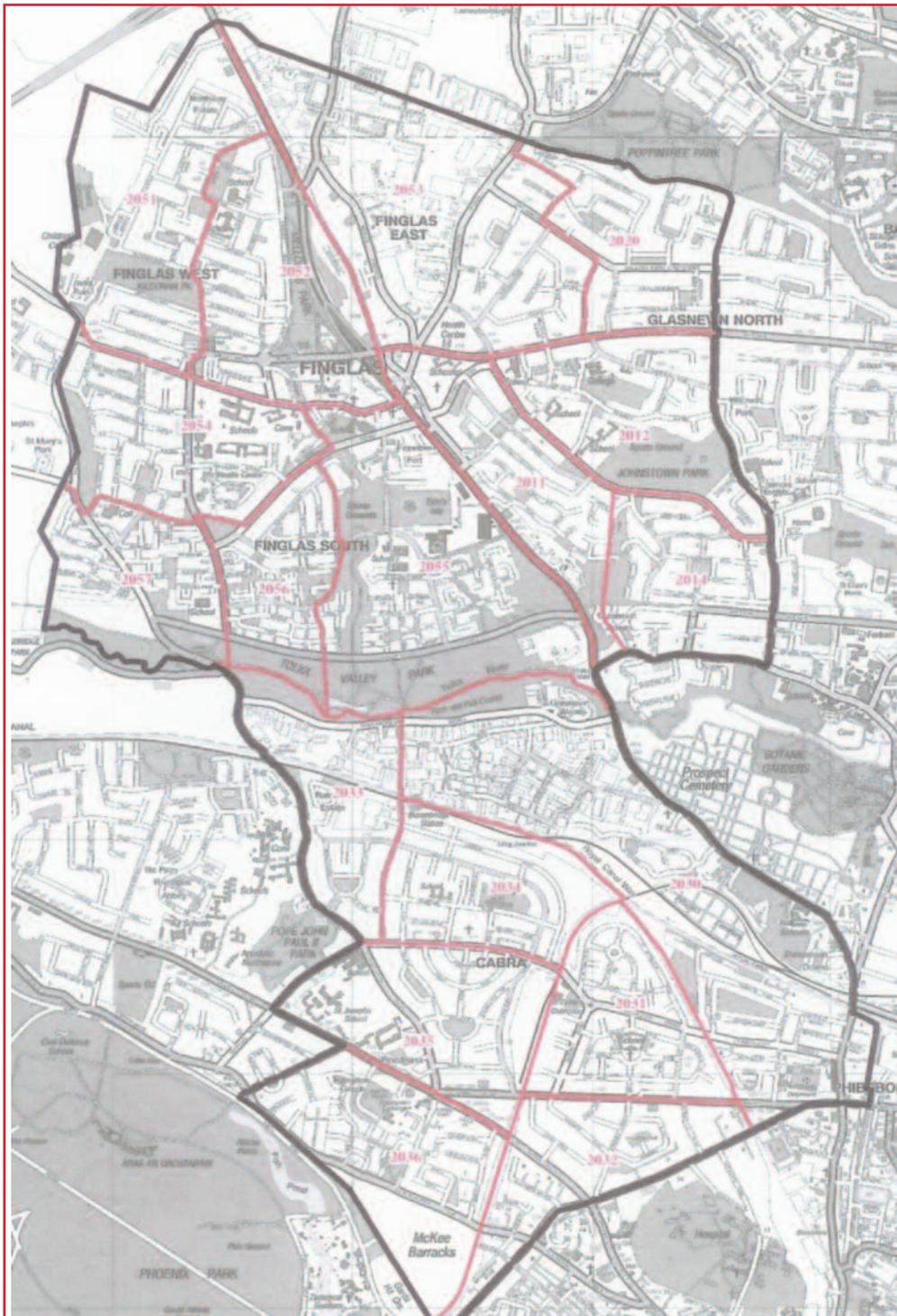
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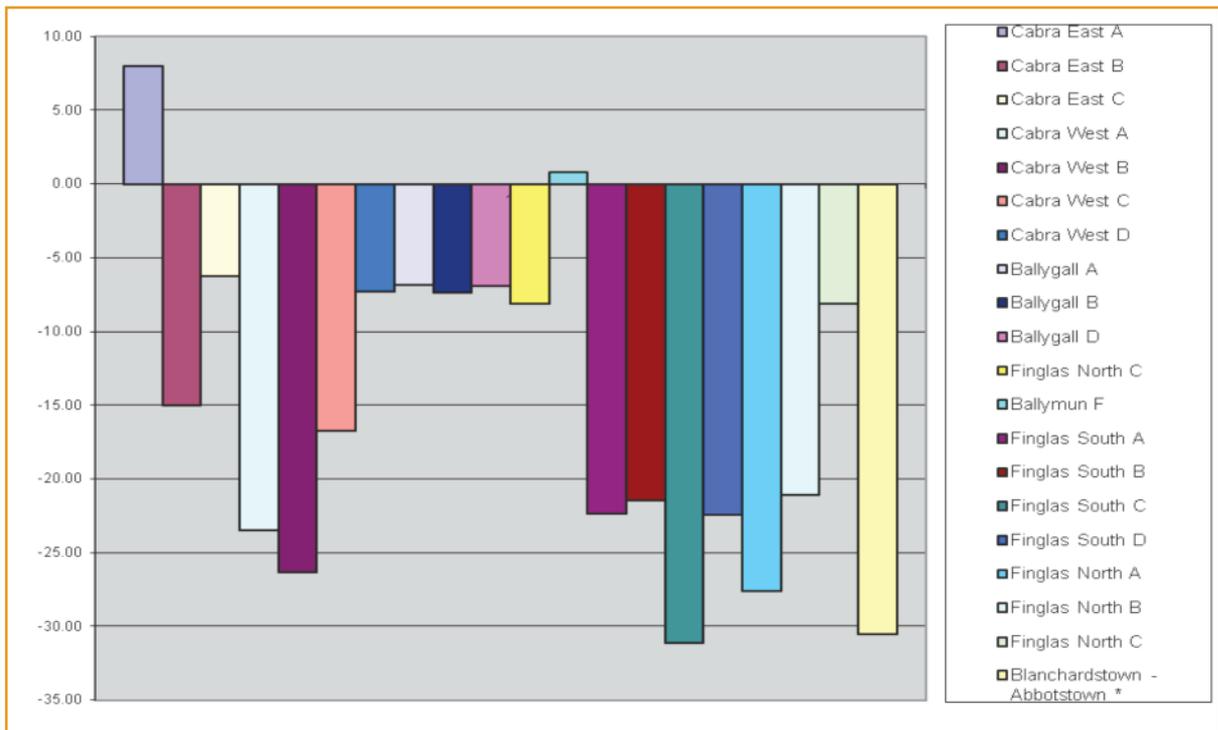
APPENDICIES

APPENDIX 1: MAP OF THE FINGLAS/CABRA LOCAL DRUG TASK AREA



APPENDIX THREE: CENSUS 2006

		RIS	Prim. Ed	Un M	Un F	% Local Authority Housing	% Pop. aged 15-24	Abbreviations
Cabra East								
Cabra East A	Marginally above average	7.97	12.3	10.2	6.7	5.9	18.5	- RIS = Relative (Deprivation) Score
Cabra East B	Disadvantaged	-15.03	34.4	13.1	10.0	5.0	13.7	
Cabra East C	Marginally below average	-6.24	22.5	17.3	12.2	7.4	16.4	
Cabra West								
Cabra West A	Very disadvantaged	-23.47	42.2	16.1	11.2	11.1	14.8	- Prim Ed= %
Cabra West B	Very disadvantaged	-26.35	43.4	16.6	13.4	19.8	12.6	Percentage of
Cabra West C	Disadvantaged	-16.73	35.3	15.1	11.4	8.9	14.1	residents aged 15
Cabra West D	Marginally below average	-7.28	24.0	13.9	8.4	16.1	17.0	and over with
Finglas East⁹								primary education
Ballygall A	Marginally below average	-6.83	24.0	13.4	11.4	8.8	18.0	only
Ballygall B	Marginally below average	-7.35	30.4	9.8	6.4	13.2	11.3	- UN M = % of
Ballygall D	Marginally below average	-6.96	26.7	10.5	10.0	6.4	14.2	Unemployed Male
Finglas North								- Un F = %
Finglas North C	Marginally below average	-8.15	30.3	7.6	4.5	2.4	13.6	Unemployed
Dubber (Charlestown) *	Marginally above average	N/K	N/K	N/K	N/K	N/K	N/K	Female
Ballymun F	Marginally above average	0.80	21.8	6.8	5.5	0.7	16.0	- LA Hsg = % of
Finglas South⁹								Local Authority
Finglas South A	Very disadvantaged	-22.39	37.8	19.1	15.2	12.8	14.8	rented
Finglas South B	Very disadvantaged	-21.45	36.4	16.4	13.8	18.4	14.6	households
Finglas South C	Extremely disadvantaged	-31.09	44.4	22.1	14.3	26.7	15.0	- 15-24 = % of
Finglas South D	Very disadvantaged	-22.40	36.8	19.0	13.9	12.1	14.2	Population aged
Finglas West⁹								15-25
Finglas North A	Very disadvantaged	-27.60	41.1	21.4	18.4	23.7	17.8	
Finglas North B	Marginally below average	-21.10	37.3	16.2	15.0	23.0	15.6	
Finglas North C	Marginally below average	-8.15	30.3	7.6	4.5	2.4	13.6	
Blanchardstown/ Abbotstown *	Extremely disadvantaged	-30.56	63.6	55.7	43.8	19.0	12.5	



The following areas have been defined by TAP as geographic areas that are naturally affiliated and used terms that would be recognised to the communities within those areas

RIS -50-- + 50

* outside TAP area but included as Finglas is the natural hinterland for residents of the areas in seeking services and supports

⁹ RAPID or PART RAPID area

Source: Tolka Area Partnership (TAP) Demographic Overview, March 2011

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