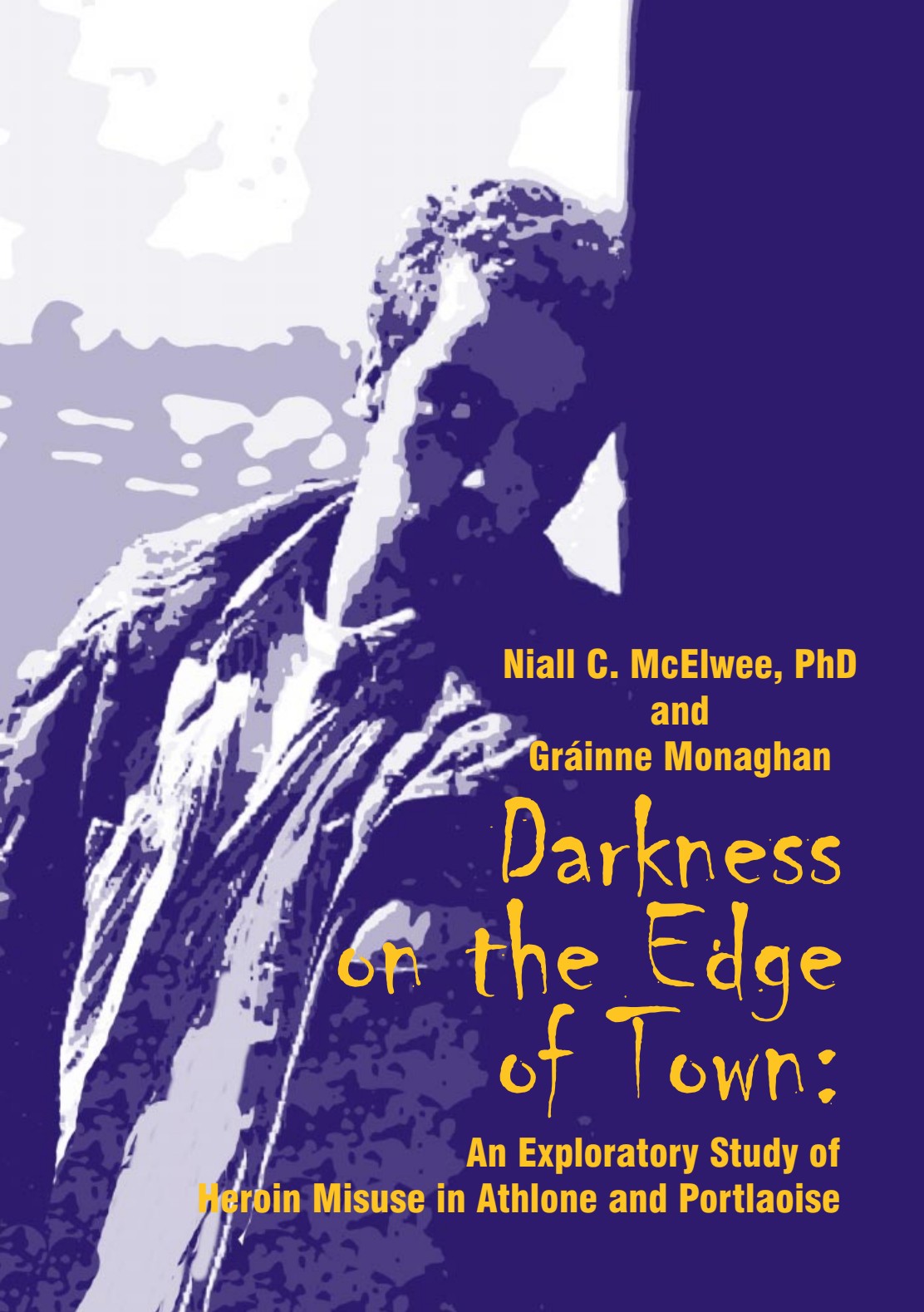

Niall C. McElwee, PhD
and
Gráinne Monaghan

Darkness on the Edge of Town:

An Exploratory Study of Heroin Misuse in Athlone and Portlaoise

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For Conor and Tiarnán

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Foreword

The sounds of sniffing and images of a young adult shuffling in his chair and periodically scratching at the inside of his arms were memories that came flooding back as I read of this exploratory study about heroin misuse and abuse in the seemingly quiet midlands towns of Athlone and Portlaoise. The personal and family accounts shared through this report left no escape from the human misery, pain and suffering associated with heroin misuse in a part of Ireland previously thought sheltered from the realities of social issues traditionally considered city problems. The authors are to be commended for walking the fine line between science and art, where rigours of research protocol, methodology and subject left room for the real life experiences of men and women living rough or in temporary shelters, plotting how to 'score' their next bag of heroin while contemplating bleak futures and premature deaths through risk-taking with needles or unknown 'gear' and mothers agonised about children or grandchildren while victims of theft sought help, restitution or justice from the Gardai, the Courts and human service agencies.

The authors of this report have shown that heroin use and abuse in local communities – as with use and abuse of alcohol, tobacco and other so-called 'soft' or 'hard' drugs – is fundamentally a personal and family issue that touches on the lives of far more people than one might have previously thought. From attempts to define heroin use, misuse and abuse – whether by smoking or injection – to an exploration of quantities used measured in 'bags' or Euros, and human suffering measured by health statistics, prison sentences or tears, the authors have succeeded in sharing a story that should be of real interest to local people in Ireland, public officials, social and health service providers, students and teachers engaged in social care/nursing/social work education and training as well as researchers engaged in and planning social research. It is one thing to do research and write about a subject such as heroin misuse and abuse. It is quite another challenge to engage with people living in and around the 'heroin market', whose

lives and those of their families, friends and neighbours have been touched and influenced by the social behaviour of users.

The methodological dilemmas associated with research of this kind were many. As members of local communities chosen as the focus of study, the researchers faced a plethora of expectations. On the one hand, they had to operate within ethical guidelines and seek after valid and reliable accounts about the nature of 'the problem' and its many manifestations. On the other hand, the researchers had to bridge chasms that commonly exist between an underworld of criminal behaviour and the otherworld of social norms and community expectations in the midlands of Ireland. This was no mean feat.

For some, the campaign against drug abuse and addiction has become a moral crusade characterised by intolerance and punishment. For others, the campaign is about harm reduction, public health and community education. For still others, the challenges are about relationship-building with people for whom relationships have never been strong, or where bridges of relationship have been systematically destroyed. In seeking to address the phenomena of heroin misuse in two midlands' towns of Ireland, these researchers have opened themselves to public misunderstanding while at the same time enduring the suspicions of heroin users with legitimate fears about sharing their identities and stories.

The most compelling themes for me were found in the actual narratives shared throughout this study. The lyrics and tune of Bruce Springsteen's song – Darkness on the Edge of Town – that inspired the title of this study kept resonating throughout each chapter. The tearful accounts of mothers concerned about their children and grandchildren. The challenging accounts of Gardai seeking to contain local crime and protect local communities. The worrisome accounts of health care providers seeking to manage potential health epidemics through harm reduction initiatives whether HIV-AIDS awareness campaigns or needle exchanges aimed at containing hepatitis. The thoughtful reflections by social workers encouraging calm and considered responses while highlighting the significance of realistic assessments about needs. The alarmist views of those who would have communities look suspiciously around every street corner or pub for drug dealers spreading their evil

gear. But, most importantly, in this study are the graphic accounts from heroin users themselves, telling about their substance use and abuse, about their physical health and emotional wellbeing, about their experiences in prison, about their friends and family members – both living and dead – and of the many children abandoned by parents living in the netherworld of heroin misuse and abuse.

For those hoping to find definitive statements about the precise nature of the problems of heroin misuse in the principle midlands towns of Ireland, there will be some disappointment. Such precision will have to await further examination and study. If one accepts – as the researchers have shown – that the problems of heroin misuse have developed rapidly over the past decade, then it follows that care and systematic planning and review – as well as continuing research – will be required in order to contain this problem. As the researchers have shown, the patterns of heroin misuse are multi-faceted. The reasons and motivations for heroin misuse are also many. It is worth noting pointers about identifying characteristics of the sample population who participated in this study. These highlight the presence of solitary figures often cut-off or alienated from friends and family members. Many began heroin misuse very early in their lives but many were males in their late 20s and 30s. Those who participated often presented as emotionally needy people – estranged from others – with escalating patterns of heroin intake.

It must be remembered that few of the so-called "recreational users" of heroin in the midlands of Ireland stepped forward to tell of their stories in this study. That these users exist is confirmed through accounts shared by others and in projections made by service professionals. However, little is really known about them. For all one knows, these men and women – and they are most likely to be men – use heroin at particular times during the course of their daily lives while maintaining appearances of healthy living, daily employment and sustained family responsibilities. These recreational users – invisible at the tip of the iceberg – represent the unknown extent of heroin use and misuse in the midlands of Ireland.

While alcohol use and misuse has been an historical feature of Irish cultural life, the full story about heroin use and misuse remains

unknown. As recommended by McElwee and Monaghan in this study, further research is required in order to sensitively address such policy and practice issues.

This study represents a brave initiative on the part of the Regional Drugs Task Force, the Midlands Health Board, by the Gardai, by the community leaders of Athlone and Portlaoise, by local health and social service providers, by family members living in the midlands of Ireland, and most importantly by the brave men and women with courage to share their stories. It is only through such relational engagements that there can be any hope of understanding the precise nature of heroin misuse and how to address it in human terms. It is one thing to do research about social problems. It is quite another challenge to carry out research with others in such a way as to inform problem-solving, by helping policy makers, community leaders, professionals and family members to identify specific actions that help build bridges towards participation in community life while at the same time fortifying defences that can protect future generations of children and young people from entering the dangerous world of heroin use and misuse.

There is still much to learn along that journey. However, this study offers important guidance about traversing the minefield of social expectations that often prevent full and frank examination of the issues. I commend this study as an example of good research that offers an important start on the journey towards enhanced understanding. While further investigation is still required, there can be little doubt that future investigations will benefit enormously from such a solid beginning. More than 2 out of 3 heroin users who participated in the pilot study for this Report said they were parents of children. If only for the sake of these children, may God help all concerned towards better understanding and relationships that matter for the future of Ireland's children and young people.

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Contents

CHAPTER 1

Darkness on the Edge of Town: Heroin Misuse in Athlone and Portlaoise

Niall C. McElwee, PhD

The court room shuffle

It is a late September Friday morning and Gráinne and I are sitting in a courtroom in Portlaoise. The court is surprisingly quiet as cases unfold and we are getting accustomed to court rituals. Indeed, we are now seasoned court attendees as we attempt to track the path of 'problem' drug users and their families involved in heroin addiction in the midlands of Ireland.

The court has the usual scattering of Gardai, Prison Officers, Solicitors, Court Personnel, family members of accused, the accused – and the two of us. There are about a dozen members of the public sitting on benches that were surely constructed with the deliberate intention to reduce comfort. Behind us sits a young woman dressed in a long green army style parka and filthy jeans. Her streaked peroxide hair badly needs a wash. Her fingernails are bitten to the quicks. She has an overnight bag at her feet and she is clearly edgy and distressed. Gráinne and I both notice that she has two prison-style tear tattoos under her left eye. She is up on a charge of stealing €80 of goods from a store in Portlaoise town. She is addicted to heroin.

In front of us, a young male from Athlone in his early twenties sits in the witness box. He, too, is edgy. He seems all-too familiar with the proceedings and his head hangs as the presiding Judge reads through

his lengthy case file. His accompanying prison guards shift from foot to foot as we all await the Judge's thoughts. 'Derek' is up on several charges. He has *eighteen* previous convictions stretching back to the mid 1990's. His Solicitor informs the court that Derek has a heroin addiction. He slept rough in a doorway the night before he stole a stereo player in Portlaoise and was apprehended and arrested by the Gardai. 'Derek' had missed a court appearance in Athlone town the day he was arrested in Portlaoise because he had no money for the bus, hence his stealing the stereo to get money. 'Derek' has started on a detox programme in Clover Hill Prison and says he is desperate to get off his heroin addiction. The Judge refers the case to a later date. He has heard it all before but treats all in the court with respect.

A number of things strike us, as researchers, investigating heroin misuse in Athlone and Portlaoise as we attend court sittings, talk with drugs service providers and families affected by heroin misuse. There are few people who are not fully aware of how 'the system' works. All actors involved generally go about their business in an unhurried, calm manner. There is the odd incident where a prisoner articulates anxiety or anger towards officials and is restrained.

A world without love?

In the main, we sense a profound sense of hopelessness and fatigue from the families of heroin addicts and, indeed, the heroin addicts themselves. Cigarettes are shared; jokes are exchanged between the accused and prison officials and Gardai as all wait outside court for prison cars and vans to remove people to places of detention. Families mill around trying to sneak one last kiss or hug or message from a sibling. But, removed they are and smiles quickly disappear as the cars and vans depart.

As Gráinne and I walk to our next scheduled interview, people with heroin addictions are being moved back and forth between places of remand and detention to court rooms throughout the country. This is a mini-industry. How did we get to this?

Earlier in the morning, we sat in an interview room as a mother of another heroin addict told her story about the devastation that her son's addiction has caused her family. She is at her wit's end. She looks tired

and deeply distressed and fights to keep back tears. Her story unfolds,

"I have a son, he started using heroin at fifteen years old, he's now seventeen. He met this girl aged nineteen, she started him on drugs. We've been to social workers, we've been to everywhere really to get him help. I left Portlaoise to go to Athlone, to see could I get him help and he ended up coming back to Portlaoise to this girl. He's been in St. Pat's a few times, he's only out on appeal, and the reason he got out on the appeal was he was to live with me, but he only lasted two days and went back on the heroin, and he got on cocaine now and… I believe, but not injecting. That's one thing but he's smoking or whatever he does with it, and there's a lot of sellers and all in Portlaoise so it's easy get it and actually his girlfriend is a seller so he gets it from her."

She tells us that she is going to throw her son out because she is fearful of the effects of his behaviour on his siblings. "What can I do?" she asks. What, indeed as so many issues have been raised in this brief section of text?

Stories tell the tale

We thought a great deal about what we might title this study for it is essentially about stories: stories from heroin misusers, about the effects of heroin on their lives; stories from service agency personnel about their experiences of people accessing their services; stories from family members of heroin misusers; stories about life about death. Stories about heroin.[1] The iconic rock star, Bruce Springsteen, penned a wonderful song which we played sometimes on our many car journeys back and forth between Athlone and Portlaoise towns. In it he sings:

"Everybody's got a secret Sonny,
something that they just can't face.
Some folks spend their whole lives trying to keep it, they carry it with them every step they take
'til some day they just cut it loose, cut it loose or let it drag them down.
Where no one asks any questions or looks too long in your face
In the darkness on the edge of town." (Darkness on the Edge of Town)

1 We employ the term 'drug-misuse', rather than 'drug-abuse' in this study to reflect the change in official discourse.

We have been privileged to learn a great deal about the sub-cultures that surround heroin in Ireland and, in particular, heroin misuse in two provincial locations. We say 'sub-cultures' because we do not feel it is accurate to speak of only one sub-culture as is often the case. We have interviewed heroin misusers who are third level students, who are employed, who are unemployed, who are homeless, have spent time in prison, are about to go to prison, who are on training programmes, who started taking heroin twelve months ago with just one bag and have progressed to sharing ten bags a day, who are on methadone, who sell their methadone, who deal drugs to get enough money to buy their next bag of 'gear', who have accessed services, who have accessed services and left them again, heroin misusers who are mothers and fathers.

Although disadvantage is the norm, for sure the only commonality between all our interviewees is heroin itself. Educational disadvantage was one of the dominant factors that respondents felt can lead to heroin addiction and research shows that 95% of heroin addicts in Ireland have not completed formal education (Morgan, 2003), pointing towards the inequalities in society and how addressing educational disadvantage would be hugely beneficial.

However, not all of our interviewees were from poor socio-economic environments as we interviewed an individual who is currently in third-level education. Every individual story is just that – an individual story. An individual set of experiences and, indeed, non-experiences that our interviewees have tried to make sense of and communicate to us. We are interested in these stories as they have immense value in, and of, themselves. And it is these stories that tell the tale.

The irony of heroin

It seems deeply ironic that the word 'heroin' comes from the German language and means 'powerful' or 'heroic'. There is little heroic about an 'addict', certainly not in physical appearance. Heroin became both trendy and notorious in the 1980s, particularly in the fashion and media industries where the so-called 'heroin chic' look was cultivated and a new generation of younger people became interested in the drug. The age at which people started experimenting with heroin across the

western world lowered and heroin was used much more extensively as a 'recreational' drug. Unfortunately, heroin devastated communities and we witnessed the birth of new social movements such as the Concerned Parents Against Drugs in the inner city areas of Dublin in the mid 1990s as a response to the widespread pushing of heroin.

Communities have been, and continue to be, ravaged by the effects of heroin and the 'heroin addict' remains one of the most stereotyped and marginalized persons in our societies. It is little wonder that we tend to find heroin abuse amongst the dispossessed and the alienated in high density housing estates, in prisons, in half-way houses and shelters as people therein face so much adversity. It is worth remembering that behind every statistic there is an individual and people who felt 'this only happens to other people' mark out their path to addiction. Many times we heard interviewees ruefully acknowledge that, 'This drug got hold of me'.

While some people argue about the supposed dangers of heroin, longitudinal studies tracking heroin users from the early 1960s in the United States, to take one example, clearly illustrate the destructive impact heroin can have on users. Researchers at the University of California at Los Angeles (UCLA) followed 581 male heroin users who were involved in the California Civil Addict Programme in the early 1960s finding that 48.9% of the heroin users had died, while 20.7% of the survivors still tested positive for heroin when surveyed in 1996-97 (Yih-Ing Hser, 2001).

Statistics in context

One might think that very few people would start to use such a drug with all the negative publicity around heroin however, this is not the case. Estimates suggest that 180 million people worldwide were consuming drugs in the late 1990's and nine million people worldwide were addicted to opiates (World Drug Report, 2000). Drugs are big business. In 2000, a total of 51 tons of heroin was reported seized by government authorities around the world. The table below breaks out the approximate percentage of heroin seizures by region.

Table 1:1 Heroin Seizures	
Europe	37%
South and Southwest Asia	35%
East and Southeast Asia	14%
Central Asia	6%
Americas	6%
Oceania	2%
Africa	0.4%

Source: World Situation with regard to Illicit Trafficking and action taken by subsidiary bodies of the Commission on Narcotic Drugs: Report of the Secretariat, United Nations Economic and Social Council, Commission on Narcotic Drugs, E/CN.7/2002/4 (December 2001), p. 15.

The income of the drug barons is an annual $500,000 million, which is greater than the American defence budget (*Guardian,* 14.6.2001). Of course, drug markets do not behave like any others because the mark-ups from source to consumption are so extreme.[2] In Bristol, England, the wholesale price of an ounce of 'fairly' pure heroin cost around £800 at the end of last decade. Of course, dealers never sell pure heroin; instead cutting it up to five times. Moreover, dealers have become skilled at reducing the risk for themselves by, for example, using juveniles in high-risk situations.

In 2001, a thirteen-year-old girl, acting as a drug mule, was arrested at Manchester airport with over 13kgs of heroin, with a street value of £910,000. We learned of a young female teenager in Athlone who was arrested by Gardai for transporting heroin for a dealer.

Scotland has not fared much better than England where Glasgow has long been regarded to have had a very serious heroin problem. At least 15,000 addicts – 3.1% of the population aged between 15 and 54 – live in the greater Glasgow area and spend more than £160 million a year on their drug habits, largely funded by crime. Of the 300 people who died through drug overdoses in Scotland in 2002, the vast majority

2 To buy enough coca leaf to manufacture a kilo of cocaine, with a street value of at least £50,000 costs only about £200 (Observer, 8.7.2001).

were in Glasgow (*Observer*, 6.7.2003).

In the UK, cocaine and heroin seizures have risen by 600% since 1981, yet the street prices have plummeted from £100 and more per gram of either drug to between £30 and £50 today. In 1989 about 4,000 people were convicted of drug dealing or possession with intent to supply; 10 years later the total was more than 15,000. Nevertheless, the evidence is overwhelming that there are more dealers, and many harder drug users, than ever before (*Observer*, 8.7.2001).

At a European level, out of a population of around 375 million people, an estimated 1-1.5 million persons are 'problem' drug users with heroin being the most prevalent source of the problem (Department of Community, Rural and Gaeltacht Affairs, 2003). Estimates indicate that half of these 'problem' drug users, around 500,000-750, 000 people, are injecting their drug of choice (EMCDDA, 2003: 10).

Cannabis is the most commonly used drug in Europe today. In all countries, recent use is at it's highest among the 15-25 year age group (European Monitoring Centre for Drugs and Drug Addiction, Annual Report, 2003: 9). It was also reported that more men than women use illegal drugs across all countries (EMCDDA, 2003:16). Opiates are the main substance of misuse among people seeking medical treatment, with 50%-70% citing heroin as the 'problem' drug (EMCDDA, 2003: 21) In Ireland, 65% of those seeking treatment are heroin users while in Finland and Sweden heroin users represent below 50% of those seeking treatment (EMCDDA, 2003: 21).

The Irish landscape

In a general population survey conducted by Friel, Nic Gabhainn & Kelleher (1999) heroin was found to be the drug least used in the general population. Nonetheless, during 1998, eight out of ten people receiving drug treatment were doing so because of opiate use (NDTRS, 2000). There are wide variations nationally in the nature of drug use so it is difficult to provide commentary that is representative of all areas. There is no single drug problem requiring one solution, instead there are complex patterns of 'problem' drug use and there are many

influencing factors (NACD, 2001) [3]. Indeed, one of our interviewees pointed out that crack was his preferred drug and that he only started to use heroin because he "*wanted an even greater high.*" Despite the fact that he almost died on his first two attempts at injecting heroin (in two different locations in Dublin) and was involved in three separate shoot outs over drugs whilst abroad, he only sought help when he decided, himself, that he "was sick being sick."

An RTE news broadcast of 1.3.2004 noted that there are now more deaths as a result of heroin abuse in the Dublin area than as a result of road traffic accidents. The National Drugs Strategy 2001-2008, states that heroin issue in Ireland is predominantly a Dublin or urban phenomenon; however, in recent years *both* urban and rural areas have experienced an increase in drug use with 25% of the overall population having tried an illegal drug at some time in their lives (NACD, 2003).

In May 2003 at the launch of a report on opiate use in Ireland commissioned by the NACD, the Minister of State with responsibility for the National Drugs Strategy, Noel Ahern, made what we consider to be a courageous remark, "The fact that there are over 2,000 heroin users outside of Dublin means that we cannot afford any degree of complacency in tackling the problem" (*Irish Examiner*, 2003). We wonder how many users live in Athlone and Portlaoise out of this 2,000.

The age at which people start to take most drugs is usually between 15-29 years. Heroin and cocaine, however, are different with 40% of clients reporting having first tried heroin between the ages of 20 and 29 years. We have found several cases in this study of both males and females who were reported by their peers as first smoking heroin under the age of fifteen. We will return to this later in the study.

The Midlands: Uncovering the heroin scene in Athlone and Portlaoise

It could be argued that 'the heroin' issue to date has existed predominantly in urban areas, but changing patterns are increasingly evident. Cities such as Dublin, Limerick, Galway and Cork are affected

3 A national drug treatment reporting system was established in Dublin in 1990 and has operated since 1995.

by heroin use but prevalence is also recognized in towns such as Carlow, Athlone, Bailieboro, Co. Cavan, Mullingar and Birr, Co. Offaly (see *Irish Examiner*, 2002; *Athlone Voice*, 2004). The availability of heroin and the reported cases of addiction to this drug in the midlands have increased rapidly since the 1990's, indeed at the time of writing up this study, three people from Athlone died as a result of their heroin misuse in just a four-week period.

The National Drugs Strategy targeted an increase in the number of drug treatment places by the end of 2002 to reach 6,500, which was exceeded. Regionally, it was found by the Midland Health Board, Drug and Alcohol Services (2004) that the numbers of people attending the clinics for drug related problems *rose* between 2001 and 2002. They also found that heroin was the main primary drug of use for people attending the service with the highest numbers attending in the Athlone area. People injecting their drug of choice are also increasing (Midland Health Board, 2004). Over 80% of people first used drugs under the age of eighteen and over 17% of people attending the clinics first injected between the ages of 18 and 24 years (Midland Health Board, 2004).

In fact, the number of drug users presenting for treatment in the Midland Health Board doubled in the five-year period 1996-2000 with 150 persons in receipt of treatment in 2000. Worryingly, the number of first contacts increased from 49 in 1996 to 87 in 2000 (DMRD, 2001). We know from the established literature that the majority of drug misusers in the Midland area are (a) male, (b) in their teens or early 20's, ©) living in the family home and (d) poorly educated.[4] However, we have noted in this study the increasing numbers of female drug users.

In terms of heroin use, we note that 7 persons were in treatment in 1996, but this had dramatically increased to 57 in 2000 in the MHB area (DMRD, 2001: 5). Anecdotally, we have been informed that this figure is a serious under-representation of the heroin problem that exists in Athlone and Portlaoise towns with suggestions, and they remain

4 In terms of a child and youth care perspective, the majority of 'clients' started taking drugs around the age of sixteen to seventeen, so there is much that could be done in terms of preventive strategies (see NACD, 2002).

suggestions, of between 80 and 300 persons misusing heroin in Athlone and 70 and 250 in Portlaoise. A question one might ask is, how does one sort out the difference between the increase in numbers of people attending services because there is an increase in drug use, versus the increase in the number of people attending services, because it is now more acceptable to get help?

Drug prevention and a harm reduction approach in the Midlands

In Ireland, successive politicians have vowed to defeat both soft and hard drugs at times demonising addicts, and at others using the media to create waves of what criminologists call 'crime panics' (McElwee, 2001). The result has been an almost complete restriction on political room to manoeuvre which, we suggest, is dangerous to all. There is another approach – termed harm reduction.

Marlatt (1998) described the principles which underlie a harm-reduction approach (to adolescent alcohol and drug use):

- Harm reduction is an alternative to the moral, criminal, and disease models.
- Harm reduction accepts alternatives if total abstinence is not a realistic goal.
- Harm reduction is a bottom-up, consumer-oriented approach.
- Harm reduction promotes easier access to services.
- Harm reduction involves compassionate pragmatism rather than moral idealism.

The Midland Health Board, Education and Prevention Policy: 14 states that in developing prevention programmes, the issue of harm reduction cannot be ignored. The policy expands to state that the essence of harm reduction is in placing an emphasis on the prevention of dysfunctional drug use, rather than striving to eliminate use altogether and that harm minimization has a role.

During the 1990's the Irish government started to acknowledge the role of harm reduction after the HIV/AIDS crisis. Intravenous drug users were identified as "high risk" (McElwee, 1997; Kiely & Egan, 2000:13). Harm reduction also applies to 'sensible' drinking, sensible clubbing

and other drug uses. However, harm reduction usually applies to more serious drug risks such as needle sharing and overdose. Harm reduction messages are not directed only at drug users but also relatives, members of the community and parents. Increased understanding in these circles can reduce the social isolation experienced by many drug users. Again, one of our interviewees stated "*I was lucky to get away with just having Hepatitis C after all my risk behaviours.*"

Treatment for heroin misuse

A useful place to start a study of heroin addiction/misuse is with the numbers of people attending for treatment – either with medical services, addiction services or drop-in projects. A central challenge in the Midlands is how treatment services might improve their 'capture' rates: by this we mean (1) attracting into treatment drug users who have not been attracted by existing services, and (2) retaining people in treatment programmes once they have been identified.

Socially marginalised groups and individuals who avoid and mistrust official programmes and services are extremely difficult to attract into services in the first instance for example, younger users, with a shorter history of drug use/drug injecting, including individuals who are not necessarily dependent but who intend to continue using and injecting (Hartnoll, 1993), ex-prisoners, people who are out-of-home and transient and people with psychiatric illnesses and severe emotional problems.

The aims of this study

A central aim of this study is to uncover some of the real life perspectives and views of people who have used or are using heroin in the provincial towns of Athlone and Portlaoise. Our hope is to chart direction for good practice service access and provision. We are also interested in their perceptions of the availability and usefulness of statutory and voluntary assistance currently on offer. Essentially, we want to uncover stories. Specifically, our aim is to gain a deeper understanding of the pattern of growth of heroin use and the practices associated with this.

Why a qualitative approach

Several experts have suggested that no single research method, by itself, will present an accurate picture of drug prevalence (NACD, 2003; Magnuson, 2004) and that "differences in theoretical approaches (health behaviours heath promotion, education/prevention, problem drug-use behaviours) reflecting different perspectives can preclude meaningful comparisons of survey results" (O' Brien, 2001: 41). Qualitative research methods which allow for direct input from participants in their own language, e.g., through the process of interviewing, provide the opportunity for us to understand the "meanings and interpretations" of the subjects of our inquiry (Gilgun, 1992: 25). Qualitative approaches are particularly useful in researching hard to reach populations as we will see later.

We decided, then, to avail of a mainly qualitative research focus with persons who have either used heroin in the past or are currently using heroin or methadone in an effort to elicit their *views* and *experiences* in relation to their drug misuse and their thoughts around service and treatment. This took the form of individual in-depth interviews

Figure 1:1 Triangulation of Sources

understood through a phenomenological perspective (see Garfat, 1998; McElwee et al, 2003; NACD, 2003). We triangulated this with qualitative and quantitative research amongst various stakeholders right across the youth, health, medical, policing, community development, human services and social services. Our investigation sites included Athlone and Portlaoise as little was known about 'serious' drug-taking and associated lifestyles among people living in these towns until recently. We also travelled to a number of other sites including Dublin, Galway, Tullamore, Mullingar, Birr, Limerick, Glasgow and Calgary to further cross-reference and triangulate our information and sources.

The research team has contacts in each of these sites that enabled access to gatekeepers and/or workshop participants for comparative purposes.

In our travels to these sites we spoke with many people and found a commonality in the understanding of a heroin misuser that might be explained in Table 1:1 on the following page.

Searching for individual narratives

As mentioned previously, the main concern of this study is to facilitate individual narratives around heroin misuse in Athlone and Portlaoise. We include commentary, observations, experiences and thoughts of both males and females who have been directly affected by heroin misuse and from a range of service providers, for we believe that it is important to hear from both the providers and the service users to gain a more comprehensive picture. For some heroin misusers, their addiction has visited absolute devastation to their lives (and, indeed their families) whilst, for others, a seemingly irrecoverable situation has been salvaged. Some interviewees smoke just one bag of heroin a day (which costs about €25) whilst others reported smoking or injecting as many as ten to eleven bags a day. We interviewed dealers and ex-dealers to get an insight into how they might construct reality.

Table 1:2 Someone who uses Heroin is:
Human, a person, family, me
In need of treatment
Hurting
In need of support
In need of compassion
Depressed
Wanting to hide from something
Searching for something
Alone and lost
Feeling confused
Feeling scared
Given up on life
Marginalized
Misunderstood
Worthy of support

Kevin: A case study

It is a wet October afternoon and we have been waiting all day in Portlaoise to secure interviews with heroin misusers. Unfortunately, it's proving extremely difficult to achieve even one full interview that has not been set up with a key agency provider. We really want to interview an individual who is not currently in treatment. Gráinne's diary is replete with missed interviews; people who for a variety of reasons failed to show at their designated time slots. Finally, we get yet another call on one of our mobile phones and are informed that some people are coming to talk with us. We wonder who will knock on the door. Three people enter the room, two females and one male. The male is dressed in street gear – a 'hoodie', jeans and trainers. He says "hello" and sits down at the table in front of us. We explain that we are neither Gardai nor social workers; that we would like to read out what our study is about, that he is free to leave if he wishes and tape the interview. "Yeah,

go ahead." Just like that, our interview begins.

'Kevin' commences the interview by informing us that he started *"smoking the gear at thirteen and I've been strung out since*." He is now in his early twenties and considers "*That I'll probably be dead this time next year*." He is serious about this.

'Kevin' was born and raised in Portlaoise town and has spent time in care of the State and in various places of detention and prisons. At the time we interviewed him, 'Kevin' was "*on the run from the cops for seven months*" for failing to sign on after prison release.

'Kevin' did not look, at all, well. His clothes were too big for him, his skin was pocked and his hair was unkempt. He had a dull stare and was both small and very obviously underweight for his age.

We explored many aspects of heroin misuse in that interview. During the course of our interview, 'Kevin' took off his jacket and shirt (which he had robbed from a clothesline as he spends all his money on heroin) and showed us two morphine patches on the right upper part of his back (which he had stolen from a cancer patient). His girlfriend had placed these for him.

'Kevin's' girlfriend, 'Norma' also attended for interview with us. 'Kevin' was sleeping rough and we could only imagine how he faced into each night curled up in old blankets or under cardboard. Both had just recently consumed a bag of gear (heroin), had another bag on their person and were about to immediately smoke this after they left Gráinne and I.

'Norma' had started smoking one bag of heroin a day with some of her female friends, but had graduated very quickly to "smoking as many as we can get" since her relationship with 'Kevin' developed. Incidentally, 'Norma' met 'Kevin' in the house of a local dealer where there were "regularly between fifteen and twenty heroin users" smoking their heroin.

Kevin's day is spent trying to locate his next fix of heroin. He awakes with his body desperate for a fix and feels "full of phlegm" if he doesn't get any. He carries a blade at all times for both protection and to instil fear into those persons he might try

to rob. A mobile phone sells for just €20 and these are favoured items on the black market.

Following up Kevin

A couple of months later we meet Kevin again in Mountjoy jail in Dublin. It transpires that he had been arrested the same day as our first interview with him. He is not, at all, unhappy with being in jail and has put on a couple of stone weight in a very short period. He is off the 'gear' for the moment but is fearful that he may take it again if he cannot access methadone. We are reminded of how difficult it is to obtain methadone if one cannot secure a place in clinic. Kevin's girlfriend is now pregnant with his child and he is looking forward to being a father. When asked what he thinks he will be doing when he is thirty, Kevin cannot answer.

Concluding commentary

"All lies and jest
Still a man hears what he wants to hear and disregards the rest"
(The Boxer, Paul Simon)

Drug use can no longer be considered a minority activity. As is the case in several other studies, we have found that heroin misuse is concentrated in the poorest and the most socially deprived areas of Athlone and Portlaoise (See Mayock, 2000). We have also found that heroin misuse is most acute within sub-strata within these housing areas and that dealing is carried out on a regular basis amongst certain extended families in both towns. It appears as if more women are involved in heroin misuse in both towns than was the case just five years ago and it is reported that there are adolescents smoking heroin in both towns. There remains a paucity of public knowledge around the drug-taking practices of those people who have not come into contact with statutory or voluntary services which makes it difficult to plan effective medium and long-term interventions.

We have heard first hand of the difficulties involved in attempting to entice heroin misusers into formal services, even when very significant

efforts have been made as seen from the following interview from another mother of a heroin addict in Portlaoise, "*… it's completely torn my family apart. He only lives around the corner from me but he's gone so thin, so small from it. He's after doing loads of robberies and social workers can't do anything. They tried but they can't. He had an appointment for Ashling in Kilkenny, he refused it. He refused any kind of help going. He'd take no help whatsoever, so he wouldn't.*" A particular challenge, then, is how we frame service delivery in the future.

Many interesting and controversial areas were explored during this study. It really was like going for a long walk on a beach where we ended up by the rock pools so beloved of our childhoods. Every time we overturned a stone in the shallow water, we were unsure what might scuttle out, what might run for cover.

We were informed early in the research (by some service providers, local politicians, heroin users and family members) that there *could* be as many as 300 persons in Athlone and 250 persons in Portlaoise taking heroin. These are large numbers when one considers the total populations of these towns. Towards the very end of our study, one influential service provider suggested that there could be up to 500 persons using heroin in Athlone! After nine months of research, we simply could not locate significant numbers of these alleged users to fully substantiate these figures, despite public calls on local radio and hours of observation, both day and night, in a number of sites in Athlone and Portlaoise, as we will see later.

Perhaps another of the service providers summed up the search for accurate statistics best when he stated in relation to the Athlone research site, "*I don't think they're accurate. I don't think anybody really has an accurate number or around the number. It's anecdotal, exaggerated, it depends who you're talking to. The press have one angle on it, the Police have another angle on it, we've another angle on it somewhere in between all of that is the reality. My reality would be that there are sixty people, who we know of. I would be inclined to think that there's another fifty to sixty people who haven't yet gotten this far, so you're talking about maybe one hundred and fifty to two hundred people who are at different stages of heroin use in Athlone.*"

What we can say with a degree of certainty is that the heroin problem in both towns is serious. Perhaps most importantly, all of our

interviewees who were using heroin, or methadone, felt that heroin should be taken seriously and that they knew people who had either accessed services and left them (for diverse reasons), or had not yet looked to services for assistance. We were also consistently told of children as young as twelve and thirteen who were now smoking heroin which surprised us. One mother of an addict informed us, "*I know the youngest down there is twelve years old.*"

One afternoon whilst having coffee with a couple of agency providers in Athlone, another service provider commented that she suspected it would be less than twelve months before heroin starts to enter mainstream life in Athlone. When pressed to elaborate on this, 'Michelle' said that she was expecting to be offered heroin at house parties "around the town" in the same way as one might be offered a 'joint' as "so many people are experimenting with smoking heroin now."

There seems little doubt that the service providers in both towns, whilst working well in isolation, have much to do in terms of pooling resources. This is for a number of reasons and we will return to this also later. At the time of concluding this study, several significant agency providers have talked about leaving the Regional Drugs Task Force in Athlone to start another forum that can react more quickly to the perceived heroin problem. This is a serious issue.

It is our experience in social care that the path of heroin use predominantly follows the most vulnerable people in our society. Kevin's father, to take but one example, is an addict himself who has spent much of his time in and out of men's hostels. As highlighted in many studies, the provision of statistics alone does not adequately reflect the totality of the individual, familial and societal disruption heroin misuse causes. We felt that, in general, the research and the experience of discussing their individual stories were welcomed. Ultimately, it is important to hear any story for all stories have value in, and of, themselves.

CHAPTER 2

Heroin: An Historical Perspective

Gráinne Monaghan

Introduction

My work with the Midland Health Board over the past three years has, at times, drawn me into the lives of people using heroin and I have noted the ecological impact on the individual, the family and, indeed, the community. I have wondered how, for example, a young man or, indeed a young woman, living in a provincial town might end up with a bag of 'gear' on a kitchen table. It seems to me that to understand how we arrived at where we are today vis-à-vis heroin misuse in the Midlands area of Ireland, we need to look back. Many people are unaware of the physical movement of heroin from the poppy fields of Afghanistan (to name but one source) to the streets of Athlone and Portlaoise and all the dangers associated with this cultivation, collection and transportation *en route.* This chapter, then, explores the pathways of heroin from Eastern society to Western and from marginalised to mainstream.

An historical perspective

Opium is an extract derived from seedpods of the opium poppy and originates in the Middle East and the areas bordering the Mediterranean Sea. A tribe of people known as the Sumerians, who are believed to have migrated from Persia (modern day Iran) to the Persian Gulf, recorded the first references of opium use for both recreational and medical purposes in their writings as far back as 4000BC (Fernandez, 1998: 8). They called it the "plant of joy". By the 2nd

Century BC, opium use had spread through the Middle East and North Africa into Egypt and Greece (www.willow-web.net). The Greek physician Hippocrates described some of the healing powers of opium and began prescribing it to his patients for insomnia. At this time, the most common way to ingest opium was as a liquid elixir. The sappy white milk was mixed with wine or water and produced a euphoric effect. By the 7th Century AD, opium use had reached China and Chinese scholars recorded that "the poppy seeds have healing powers" (Fernandez, 1998: 9). Originally, in China, it was used for medical purposes but following the Chinese ban on tobacco in 1644, people turned to smoking opium.

India had been supplying China with their opium for hundreds of years, which was of a higher quality and potency than Chinese opium. The effects of smoking the opium was stronger than drinking it and with this the number of Chinese addicts grew. The Dutch then began to trade opium at the beginning of the 17th Century. Thereafter, the French and the British also became involved. The British had strong political influences in India and they expanded the trade of opium in China using the Royal Navy to protect the illicit trade. (Walton, 2001: 112) It was 1729 when Warren Hastings, then chief executive of the British East India Company realized the potential of foreign revenue in exporting Indian opium to China. By the late 1700's the British East India Company controlled the prime Indian poppy growing areas (www.opiates.net, 2004).

By 1840, there were some three million Chinese opium addicts. The Chinese government had made smoking opium a capital offence in 1796, but this did little to curb its use. In 1838, the Chinese Emperor appointed a mandarin named Lin-Tse-Hsu as a special commissioner to assess the opium problem and to determine and act on a solution. Determined to stamp out the opium trade Lin threatened the British with the loss of the tea trade another lucrative mainstay business of the British East India Company (www.ukcia.org, 2004). Then, Lin-Tse-Hsu demanded the surrender of all opium cargoes from foreign ships (Fernandez, 1998: 13). 20,000 barrels of opium were seized from the British and this was the starting point for two opium wars between the Chinese and the British (www.opiates net, 1999). On both occasions the

Chinese were defeated and forced to sign two treaties, the treaty of Narking (1842) and the Treaty of Peeking (1860). Both treaties expanded the use of Chinese ports for foreign trade (Fernandez, 1998: 13). The main consequences of the second opium war were that China was forced to legalize the trade of opium and were only permitted to tax the product at a level acceptable to the British. Consumption increased from 60, 000 chests in 1860 to 105, 000 by 1880 (www.ukcia.org, 2004). This trade was extremely productive in generating taxes for the British and Indian governments. By 1900, China had 13.5 million opium addicts. In 1906 the imperial Government reported that 27% of Chinese males were opium smokers (Fernandez, 1998: 15).

Introducing a new market

Opium was first introduced to Europe in the sixteenth century in the forms of medicines and elixirs and was used to treat almost every disorder (Willow-Web, 2004). The popularity of opium grew during the seventeenth and eighteenth centuries.

In the 1800's in Europe and the United States, a liquid form of opium was used. Laudanum, or "black drop", was used for numerous purposes such as soothing coughs, quieting cranky children and as a substitute for alcohol. The European and the American consumer became legally addicted to opium that was sold under innocent sounding names (Fernandez, 1998:16). In 1805, a German pharmacist first synthesized morphine from opium (www.willow-web.net). He named it morphium, after Morpheus, the Greek God of dreams. Alexander Wood from Edinburgh introduced the method of using a hypodermic syringe to administer morphine in 1853 and, tragically, Wood's wife was the first person to die from an intravenous overdose. Ladies, particularly in France and Britain, used the intravenous method of administering morphine, as drinking alcohol at that time was not considered to be a social option. In 1902, the British Medical Journal reported the craze of morphine tea parties hosted by women in the country who invited guests to receive a divine morphine injection (Walton, 2001: 113).

In1874, heroin was discovered by a British chemist named C.R. Alder Wright. This new powder proved to be twice as potent as morphine

(www.willow-web). It was perfected to a more fat-soluble substance and renamed heroisch in 1898 by a German pharmaceutical company. Heroisch is the German word for heroically strong and powerful (Walton, 2001: 114). From 1898 through to 1910, heroin was marketed as a non-addictive morphine substitute (www.informationheadquarters.com, 2004).

A survey in America in 1884 found that 56%-71% of opiate addicts were white, upper class women (Fernandez, 1998: 20). In 1914, the American President, Woodrow Wilson, passed the Harrison's Narcotic Act. The government used this act to prosecute addicts, traders and doctors who prescribed the drug. This did not cease the use of heroin, but did change the social face of heroin use from white middle class women to white lower class men (Fernandez, 1998: 24). Also, the League of Nations adopted restrictions on the recreational use of heroin and opium in the early 1900's, which subsequently produced a major drop in legal production (www.druglibrary.org)

Given this number of addicts coupled with the prohibition of a drug never to be made legal again, it was ensured that significant amounts of sustainable money was to be made from dealing illegal Heroin in America at this time. In the early 1900's in America, treatment for heroin addicts was quite unsophisticated and users were viewed as deviant criminals. Heroin use among American soldiers was very popular during the Vietnam War in the late sixties and early seventies. It was after this that treatment of heroin and the perceptions of addicts changed (Fernandez, 1998: 29-36).

By the eighteenth Century, opium had hit the British market with Chinese labourers introducing opium smoking around the middle of the Century. Heroin had arrived on the British market by the end of the eighteenth Century (King, 2003: 16).

The Port of Marseilles in France was used for more than twenty-five years up to the late seventies as a processor of opium grown in Turkey and the Lebanon.

Heroin comes to Ireland

For centuries alcohol has been the primary drug of use to produce a mood altering state in Ireland. However, in the 1970's and 1980's

dabbling in the illegal 'hard' drug scene also began here (King, 2003: 16). Due to the relatively late development of the illegal drug scene in Ireland compared to our near neighbours in the UK, people and particularly policy makers, were unprepared for the size of the illegal drug scene when it did come to public attention.

With a culture already steeped in alcohol, which Morgan (2003) believes, is "very much a part of our agricultural make-up", illicit drug use has also increased in a somewhat relatively short period of time. Heroin really became noticeable in Dublin in the 1980's when Dublin was still quite an agricultural city in a wider European context. As the situation spiralled out of control in Dublin, heroin started to find its way across the country to provincial towns and, indeed, villages. Athlone and Portlaoise fell victim as with so many other locations as we will see from the interview data in this study.[1]

Most of the heroin coming into Britain and Ireland today comes from Afghanistan with some from Thailand, Laos and Burma (Corrigan, 2003). The Irish Independent, (2003) noted that a moral and humanitarian dilemma exists when one delves into the trade and looks at the people situated at the very beginning of the cycle (poppy farmers) and, in turn, the end of the cycle (the addicts) commenting that "*Nazim is a dirt- poor poppy farmer, John is a scrawny junkie. They're two weak links at either end of a trafficking chain bringing heroin from the wilderness of Afghanistan to the wastelands of Ireland.*" Of course, both are striving to survive, but both emerge victims from a global multi-billion dollar business. Therefore, simply expecting the Gardai to cleanse heroin from the streets is somewhat naive. We return to this later in the study when we call for an ecological agency response.

Ireland's heroin addicts are the youngest in Europe, with an average age of 24, compared with, for example, 34 in the Netherlands. The overwhelming majority come from the most socially deprived areas of large cities, although heroin is certainly becoming more available in

1 In the *Irish Independent* in November 2004, a number of people including Justice Mary Martin, the previous Minister Eoin Ryan and a Garda representative all concurred in the view that heroin misuse has grown significantly outside the Dublin metropolitan area. The article cited the reason for this growth outside of Dublin to the fact that heroin is more plentiful and cheaper than it has ever been before.

rural areas. At the start of this decade, there were 13,000 heroin users, of whom 4,500 were on treatment programmes with 400 more on waiting lists four years ago in Dublin. Some 8,000 addicts were not in touch with any of the social services offering some form of help (*Observer*, 2000; Merchant's Quay, 2000). In 1998, there were 70 drug related deaths; this figure was up by 16 in 1999 when there were 86 deaths. In 2000, there were 99 deaths due to overdose in Dublin (*Irish Independent,* 2003).[2]

So how seriously should we take heroin misuse today? An RTE news broadcast of 1.3.2004 noted that there are now more deaths as a result of heroin abuse in the Dublin area than as a result of road traffic accidents.

Conclusion

The National Drugs Strategy 2001-2008, states that heroin issue in Ireland is predominantly a Dublin or urban phenomenon; however, in recent years both urban and rural areas have experienced an increase in drug use with 25% of the overall population having tried an illegal drug at some time in their lives (NACD, 2003). The National Advisory Committee on Drugs (Drug Net, 2003:1) found that in 2001 there were an estimated 14,452 people between 15-64 years using opiates in Ireland. This represented a rate of 5.6 opiate users per 1,000 of the population aged 15-64. In Dublin, the rate was 16 per 1,000 population and the rate outside of Dublin was just under 1 per 1,000 of the population. Interestingly, the report noted that the number of users could be as low as 13,405, or as high as 15,819 (DrugNet, 2003: 1). Thus, heroin misuse is on the political and public agenda.

This chapter has placed in an historical context the movement of heroin use from the fringes of society to the mainstream. It located an influx of heroin into Ireland in the 1980's and concluded by tracking its use to the Midlands of Ireland. We will learn in later chapters of how and why this took place.

2 In the Blanchardstown area, alone, there are some 700 registered heroin addicts, all of whom are under the age of 21.

CHAPTER 3

Area Profiles of Athlone and Portlaoise

Niall C. McElwee, Gráinne Monaghan & Ruth Armstrong

A note

I have been conscious throughout this research that there is a danger in a town being "black listed" once data around heroin use emerges into the public domain. This is particularly the case with regard to media reporting of data that we might generate in this study. I write this because I have a very strong emotional tie to the Athlone town having been born and brought up there. I am, thus, mindful of presenting a truthful yet open account of what we have uncovered. It is sometimes the case that "out of sight, out of mind" and this is particularly the case with illegal activities such as dealing heroin, distributing heroin and taking heroin.

Through my work with the Midland Health Board, I frequently met with people whose lives have been affected by heroin misuse. This did not sit well with my worldview of Athlone town because this was not my reality! Many small or provincial towns in Ireland, such as Portlaoise, are experiencing these same conflicting realities and of course it means so much more when you have an emotional investment in a particular area. However, I really wanted to understand more about the people of my hometown and to become proactive in contributing to a meaningful response. It is my hope that, as people living in the Midlands, we can find acceptance and a way of being together and supporting each other. I would envisage a range of choices for people and a supportive environment were issues could be discussed and addressed. With this in mind, I approached this study with the hope that people will suspend judgment, jettison stereotypes and approach our findings with an open mindset.

— Gráinne Monaghan (December 2004)

Introduction

Athlone is well known also for its creative, cultural side, for its lakes and rivers and nightlife. Athlone has a great many groups, clubs and societies and a strong community and voluntary network base. Athlone town is situated in the centre of Ireland on the bank's of the River Shannon. Adamson's Castle, which was built in 1210 dominates the town environment and sits on the West side of the town bridge. Athlone has become one of the fastest growing inland areas with the current population at 23,670 (Census, 2002).

The South East of the town hosts the Golden Island Shopping Centre, which makes Athlone a focal point for shopping in the Midlands. Athlone has always been a significant location for the Irish army with approximately 1,000 staff currently located there. The Central Railway station in Athlone serves the Dublin, Westport and Galway lines making Athlone a prime passing through location.

Snapshot: Education in Athlone

In 1996, 28% of people in Athlone had no formal education or had a primary education alone. This compared with a national average of 30%. However, if we break down the urban and rural locations in Athlone a different picture emerges. An average of 40% of people living in urban Athlone have no formal past primary education compared to just 20% in the rural areas. Only 10% of people on the West Side of the town have a third level qualification (Social Inclusion Programme Plan, 2000; 15-29).

Snapshot: Unemployment in Athlone

In urban areas of Athlone, unemployment remains high. Despite the more prosperous times experienced by Irish society of late, long-term unemployment remains a serious issue in Athlone. Three quarters of all unemployed men are long term unemployed, while 57% of unemployed women are long-term unemployed. If these people are out of the work force for such long periods of time, employment opportunities are less available to them. Training options are often more appropriate at this stage to build self-esteem and to engage in the work system again.

In February 1999 there were 1,554 people on the unemployment register in Athlone by February 2000 it had fallen 10% with 1,391 people on the register (S.I.P.P, 2000). However if we take these statistics as they are, we may not be looking at the local reality. We must account for the partners of unemployed people who are unable to access social welfare payments due to the restrictions and regulations of the system. Also, if we consider those who are temporarily marked off the register for a few months at a time on training initiatives, then we might see a truer reflection of unemployment in Athlone.

Work with 'disadvantaged' people in Athlone shows that families where unemployment is a feature are more likely to have low levels of parental educational attainment (S.I.P.P., 2000: 19). Three schools serving one of the largest inner urban areas on the west side of Athlone report high levels of students with poor literacy and early school leaving (SIPP, 2000:19). All of these schools, which are in close proximity, have disadvantaged status.

Snapshot: Local authority housing issues in Athlone

Issues such as substance misuse, crime, and long housing waiting lists are features of some of the local authority housing estates in the town. It was noted that one estate on the west side of the town has an identifiable substance misuse problem and this has led to high crime in the area (SIPP, 2000). This is also an identifiable issue in the newer estates.

Local media reporting of heroin in Athlone Town in Athlone

At the time this study was commissioned, a local paper reported that Athlone town had become a 'heroin black spot' with over 100 heroin users. It then expanded to say that heroin is more available in Athlone than in either Limerick City or Cork City. From the Garda statistics 2000-2002, this does seem to be a credible revelation and somewhat shocking if we compare the populations of these cities in comparison to that of Athlone town. Athlone's strategic location has been cited as a key to why this provincial town is growing into the heroin supply center in the Midlands. It was further reported that a rising number of teenage girls are also using heroin and that some people started to use heroin to come down off the effects of ecstasy. It was suggested that there were

between 80 and 120 people using heroin. That paper quoted a local GP as stating, "There are so much drugs in Athlone, it is almost impossible for anybody who had any dealings with drugs not to run into people who is using them" (24.2.2004). We will explore these matters later in our analysis.

Reports from the local papers which present themselves as fact in the public domain can have the effect of sensationalizing issues and causing significant upset to stakeholders and agencies and, of course, individuals and families directly affected by heroin as articulated at a Midland Health Board sponsored evening creating awareness around drug and alcohol misuse (MHB Public Consultation, 16.5.2004). It is unfortunate that one newspaper, for example, utilised headlines such as "Athlone is Revealed as Top Heroin Black spot" (17.2.2004), "Dealers Selling Heroin to Recovering Addicts", "Heroin Dealer Gets Suspended Suspense" (24.2.2004).

Nonetheless, heroin misuse is never far from national media attention. It is associated with serious health conditions, including fatal overdose, spontaneous abortion, collapsed veins, and infectious diseases, including HIV/AIDS and hepatitis –all of which we have come across whilst researching this study. In the *Sunday World*, two deaths as a result of heroin misuse were discussed and the resultant devastation that such deaths bring to the families of the deceased. Under a banner headline, 'Town's Heroin Horror', the reporter notes that, both addicts attempted to give up heroin prior to their deaths but could not do so. One victim was found lying on the floor with a needle beside him whilst the other was found dead in an apartment (O' Shea, 23.5.2004).

One tends to hear of 'serious' drugs problems in such Prisons as Mountjoy on a regular basis, but not in the smaller prisons in the midlands and west of Ireland. The *Sunday Star* 16.5.2004 claimed that Castlerea prison in Roscommon, with a population of some 185 inmates, "has become swamped with heroin" (Cambell, 2004: 33) despite the fact that the Governor there, Dan Scanell, has introduced a zero drugs policy. It is believed that the fact that Cannabis stays detectable in the body for some 30 days, whilst heroin stays detectable for only 3 days is a cause for this increase in misuse whilst visitors were "bringing in the heroin with relative ease" (ibid: 33).

Heroin misuse in Athlone: Garda statistics for Athlone

The Garda Annual Reports from 2000, 2001 and 2002 provide us with interesting statistics on heroin related offences where proceedings commenced. The 2000 report noted ten offences in the Longford/Westmeath statistics. This was the highest number of proceedings outside of the Dublin region. Laois and Offaly followed it closely (Garda Annual Report, 2000:113).

The Annual report of 2001 showed similar findings however, the number of offences had increased to twenty-five cases for Longford/Westmeath, which was again the highest outside of Dublin (Garda Annual Reports, 2001: 119). The 2002 Garda Annual Report showed the Longford/Westmeath proceedings at twenty-four cases just after Cork city, which had thirty-three court proceedings for heroin offences in that year. The seizures for heroin in Athlone town also paint a picture of an active market of heroin users however, it may also suggest that the heroin is being supplied from Athlone to other towns (as has been intimated to the authors). Indeed, the *Athlone Voice* newspaper reported the local drugs unit for Longford/Westmeath, stating that a batch of heroin seized in Athlone in 2002 was destined for Galway.

Area profile of Portlaoise

Laois is one of the most strategically located counties in Ireland. Portlaoise, the County Town, is located at the junction of the National Primary Routes N7 and N8, both of which are of major importance in the country's transportation network. There are two main railway lines: Dublin to Ennis/Tralee/Cork/Waterford and Dublin to Galway. Portlaoise is also home to the Midlands Prison, which has a capacity for 500 prisoners, it is a closed institution for male prisoners aged 18 and over. Portlaoise Prison is adjacent to the Midlands Prison and is a high security prison for males aged 18 years and over, serving sentences up to life. The prison has a bed capacity of 203 but operates below capacity for security/operational reasons.

The Census (2002) recorded a total population of 58,732 persons in Laois County with an urban Portlaoise population of 3,482 and a rural population of 8,934.

Snapshot: Education in Portlaoise

In 1996, approximately one-third of the total population in the county had only primary level education while only one-eighth had a third level qualification. Early school leaving has been identified as an issue within the County. In 2002, 13.41% of the total Portlaoise population had no formal/primary education. If these figures are looked at from an urban/rural perspective, the percentage is higher in urban Portlaoise with 19.39% having no formal or primary education compared to 11.08% in the rural area. There are no Institutes of Technology, or dedicated third level institutions in the County. The nearest Institute of Technology is 38kms from Portlaoise in Carlow, and the nearest University is in Dublin, 86kms away. If we look at the figures of those whose education has ceased, 17.5% of the urban Portlaoise population have received a third level education; this is low when compared to the National average of 26%.

Snapshot: Unemployment in Portlaoise

Portlaoise shows high rates of unemployment in both rural and urban areas. In 2002, the unemployment rate in urban Portlaoise was 19.8%, compared to the national average of 8.8%. The figures also show a significantly high unemployment rate among males in urban Portlaoise (23.5%) and rural Portlaoise (21.7%). A total of 213 males in urban Portlaoise and 55 females over the age of 15 are unemployed. Such high levels of unemployment have a major impact on the town.

This high unemployment rate is coupled with a low literacy level in urban Portlaoise with VEC figures for those attending literacy classes in 2003 at 400, 138 of these were at the lowest level of literacy, level 1.

Snapshot: Local authority housing issues in Portlaoise

There is a high density of local authority housing estates in urban Portlaoise. This high density of local authority housing with a lack of facilities for residents contributes to a number of problems such as anti-social behaviour, drugs, crime and vandalism. There are currently 751 applicants for local authority houses on an approved waiting list.

Local media reporting of heroin in Portlaoise Town

According to a newspaper report dated 4th November 2002 (Laois Nationalist archives), heroin was first noted in Portlaoise in 1996. Since then, heroin is believed to have become more widely available. The Gardai acknowledged there was a problem with heroin in an article appearing in the same paper on the 7th May 2002. In this article, the local Superintendent was quoted as saying that there had been a minor problem in Portlaoise in 1996 to 1997 and the problem came to a head in 2000. He estimated that in 2000 and 2001 there were about 50 people who had used heroin and 20 who were addicted to it. One headline in the local paper on July 21st 2000, stated that "Heroin not a serious problem but concern is growing" .In this report local garda sources suggested that the figure for those using the drug was as low as 2.

Further reports in March and April 2002, contribute comments from a local solicitor and Judge stating that Portlaoise is now "awash with heroin" and that the lack of services could "lead to anarchy" in a few years time. These comments were prompted by the death of an 18-year-old man from a suspected heroin overdose. Following this report the attention of the national media was drawn to Portlaoise with articles in the Irish Times and the Sunday Tribune and coverage in RTE.

Heroin misuse in Portlaoise: Garda statistics.

The Garda Annual Report (2001) reports that there were 7 offences for heroin under the Misuse of Drugs Act in the Laois/ Offaly region. In the previous year there had been no recorded offences. The figures for 2002 and showed a decrease from 7 in 2001 to 5 in 2002.

Section Two: Uncovering the Terrain around Heroin Misuse

"I'm not sure that there has been an open and frank discussion in relation to the heroin issue at a strategic management level within the Health Board. I think there's certainly a recognition in the last twelve months, and I think that has been due to the change of appointments, that there is an urgency in getting key personnel into Athlone and into the region to respond to the heroin issue. But my concern is that it is very much focussed in relation to methadone services rather than maybe a more holistic picture. I think some people on the Board may feel that the task force will address the more holistic, but my own personal concern would be that there should be a range of services provided by the Health Board, for anybody who needs them rather than just the methadone service. And I think one of my concerns is that once it's in there, people see that as the answer and the only way of dealing with the heroin issue. So, I think there's probably apart from the coal face workers there is now perhaps maybe somewhat of a deficit at senior management level in relation to how to respond to the drug issue."

Within the midlands there is a complex array of treatment services currently provided to 'problem' drug users. These include community prescribing of methadone and other drugs such as DF118's; residential services (detoxification and rehabilitation – the latter being with the Marist Community in Athlone); and non-clinical interventions (such as counselling and group work). Such services are provided by a variety of specialist voluntary agencies (such as the Open Door Project in Athlone) and statutory agencies (such as the Midland Health Board), the primary care sector (St. Loman's Psychiatric Hospital in Mullingar)[1] and the Prison Service (Portlaoise Prison). In fact, the largest methadone programme in the State is in Mountjoy prison with hundreds of patients registered at any time.

There is no doubt that the Midland Health Board takes heroin misuse seriously. It has plans to redevelop services in Athlone into a

1 St Loman's Psychiatric Hospital in Mullingar had 41 admissions for drug related disorders in 2000 (MHB, 2004: 3).

dedicated building and is actively looking at leasing or purchasing another building in Portlaoise with a similar purpose in mind. The Board meets regularly with the voluntary providers and is active with the Regional Drugs Task Force and its sub-committees. Nonetheless, our interviewees have consistently informed us that the three most pressing needs for them are (a) ease of service access, (b) point of service access and c) continuity of service provision. Simply put, they want to know that if they come forward for advice, intervention or treatment that they will get it in a timely fashion and that there will be adequate follow-up. The widespread perception at the moment in both towns is that waiting lists for all services are far too long and this is a major disincentive to try to come off heroin. This lengthy wait is having a disastrous effect on families as well as individuals. For example, one GP commented that patients had contracted Hepatitis whilst waiting for treatment after they had been referred on by him. This is not good enough.

A crisis in the making?

Heroin remains a largely taboo subject and it is easier to pretend that misuse and chronic addiction are issues for other large urban areas than to admit that there may be a crisis about to unfold in the next five years in Athlone and Portlaoise. To ignore early signs of heroin misuse and spread is a very dangerous mistake. To believe that if heroin misuse remains in poorer socio-economic areas, it will not seep out to other more affluent areas is a mistake. To leave heroin misuse to only the Gardai is a mistake. To place sole responsibility on the health board is a mistake.

We know this because we have listened to the considered opinions of service providers and to the individual stories of misusers and their families. We have spent a great deal of time in projects and centres throughout the midlands talking with people attempting to gather some basic biographical information: (see diagram overleaf): life situation; expectations around treatment; drug treatment history; contact with statutory and voluntary services; current and previous drug and alcohol use; risk behaviours; health; relationships; and legal status. (See DORIS study in Scotland).

If we have one message in this study, it is that we all have a part to play because heroin misuse affects us all. Let us not deny any voices in this. Existing services should not have a territorial attitude to delivery.

"*In the whole of Portlaoise, I think nearly every one of them is drugged. Yeah, every one of them. There's loads.*"

We were asked in interim workshops related to this research around drugs terminology; 'heroin use' versus 'heroin misuse.' We alluded in chapter one to the established designations in drugs social policy literature, but we would like now to add the thoughts of those working in the area. A feeling emerged that the term heroin misuse applies when, for example, 'one becomes addicted', 'when one loses control of one's drug taking behaviours', 'when it begins to affect those in the life of the user', 'when it affects the public' and 'when it is being taken to hide or run from other problems'. Thus, we use terms interchangeably to denote levels of use amongst our interviewees.

Moreover, it was felt by interviewees that what one might term the heroin scene in Athlone and Portloaise was qualitatively different from taking it in, say, Glasgow or Dublin as represented in table 3:1.

Table 3:1: Perceptions around Heroin Misuse in Urban versus Provincial Areas	
Urban Area	**Provincial Area**
Heroin more readily available	Heroin less readily available
More noticeable activity	More hidden activity
Feeling that it is limited geographically	Feeling that 'everyone is doing it'
More treatment options	Fewer treatment options
Less immediate urban impact	More immediate community impact
Individuals difficult to identify	Individuals easier to identify
Individuals more easily absorbed	Individuals less easily absorbed

So, how many persons are using heroin in Athlone and Portlaoise towards the latter part of 2004? The truth is that we still do not know – at least to provide figures that we could 'swear by'. We are hesitant to use 'multiplier' figures, favoured in other research because we feel even this is only a valued guess. The drugs research literature utilizes a number of approaches in gathering and analyzing data such as capture/recapture studies, participant observation, questionnaire distribution, epidemiological methodologies to name but some. All of these are useful.[2]

We certainly have a very strong sense that there remains much heroin use that is hidden and there are both males and females that refuse to present for any services or treatment for their heroin use, or who are only at the stage of experimentation. We were also consistently informed in both towns that the majority of heroin use takes place in home environments as opposed to public places, so there are issues of visibility.

2 What we have attempted to do in our study is concentrate mainly on the regional providers and persons living in both Athlone and Portlaoise for the majority of our information. Thus, we hope they have a sense of ownership of the data and any outcomes that may come.

This is a significant finding in itself as it points to the hidden nature of much provincial heroin use and explains the lack of visibility of persons 'shooting up' in public parks, alleys, bars and in public toilets as is the case in other larger cities. On our extensive walks around the town areas and hinterlands of both towns over the eight month period, we found no needles, no drug-taking paraphernalia and no addicts huddled together taking heroin. Even when we visited homes of people involved in heroin use, we saw no needles lying strewn throughout the houses.

We did sit down and try to work out an exact number of people that we had come into contact with during this research. In Portlaoise, for example, we counted forty people using heroin that we could verify. This is only ten more than are reported to be in treatment with the counselling service, but illustrates that there are more people out there in the community who have yet to be uncovered by services. We feel that if we had more time, we could, perhaps, uncover further people. Our experience in Portlaoise was that people were more reluctant to discuss their involvement in heroin despite us travelling up there on a weekly basis at one stage.

All of the service providers and users in Portlaoise felt that Athlone had a more significant problem with heroin than Portlaoise. However, it was also thought that the problem of heroin misuse in Portlaoise was rapidly getting worse and great care should be taken to avoid making similar mistakes as have already been made in Athlone over the past decade. We concur with this.

We might ask does it really matter, then, if there are 80 or 300 people using heroin in Athlone and 70 or 250 using heroin in Portlaoise as we consistently heard. What matters, for sure, is the fact that everyone agrees that something more radical and timely needs to be done to effect change. Let us look firstly to official figures sourced from a number of treatment programmes.

Interventions in 2003		
	Athlone (addiction counselling service)	Portlaoise (addiction counselling service)
detoxification /short term reduction	9	6
long term substitution/ maintenance	19	1
medicament free/ psychosocial therapy		3
advice /counselling /support	33	30
social and/ or occupational reintegration		
other (specify)	2	
assessment		
not known		
Total	39	30

Interventions in 2004		
	Athlone (addiction counselling service)	Portlaoise (addiction counselling service)
1. Brief intervention	19	
2. Alcohol detoxification	3	2
3. Benzodiazepine detoxification		
4. Opiate detoxifiaction (buprenorphine)		
5. Opiate detoxification (lofexidine)		

... continued overleaf

6. Detoxification symptomatic medication	1	1
7. Substitution (methadone)	5	4
8. Substitution using other opiate		
9. Substitution using other substitute drug		
10. Substitution with drug (name unknown)		
11. Medication free therapy		
12. Psychiatric treatment	5	8
13. Counselling	25	30
14. Social and/or occupational reintegration	2	
Total	27	32

Note: clients may have received more than one treatment intervention, hence the total refers to the number of cases not the number of interventions.

Treatment figures for heroin in Athlone

The Community Alcohol and Drug Services for Longford/Westmeath and Laois/Offaly covers a catchment area of some 225,000. Mullingar, Birr, Longford, Moate, Athlone and Portlaoise all have been identified in this study as having 'heroin problems'.

The Community Alcohol and Drugs Service of the Midland Health Board report that in 1995 they had ten people reporting for treatment of opiate dependence, while in 1998 they had twenty three people reporting for treatment. That was 27% of all the people using the service in the Midlands (Education and Prevention Policy, MHB). By the end of 2001, there were 22 attendees with 7 on the waiting list for treatment in Athlone and 10 attendees with 8 on the waiting list in Portlaoise. By 2003, the Methadone maintenance clinic in Athlone had 23 places. All 23 places were filled and a waiting list exists whereby it can take quite some time for a place to become available.

In 2002, 76.7% of clients using the opiate services in Athlone were injecting heroin while 78.3% of those reported sharing equipment. The average age of first injecting was 20.9 years and the average age of current injectors is 26.7 (MHB, 2004: 4). The MHB reports that the main site of attendance for 'problem' drug use in the Midlands is Athlone. Young people under the age of eighteen are also accessing the service, despite the service having been directed towards adults (MHB, 2004). This was verified in our interviewees with family members and heroin addicts.

Methadone in Athlone

A level 2 GP has been providing the methadone service to the Midlands since 1999. Clients are assessed on their suitability to join a methadone programme and pending this, arrangements are made with a local pharmacy for dispensing the methadone. The level 2 GP attends the Opiate Clinic in Athlone.

Treatment figures for heroin in Portlaoise

"He doesn't go to bed until all hours in the morning and he doesn't get out of the bed until three or four that evening, because the social worker has been down a few times and she went in one day and she said he was sprawled out on the bed. Now she said there's more fellas in that house. It's only a one bed roomed little maisonette with three or four fellas staying that one bed with them all and a little baby there as well, you know."

We spoke at length with Addiction Services in Portlaoise who were good enough to trawl through their logs in an effort to supply us with treatment figures. We asked for a twelve-month period and received the following information: There were 48 contacts for illegal drugs between 01.08.02 and 31.08.04. This comprised of 29 males and 19 females. Of these figures, 30 persons claimed to have used, or be using, heroin with an even gender split of 15 males and 15 females.

At the time of concluding this study, there are currently 17 clients attending the opiate treatment service with 16 on the waiting list. Approximately 8 clients are attending the service in Portlaoise once a week by taxi from Mullingar. The clinic is working at maximum

capacity and is unable to take on new clients from the area. There is an added problem of lack of pharmacists in the area who will dispense methadone. Currently, only one Pharmacist is involved in a scheme as we will see later.

Profound dissatisfaction was articulated by, for example, two community activists in Portlaoise with a perceived lack of access to services amongst the "heroin community". It was stated that the waiting list for methadone treatment was far too long and acted as a major disincentive for "coming off the gear". In fact, we were told that heroin users in Portlaoise were purchasing methadone that was being imported in from the UK which was often 'dirty' and users were fearful of contamination. We heard one example where an addict purchased €60 worth of methadone as he was desperate and did not want to take heroin. We heard of another tragic case of a mother with a young child who had to be locked into a bedroom in a private house for a period of two weeks whilst her child was looked after by a number of concerned neighbours whilst she attempted to come off heroin.

Treatment specific to females

Approximately 25% of those presenting for drug treatment in Ireland are women who are more likely than men to suffer negative consequences from their drug use (Drugnet Ireland, 2002: 4). As noted earlier, in Portlaoise 50% of those in counselling for heroin addiction are female. Current service provision for women in both towns show a very significant gap and needs to be looked at more closely. The Open Door Project in Athlone, for example, has reported that it regularly has women coming to the centre in crisis situations as a result of hard drug use – including heroin. Indeed, the Athlone Training for Employment Project (Women) has no facilities or expertise for dealing with heroin addiction and tends to refer these one.

Conclusion

We have presented just a brief snapshot of some areas relevant to heroin misuse in both Athlone and Portlaoise. We would, however, like to emphasise that both towns have entirely separate identities. It is obvious that service demand is significantly greater than currently

available and this is a significant challenge for both the voluntary and statutory sectors. Problem drug misuse affects all sectors of society, but some more than others.

CHAPTER 4 (a)

Study Methodology: Seeking Stories

Niall C. McElwee & Gráinne Monaghan

"I can address myself only to my experience of the world, to that blending with the world that recommences for me each morning as soon as I open my eyes, in that flux of perpetual life between it and myself which beats unceasingly from morning to night…" (Merleau-Ponty, 1968: 35)

Introduction: A heavy responsibility

Gráinne and I are both primarily child & youth care workers and, thus, have professional and ethical responsibilities that weigh heavily on us in a study such as this. Although we guarantee anonymity to our interviewees, this does not mean that all information we receive is merely recorded and then forgotten about. We are acutely aware that many of our interviewees have talked with us because they understand us to be researchers and are not Gardai or social workers, but we explained that we have other responsibilities pertinent to child protection and welfare such as Children's First and various codes of ethics from professional and practice associations.

Early in our planning meetings, we agreed that we would not interview children. We were so concerned with ethical issues in this study that we discussed our methodology with over 250 social care and child and youth care students, front-line staff and supervisors in workshops in various locations in Ireland and Canada to ensure we bought into current best practice and to share our approach and

theoretical framework.[1]

All of our interviewees were adults (i.e. over the age of eighteen) and all signed consent forms for their interviews. Some interviewees were more forthcoming about illegal behaviour than others and sometimes we had to make a judgement call as to what we should do with information we received. An example of this was in relation to being told by an interviewee that he had stolen a mobile phone off a victim just prior to an interview with us. We took the view that as no violence was used and the theft was going to be reported to the Gardai anyway, it would serve no useful purpose to stop our interview and call the Gardai ourselves.

Whilst there is voluminous literature around drugs research methodology, there is far less dealing specifically with the precise responsibilities of researchers who are working with 'hard to reach' communities where obtaining and maintaining their trust is our main challenge.

Stories we could tell: Some cautionary comments

Having stated the above, this study is fundamentally interested in the individual stories of persons involved in heroin misuse. To attempt to gather information on heroin misuse in two Irish provincial towns posed several challenges for us and we detail some of these below. This chapter includes a discussion on the methodologies employed; qualitative and quantitative.

While using large-scale population surveys of drug use such as the NACD's (2003) report, a lopsided picture of drug use can be portrayed. It does not account for the pocketed, over representation of users in certain geographical areas of high unemployment, high poverty and low educational attainment. Although a small percentage of heroin users may be outside of Dublin, how are they represented throughout the country and what are the effects on the communities?

It will be apparent that any attempt to enumerate a population that is using heroin is fraught with difficulty around the very definition of

1 Gratitude to Joe Coughlan, Manager Aras Geal, for helpful comments re: a child and youth care approach.

heroin addiction, its measurement and its interpretation. Drug users are often divided into three distinct categories – experimental users (curiosity and often under peer pressure), recreational users (taken regularly but at intervals) and problem drug users (dependent characteristics). *We have met persons from all three categories for this study.* Of course, not all experimental, or recreational, users will become 'problem' drug users so it is both unfair and misleading to write about 'heroin addicts' when referring to categories one and two above. Unfortunately, this is often not the case in the media when over inflated figures are thrown around as has been alluded to by several service providers in this study. We use the terms heroin misuser and heroin addict in this study interchangeably to denote particular levels of addiction as we see it.

One should also attempt to differentiate between smoking and injecting heroin. One interviewee, for example, informed us that in his experience of heroin users in Athlone town, some 45% were injecting with 55% smoking, whilst another key community informant in Portlaoise stated that her experience was that only three persons were injecting out of some sixty people directly known to her. Very often in the life of this study we received conflicting information from all manner of sources.

It is also the case that the variability in drug taking behaviour varies considerably from one community and region to another. Thus, not all comments about Athlone will apply to Portlaoise despite the fact that both towns are located in the midlands and it might be attractive to speak of then in the same breath when discussing 'the midlands heroin problem'. An obvious case in point is the geographical location of each town and points of access into, and out of, each area. Heroin misuse has many individual traits, which preclude easy categorization.

It is also extremely difficult to 'believe' or accept as fact what one might consider to be informed sources at all times and we spent significant time checking one source against another source – sometimes with confusing results. One person, for example, informed us that she had discovered over thirty used needles in Portlaoise in one area and that she (and the community) was certain heroin addicts had discarded these. However, the health board subsequently informed her

that they were, in fact, needles used by insulin injectors. The particular source disputes this vigorously. Thus emerge urban tales.

Attempting research with 'difficult to reach' populations

It is no secret that people using, or misusing heroin, constitute a 'difficult to reach' population for research and we had to carefully consider how we might access such a population. Strauss & Corbin (1990: 19) have stated: "Some areas of study naturally lend themselves more to qualitative types of research, for instance, research that attempts to uncover the nature of persons' experiences with a phenomenon…". A qualitative approach not only allows us to understand the participants' experience but also how they are interpreting and making meaning of that experience. By allowing for direct personal input from participants in their own language, a qualitative approach permits a more direct representation of that experience (Garfat, 1998; McElwee, 2001). The single most important factor is that the interviewees are "knowledgeable about the topic under study…have experiential knowledge…be willing and able to critically examine this experience and their response to that experience (Lindsey, 1994: 68). This we certainly found to be the case.

The primary focus of the qualitative research components in this study will be on interpretative phenomenological inquiry, which seeks to elicit, to describe, to reveal, to understand rather than to know, the experience of the persons who are the focus of the research. As Van Manen (1990) has stated, "a phenomenological approach can reveal what one personally and immediately experiences. It describes "those aspects of a situation as experienced by the person in it" (1990: 183). Thus, it includes interpretation from both the interviewer and interviewee as we shall see in the notes provided below.

Qualitative pilot research methodology: Heroin misusers

We contacted a number of key stakeholders involved in human services provision in the Athlone area and set up interviews and an exploratory focus group with people misusing heroin in April 2004. The focus group took place in a local men's center in Athlone Town and twelve men between the ages of twenty-two and forty with experience

of heroin use took part. In addition, one in-depth interview was carried out with a male in his mid thirties who had been using heroin in the town for many years.

A semi-structured interview technique was used to allow the authors to seek clarification and elaboration on the answers given and to engage in dialogue with the research partners. Interviews such as this allow individuals to answer more on their own terms, but still hold the structure for comparability.

The preliminary qualitative data was supported with sixteen pilot questionnaires (n=16) from the same project. Feedback from the questionnaire construction was very useful in refining our questionnaire for wider distribution in the two towns, which took place in October and November 2004.

The qualitative pilot findings, as with many other studies on heroin, highlighted the real life experiences through the personal narratives of the interviewees. Living in a provincial town and using heroin seems to be a qualitatively different experience in these towns than in larger cities, such as Dublin, Calgary or Glasgow where we visited. These difficulties include challenges in remaining anonymous, in accessing particular services and in staying away from identified negative peer influences. The interviewees noted that, in general, people do not trust them and treat them unequally despite their efforts to get off heroin. Life, for chronic heroin misusers, in Athlone and Portlaoise has many negative connotations.

Locating participants

it is well established that the number of heroin misusers presenting for treatment and intervention can most appropriately be interpreted in terms of (increased) treatment availability in the area. On its own, therefore, this data is an indicator of prevalence rather than a true prevalence figure. Any data emanating from treatment/intervention data, such as the age and gender profile, should be qualified as relating to those accessing treatment as this may not necessarily reflect the drug using population in the area. For example, not all drug users will be in touch with treatment agencies; not all treatment agencies and/or GPS may feed into the DMRD dataset; and drug users living in the area may

be in treatment outside the Midland Health Board area. With this in mind, the authors decided that they would attempt to locate as many individuals as possible through informal contacts or 'snowballing' in the later research.[2] This had varying degrees of success as we will see.

Making contact with 'the lads'

One of the researchers, Gráinne has significant contact with many agencies in Athlone as a result of her post with the Midland Health Board where she works in the area of substance misuse. We contacted a particular organization that works with men who have used, or are using, heroin or methadone and sought permission to run a focus group and interview. The age range of participants in the pilot study is from twenty-two to an average of forty years. A letter was written to explain our intentions and the purpose of the research with the reassurance of confidentiality (see Appendix section).

This letter was followed up with phone calls and several meetings with the Director of the Project. Discussions took place with the Director around the best practice methodologies to employ in eliciting information in a manner sensitive to the research partners – methods that would be respectful of the people in the project. It was decided that a male staff member would be present while an interviewer facilitated the focus group to ensure that the men felt comfortable in the session. The group has a diverse membership representing, in the main, Athlone town. The Participants are at varying stages of the 'cycle of change' as some of the men are using heroin, others are on methadone maintenance, while still others are seeking or availing of training and are on the road to employment.

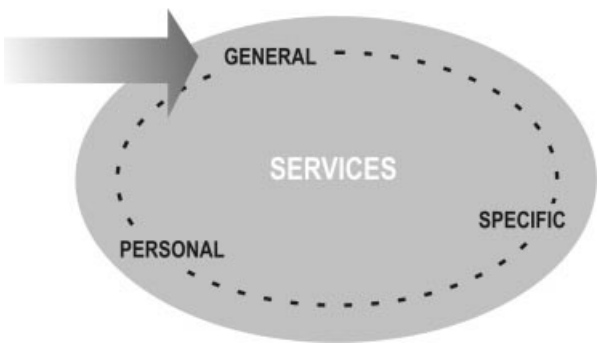
Participants of the centre were invited to bring along other heroin

2 Snowball sampling consists of identifying respondents who are then used to refer researchers on to other respondents. Snowball sampling has now advanced as a research technique (see McElwee & Lalor, 1997, McArdle-Walsh & O' Grady, 2001). Snowball-based methodologies are a valuable tool in studying the lifestyles of groups often located outside mainstream social research such as prisoner populations, persons with specific health problems and addicts. The real promise of snowball sampling lies in its ability to uncover aspects of social experience often hidden from both the researcher's and lay person's view of social life (Atkinson & Flint, 2001, Social Research Update, 33, 1).

users from the town and those who attended the drop in facility in their centre to partake in the focus group the following week. This ensured balance, as a relationship exists between the mainstream participants in the programme and the interviewer in this instance, who had worked with group members previously around Health Promotion issues. This offered scope to capture a wider audience and particularly those who are not attending any services in the town for drug related reasons.

Pilot focus group

Twelve men arrived on the morning of the focus group session. It was evident from the enthusiasm in the room that people were appreciative of the opportunity to tell their stories as is often the case with 'hidden' or 'hard to reach' populations (See McElwee & Lalor, 1997; McElwee, Monaghan & Armstrong, 2004).2[3]



Pilot schedule questions were drawn up for the focus group starting with general open ended questions and then moving to the specific, then personal and then to the services and back to general.

Prior to the focus group, the research objectives were explained to all the men. At the end of the session, the men were invited to input on the

3 The room was set up one hour prior to the focus group and the equipment, such as Tape Recorder and Dictaphone were checked to prevent disruption later. The lay out of the room was conducive to open communication and tea/ coffee and scones were provided to help people relax. From correspondence and discussions with the centre the research authors were expecting around ten men for the focus group.

type of questions and format they felt that the full research might take. From this pilot focus group, the questions were amended to incorporate the men's suggestions for future use.

Single in-depth interview

The in-depth interview with a male heroin user also took place in the premises of the above agency. The interviewee was given information about the research and voluntarily signed a consent form. The semi-structured interview questions were derived following from the pilot focus group.

Ethical framework

Consent: The authors wrote formally to the Director of the project informing him of the research and seeking his permission to meet with the men. After further informal contacts the Director invited the men to attend the focus group on a voluntary basis. A letter of consent was drafted explaining the purpose of the study, the methodology being applied and the ethical framework. The consent form was read out and the information explained and people's understanding was sought. All participants signed the form before the focus group or interview started.

Storage of information: The information gathered in the research will be kept in a secure location for five years. After the five years it will be destroyed. The information will be used only for the purpose outlined in the consent form.

Confidentiality: The research piece was discussed with the Freedom of Information Officer, with the interim co-ordinator of the Regional Drugs Task Force within the Midland Health Board and with an external international expert in qualitative interviewing. All participants are guaranteed confidentiality and all names are changed.

Respect: The dignity of the individual was held throughout the research process by continually checking with interviewees that the schedule was not upsetting.

Prevention of Harm to Research Partners: The research attempted not to apply any methods that would be harmful in any way to the participants and each individual received a copy of their interview transcript to review prior to its use in this study. We accepted all revisions and amendments.

Analysis: Adapted frameworks

After the single in-depth interview and focus group were completed, the data was transcribed verbatim and themes and sub-themes that emerged were referenced. Both transcripts were read a number of times and cross referenced. Themes were noted and then key issues and concepts were identified. Emerging data was then arranged and placed into themes and sub-themes as similar issues arose. The data was referenced under headings of the topic guide or questions and the responses numbered for ease of access to topics and issues over transcripts through cross-referencing. Each interview and focus group has a set of data that creates a method of charting popular themes in an orderly and logical flow. All Data collected was cross-referenced and triangulated.

Data analysis: Results

Each participant in the focus group and interview were given a number to ensure anonymity. Altogether, thirteen research partners are included in the pilot results section. The information from the focus group was extensive and covered a large range of issues. Participants were then given the opportunity to give feedback on the questions and identify gaps in an effort to inform the methods of data collection in the wider study.

A phenomenological perspective

Both of us were struck by a short paper by Hans Toch (1967) titled *The Convict as Researcher*. In this article, Toch and his team were viewing aspects of violent behaviour and had retained the services of an ex-inmate who had spent fifteen of his then thirty-six years in prison. In interviews conducted, each participant was asked to try to locate common denominators in the material and each interviewer was

encouraged to 'play scientist' in the experience as their views were respected and nurtured. We found this an enlightened approach.

Thus, when we reviewed the material from a phenomenological perspective, we were personally struck by a number of themes that spoke to us of the lived life experiences of heroin misusers – themes that were, as Burch comments, "meaningfully singled out and preserved" with the passage of time (1990: 133). The interviewees have attempted to give meaning to their experiences and, indeed, non-experiences and allowed us an opportunity to gaze into a somewhat familiar but yet murky pool – that of heroin misuse. Therefore, risk, fears, strain, difficulties, loss, threat, provincial experience, exclusion, secrecy, isolation, rejection, competition, exposure, privacy were all common to the interviewees. Indeed, all of the men were deeply affected by their heroin dependency and all that accompanies that in terms of health and well-being, familial relationship, employment and social status to name but some areas. As with phenomenological inquiry, we sometimes saw our own partial reflections in this pool.[4]

Summary of pilot study results

The pilot study research has uncovered many of the real life experiences and perceptions, within a sample of male heroin users living in Athlone. Heroin use, be it past or present, has clearly affected these interviewees in their interactions in society in terms of employment prospects, accessing housing and general socializing to name but some areas. Health risks including Hepatitis C, HIV, abscesses, and addiction and withdrawal symptoms were features of the effects for the respondents. The alleged increase in some teenagers using and, initiating, heroin use was highlighted and the rise in the numbers of females using heroin in the town was also noted.

There is now little doubt that heroin use has grown considerably in Athlone since the early 1990's. It was in the early 1990's, for sure, that

4 A phenomenological perspective speaks to us because we are interested in 'meaning-making' and in the idea that each of us in responsible for the structure of external reality (Yalom, 1989). Phenomenology refers to all those forms of thinking and inquiry which in some way maintain a perspective on the lived human experience (Burch, 1990: 189) and looks fundamentally at what it is to be human.

heroin use really started to become a feature of drug use in Athlone town. However, the respondents felt that heroin had been in the town as far back as the early 1980's when heroin flooded the Edinburgh, Glasgow and Dublin markets and was brought down to Athlone. Despite the concerted efforts of the Gardai, we have been informed that established dealers still could obtain relatively large quantities of heroin for sale and this means that individual heroin misusers do not have to travel far out of Athlone to buy their supply, as was the case in the past. Heroin is readily available to those who really want it. The price of heroin varies as the demand has introduced a competitive market usually a bag of heroin can be bought on the street for between €20 and €25.

The use of other drugs such as speed, ecstasy and solvents were mentioned in relation to how the men, themselves, and others have got involved in heroin use. Educational disadvantage and dysfunctional family backgrounds were also cited as reasons to why people in Athlone might be using heroin. Using other drugs particularly analgesic drugs such as D10's was noted as a useful activity to help with the sickness and withdrawal symptoms associated with heroin use. Another serious concern expressed by the respondents related to the quality of heroin, which seems to be generally quite poor and can have the knock on effect of not giving the desired 'high', in addition to running the risk of illness and overdose.

The age of people becoming involved in heroin use was articulated as getting younger than it previously would have been in the town. A particularly disturbing new trend emerging is the increasing numbers of females getting involved in use.

The impact of using heroin has filtered into many domains of the men's lives and one area that was returned to on a considerable number of occasions during the pilot study was the one of social isolation. Social isolation and stigma are stark features in the lives of heroin users in Athlone who really "feel the pinch of living in a small town". One man reported his dilemma of being chastised for dealing heroin and others came in to the discussion at this point to collaborate this view that due to their involvement with heroin they can be seen in the public domain as involved in crime for example dealing drugs.

The fear of family and community members becoming aware of the heroin use was a serious factor in deterring the research participants from potentially accessing services.

When asked how the confidentiality issue could be addressed the men felt that individual, independent GP's that they could access themselves would be the best way for them. Others want the methadone maintenance clinic to be stricter with their clients in terms of not taking them back onto the programme if they are producing 'dirty urines'. A needle exchange programme, as a harm reduction measure, was seen as a potentially positive development.

Crucially, the research partners formed a representative sample of known heroin users in the town and the information ascertained many of the research objectives. The personal narratives of the men in the study and the experiences and knowledge that they have of the heroin situation in Athlone could be channelled in a positive route of recovery for the men and the community.

The study proper: Introduction

Having obtained a range of information from the pilot study, we progressed further into uncovering heroin misuse in both Portlaoise and Athlone. Perhaps, we were fortunate in that we have an intimate knowledge of one of the research areas, Athlone, because our employment is based in that town and one of the researchers has lived there all her life including attending college there for two separate programmes. In Portlaoise, we liaised heavily with service providers and peers and, in particular, community activists and parents of youth addicted to heroin.

An example of our research difficulty in terms of trying to access heroin misusers who were not in contact with formal services occurred in September 2004 when one of our key service agency stakeholders met with nine men who were at a particular gathering because of their long-term unemployed status. He reported to us that in conversation, it transpired that five of these men had taken heroin but that none of them had presented in the past for treatment and their heroin use in Athlone had gone completely unrecorded either within the criminal justice system or in addiction/health services. They remain unrecorded.

Bearing in mind the above, we attempted a number of research methodologies to obtain interviews with heroin misusers including lengthy observation of named areas, calling to social welfare services, snowballing through other participants, scheduling interviews where people simply did not turn up (despite moving our interview schedules from morning to afternoon to evening), accessing gatekeepers who worked with 'at risk' populations, making public appeals on regional radio, sending group texts and e-mails etc. We detail some of these attempts below. In total, we carried out in-depth interviews with 32 service users and family members in Athlone and Portlaoise and with nominees from 36 agencies totalling 68 qualitative interviews. We also analysed 32 questionnaires in this research.

Lengthy on-site observation

Adopting a child and youth care research perspective, both authors 'hung' out in various areas of both Athlone and Portlaoise over a nine-month period using varying days and nights of the week and times (see McArdle-Walsh, O' Grady & McElwee, 2003; Garfat & McElwee, 2004). We spent hours walking around Athlone and Portlaoise towns, sitting in our cars in various housing estates, drinking coffee in pubs and restaurants and accompanying gatekeepers on their travels into the heroin underworld. This took up considerable time as we attempted to visit both 'reputable' and 'disreputable' environments.

Accessing gatekeepers

The researchers contacted and interviewed gatekeepers in Athlone and in Portlaoise.

Service providers from Athlone and Portlaoise were identified as stakeholders in April 2004 and were contacted in writing as part of this study in June 2004 (see letter of explanation in appendix 1:1). We detail below the individual agencies contacted in tables 4:1 and 4:2.

Table 4:1 Agency Providers in Athlone Research Site		
Service Agency	**Contacted**	**Interviewed**
Open Door Project	Yes	Yes
Community Training	Yes	Yes
Stepping Out Project	Yes	Yes
Gardai	Yes	Yes
Social Work	Yes	Yes
Social Welfare	Yes	Yes
Probation	Yes	Yes
Comm Development	Yes	Yes
Substance Misuse	Yes	Yes
Addiction Service	Yes	Yes
Athlone Comm Taskforce	Yes	Yes
Drug Awareness Group	Yes	Yes
Marist Rehabilitation	Yes	Yes
GP Service	Yes	Yes
Pharmacy Service	Yes	Yes
Traveller Training	Yes	Yes
Women's Training	Yes	Yes
Local Politician(s)	Yes	Yes

Table 4:2 Agency Providers in Portlaoise Research Site		
Service Agency	**Contacted**	**Interviewed**
Youth Project	Yes	Yes
Probation	Yes	Yes
Gardai	Yes	Yes
Comm Development	Yes	Yes
Social Work	Yes	No
NTDI	Yes	Yes
Housing Service	Yes	Yes
PhN Service	Yes	Yes
Pharmacy Service	Yes	Yes
Addiction Service	Yes	Yes
GP Service	Yes	Yes
Social Welfare	Yes	Yes
Prison Service	Yes	No
Courts	Yes	No
Local Politician(s)	Yes	Yes
Knockmay Resource Centre	Yes	Yes

Table 4:3 Agency Providers outside Athlone & Portlaoise		
Service Agency	**Contacted**	**Interviewed**
Mountjoy Prison	Yes	Yes
Psychiatry Dublin	Yes	Yes
Public Health, Tullamore	Yes	Yes
Men Can Care, Glasgow	Yes	Yes

Snowballing

This is often regarded as a main route into problem drug using populations. We found snowballing particularly useful in our Athlone-based research, but not so much in Portlaoise – with the exception of one community activist. Although interviewees were, in the main, willing to contact peers for the study, they seemed unable to do so when it came to actually securing interviews at scheduled time. This was the most frustrating experience in this study.

Public appeals for information specific to heroin use

On two separate occasions, one of the authors made public appeals on regional radio and provided phone numbers and e-mail addresses where we could be readily contacted.[5] A number of people did contact us as a result of the radio requests.

Provision of mobile phone numbers

The authors provided their mobile phone numbers to gatekeepers who, in turn, passed these numbers on to known heroin users. We did receive calls and texts from potential interviewees which proved useful. One woman, in particular, was most helpful in locating interviewees for our study.

Accessing public houses

The researchers called into several public houses in Portlaoise and spoke with bar staff about heroin use in the town. None of the staff, both males and females, reported coming across 'heroin addicts' in their pubs. One staff member in Portlaoise did say that she saw 'shady' looking characters on court days hanging around but that she denied them access from buying alcohol and the toilet areas in her pub. Another bar man told us that he knew there was a heroin problem in

5 Unfortunately, as a result of a radio interview in early September 2004, a report was carried in a number of regional and national newspapers, which sensationalized interim research findings, and, we would argue, presented data out of context. Of course, the authors are powerless over media interpretation of data but we would defend speaking on radio to raise awareness amongst the public, some of whom would not have known how to contact us during the life of this study.

town but never came across any paraphernalia in his pub. It was his belief that heroin misusers were "staying at home taking their drugs because the price of alcohol was too much for them."

Attending court sittings

The researchers attended court sittings in both Athlone and Portlaoise to get a sense, themselves, of criminal activity in both towns. We saw a number of cases held in front of three judges where heroin was a central feature.

Travels to Portlaoise and Mountjoy Prison

As this study progressed, we consistently heard that men and women from the midlands had ended up in Portlaoise Prison and Mountjoy Prison in Dublin so we travelled to these sites to meet with the Governors and several prisoners. At the time of contact, we were notified of eighteen prisoners from the Portlaoise area who had been involved in heroin and were in Mountjoy so there are substantial numbers of persons moving through the system. On our schedule date, we interviewed three prisoners in Mountjoy who were from the midlands or are living in the Midlands.

Holding workshops with social care practitioners

We also held workshops with over 250 students of social care programmes, front line social care practitioners, supervisors and managers in two countries; Ireland and Canada. We specifically teased out issues of ethical consideration in these workshops around how we might progress this study whilst being true to a child and youth care approach.

Concluding comments

The individual in-depth interview was the main research instrument used to gain information around heroin misuse from both heroin misusers and agency providers in this study. Although twelve general areas framed these interviews, the interviewees very often diverged into several related and unrelated areas of discourse. The interviewers facilitated this. A questionnaire supplemented the qualitative data as is

seen from chapter 4(b).

The research does not claim to yield a representative sample of heroin misusing populations in Ireland because our focus was on individual stories from a limited sample. However, it does retell and context some of the main themes as expressed by service providers, heroin misusers and their families in two regional towns. We present and discuss this in later chapters.

CHAPTER 4 (b)

Heroin Misuse – Quantitative Analysis

Fearghal McHugh

SECTION A – SUMMARY OF PILOT HEROIN STUDY

Summary Introduction

The total pilot sample consisted of 16 respondents. These respondents were presented and /or assisted in answering the questionnaire by an established gatekeeper. The questionnaire consists of 5 primary data gathering categories.

1. The respondents were classified by gender, age, and locations.

2. Background family and family reaction is gathered in sections of the questionnaire in relation to drug taking and alcohol. The background also includes their education and employment history, accommodation and children.

3. (a) The data on drug taking is introduced with questions relating to smoking and drinking habits of the respondents. Drug taking is explored from (b) availability and (c) respondent's first sight of drugs to taking heroin. (d) This section leads into the treatments that respondents are receiving or have received.

4. The second last section deals with the respondents view of the Gardai in terms of how often the respondents have been in contact, how often and whether or not they view the Gardai as agents of help or information.

5. Finally there is an examination of the services in terms of usage time, resources used and referrals to these services and an identification of ways to extend the services to others.

A copy of the full pilot questionnaire and results of the pilot can be obtained by contacting Fearghal McHugh or Dr. Niall McElwee at the Centre for Child and Youth Care Learning, Athlone Institute of Technology.

Sample

A centre was selected in Athlone that has a programme available for men only. This service was selected for the pilot as the three researchers are based in Athlone and there was already an interest expressed from the Director of that project to assist the study. 16 surveys were returned. As a result of the pilot research feedback, amendments to the questionnaire were suggested by one of the interviewers and from several of the respondents, which are incorporated in the main questionnaire. The results are summarised in this section.

Classification

In this pilot there were sixteen surveys returned from the respondents who were all male. The age category ranged from 21 to 50, with 56 % being above 36 years and the majority between 36 and 40. The respondents mainly lived from the age of ten in Athlone with other locations including Dublin and Longford. The majority currently reside in Athlone.

Background

The majority of the parents of the respondents were employed; the primary occupation of the majority of fathers was employees while the majority of mothers were housewives. 75% of respondents never married, nor did the majority complete second level education. Only 25% completed second education. As expected from the gender of the respondents, the schools attended were priests/brother schools, which were all boys. 70% of respondents finished school at, or before, the age of 15. The main reason stated for leaving was to get a job, with a further 25% outlining what might be termed non-socially productive reasons. 81% are currently unemployed. 75% report that they were employed for various lengths of time. Since the age of 15, 42% were in employment for 12 or more years. However, 55% have been

unemployed for more than 5 years with 25% unemployed for 10 years. 56% have been to prison and of those 25% have spent less than 1 year in prison, 30% have spent between 2 and 6 years in prison. The respondent's accommodation consists of mainly parent or privately rented terraced houses with one respondent reporting sleeping on the street. Almost 70% have children ranging from 1 to 18, 6 under the age of 5, 6 between 6 and 10 with 7 over 11 years old.

Drug Taking – Smoking/Alcohol

In this pilot, the aim of the drugs section is to focus on heroin intake. The other drugs dealt with initially consist of alcohol and cigarettes. 93% smoke with 87% smoking every day. 87% drink with 37% drinking several times a week. 87% have drank for two or more successive days in the last year with 37% reporting that this has occurred between 6 and 10 times in the year. The majority drank alcohol the last time with friends or on their own, the minority with family or partners. 68% have been drunk on 40 or more occasions in the respondent's lifetime. In addition during the last three months 25% have been intoxicated 6 or more times, during the last 30 days 43% have not been drunk. 61% report that their mother/step mother would disapprove of them being drunk. 42% suggest that their father would disapprove. Their friends would equally disapprove and would not disapprove while those who are married report that 25% of their partners would disapprove. 50% report that their other friends would disapprove.

Drug Taking – Availability

The pilot respondents report that 50% were younger than 13 when they saw their first drug with 2 being 8 years old and under. This first sight of drugs happened mainly on the street with second location being the disco/rave. According to 62%, drugs were available in their area at the time. All respondents used drugs other than cigarettes and alcohol. The drugs used by all of the respondents consisted of marijuana, cannabis, grass, amphetamines and magic mushrooms. The second category, where 81% to 93% used consists of tranquillisers, LSD, cocaine, ecstasy and methadone. Finally, 56% have used crack.

Drug Taking – Heroin

87% of the pilot sample have used heroin with 56% using for the first time above the age of 18. However, 56% no longer used heroin but 31% still use it. 25% use it every day with smoking being the primary usage method followed by injecting the drug. The main reasons as stated for using heroin are to "boost feelings", "overcome life and family problems". The last time the relevant respondents took heroin, 43% were in their own house and 25% at a friend's house, obtaining it from a dealer/supplier. The majority of respondents indicated that mothers, fathers, family would strongly disapprove however 25% suggest that their wife/husband would strongly disapprove. All respondent agree that heroin is a problem in their area with 81% stating it as a very serious problem. All of the respondents also have friends who use the drug, with 42% having most of their friends using. 49% would not discuss drug issues with their mother and 50% would not with their father. 31% would discuss it with friends and 80% with counsellors.

Treatment

On the basis that 81% of respondents have received treatment for drugs, 61% are not satisfied with the support in Athlone although the majority agree with the statement as follows, "I think the staff have been good at their jobs" and "the staff helped me to motivate me to sort out my problems".

Two centres were most often named. The main time length of treatment received was over one year by 37% of the respondents with 36% receiving up to 6 month. In an exploration of the respondents views of harm with regard to smoking, drinking and drugs the following indicate their understanding: 75% suggest that smoking is a slight risk, 62% suggest taking 205 drink daily is a great risk, smoking cannabis is a slight risk according to 62% but 93% of pilot respondents indicate that taking cocaine is a great risk, 87% indicate heroin is a great risk with all agreeing that injecting it is a great risk also. In terms of health checks 50% receive regular or annual checks.

Contact with Gardai

The pilot respondents were asked their view of the Gardai and their level of contact with them. 75% would not see them as a source of help or assistance and 85% have had occasion to have contact through their drug use with 43% of those having 4 or more occasions to have contact with the Gardai. 75% of those have had court appearances. 37% have been directed to services by the Gardai and 50% have realised through the contact with the Gardai the trouble that can result from their drug taking.

Contact with Services

87% of respondents were referred to a formal service by friends while posters are suggested to be a significant method of information while 50% suggest outreach as a favourable method. Friends are perceived to be the best method. 81% think the service they use is helpful or very helpful, with 70% using the service every day. The greatest suggested benefit is stabilisation. 93% have advised others to use the service with the counsellor being the major referral source. 62% have used the service previously. 87% suggest that the services should be located in local areas with 50 % preferring the drop-in method to use the service. The main reasons they use the service are for support, to withdraw and or stop using. There are many other uses such as washing, food, support, conversation and counselling. Generally the majority did not suggest any other uses however job guidance, harm reduction and a requirement for more experience people were suggested by a minority. The preferred times for usage were at weekends but the majority were satisfied with access. They were also aware of various services available in the area. 75% had the number of the service on their person and 81% normally contact the service by walking to it and using the drop-in approach. The respondents suggest getting others who were drug users to help while getting someone to go out. The majority use the service for stabilisation, personal and social needs.

Points of Note

While compiling this analysis from the pilot heroin-use questionnaire into summary format, it is of note that the summary, as in its nature indicates the most significant quantities in terms of maximums or minimums. However, these can exclude points of deliberation. The issues, outlined below, that emerged could disown the predetermined clichés that currently exist in relation to drug taking.

The parents of the respondents worked either as self-employed persons or were army personnel with mothers generally working as housewives. The respondents living accommodation was usually terraced or semi detached. This indicates that the pilot respondents were from what are usually termed 'working class' backgrounds.

With that, 4 respondents stated they did not complete primary education, with only one reaching third level. 6 people finished school before the age of 14 and 9 by age 15. On leaving school, 10 respondents did pursue a directional path to a job or other, however 13 are now unemployed. 11 are now over 31 years old. 9 children of the respondents are 9 years or under. 8 respondents saw their first drug at age 13 or under, with 2 respondents being aged 8 or under. The home was the first environment to see drugs for 5 of the total number of respondents. 8 took heroin after the age of 20 indicating that 'problems in life' and 'family' the reasons for using.

The respondents agree that injecting heroin is a risk to their lives and has brought them into contact with the Gardai. The Gardai are seen as a source of help or information, even though their use of drugs has brought many repeated contacts with the Gardai. The main referrals to the treatment services are from local GP's.

SECTION B – ANALYSIS OF HEROIN STUDY

The final analysis is categorised as follows:

1. Sample – sample size and location.
2. Classification – age and location
3. Background – Living standards and parent's background
4. Drug taking – Smoking/Alcohol and perceptions of others to taking drink
5. Drug taking – availability in the area, perceptions of others attitude to taking drugs
6. Drug Taking – Heroin usage
7. Treatments – taken is any general approach
8. Contact with Gardai,
9. Contact with Services
10. Limitations.

1. Sample

Following are the results from the full questionnaire as receive from respondents. The sample size is 16. The details are outlined in table format with a comment on the significant element from each table highlighted in the 'Note' attached on the right hand side. Also, there are results from the pilot study attached in some instances for comparison. 143 questionnaires were distributed.

This number was distributed to the following locations:

Athlone

Open Door Project in Athlone	(25)
Stepping Out Project, Athlone	(10)
GP Surgery in Athlone	(10)
Addiction Services Athlone	(25)
Ex-Dealer in Athlone	(10)
Hand delivered to Community	(5)

Portlaoise

PhN	(8)
Addiction Services	(25)
Knockmay Community Resource Centre	(5)
Local Politician	(10)
Hand delivered to Community	(10)

The results tables below include the question, the percentage responded and the absolute value. The percentage is calculated as a percentage of the total sample size, that is n=16,100%.

The tables present the questions that were responded to. They do not display all the possible selections that were available to each respondent. Elements that are not presented are due to the fact that there was no response to that element. The section on limitations outline issues that affected results. Respondents did not answer all questions asked.

A copy of the full pilot questionnaire and results of the pilot can be obtained by contacting Fearghal McHugh or Dr. Niall McElwee at the Centre for Child and Youth Care Learning, Athlone Institute of Technology.

2. Classification

Are you		
Male	43.8%	7
Female	50.0%	8
Responded		15

Note:
A gender balanced sample.

Which of the following categories best describes your age		
15-20	12.5%	2
21-25	12.5%	2
26-30	37.5%	6
31-35	6.3%	1
36-40	12.5%	2
41-45	12.5%	2
51-55	6.3%	1
Responded		16

Note:
62% aged 30 and under.

Please name the main town/village of your upbringing up to the age of 10		
Athlone	62.5%	10
Moate	6.3%	1
Longford	6.3%	1
Dublin	6.3%	1
Portlaoise	12.5%	2
England	6.3%	1
Responded		16

Note:
10 of the 16 respondents grew up in Athlone with 12 currently living in Athlone.

In what area do you now normally live		
Athlone	75.0%	12
Portlaoise	12.5%	2
Other	6.3%	1
Responded	93.8%	15

3. Background

What is/was the usual occupation of your father		
Army		6
Employee	(bar man	2
	teacher)	
Self employed	(pub	2
	builder)	
Unemployed		2
Deceased		1
	Responded	13

Was/is he usually employed		
Yes	75.0%	12
No	18.8%	3
Responded		15

Note:
The fathers of 12 of those that responded were usually employed or self employed, in various positions.

What is/was the usual occupation of your mother?	
Housewife	10
Employee	2
Self Employed	1

Was/is she usually employed		
Yes	31.3%	5
No	56.3%	9
Responded		14

Note:
All mothers were employed in or outside the home.

What is your marital status		
Never married	25.0%	4
Married	25.0%	4
Divorced	6.3%	1
In a relationship	37.5%	6
Other	6.3%	1
Responded		16

Note:
62% are married, or in a relationship.

Which one of the boxes below best describes your current level of education		
1.Incomplete Primary Education	12.5%	2
3.Incomplete 2nd Level Education	43.8%	7
5.Incomplete 3rd Level Education	25.0%	4
6.Completed 3rd Level Education	12.5%	2
Responded		15

Pilot Comparison:

1. *Incomplete Primary Education 25.00%*
2. *Completed Primary Education 6.30%*
3. *Incomplete 2nd level Education 37.50%*
4. *Completed 2nd level Education 25.00%*
5. *Incomplete 3rd level Education 6.30%*

What type of school did you attend		
Convent	37.5%	6
Priests/Brothers	37.5%	6
Community School	6.3%	1
Other (Specify	18.8%	3
Responded		16

Was your school		
Mixed	25.0%	4
All Girls	37.5%	6
All Boys	31.3%	5
Responded		15

At what age did you finish in school		
11	6.3%	1
13	6.3%	1
14	6.3%	1
15	25.0%	4
16	6.3%	1
18	18.8%	3
19	12.5%	2
21	6.3%	1
Responded		14

Pilot Comparison:

11. 6.30%

12. 6.30%

14. 25.00%

15. 31.30%

17. 18.80%

18. 12.50%

Recently after leaving school, did you		
Get a Job	50.0%	8
Do a Fás Course	25.0%	4
Do a Secretarial Course	6.3%	1
Do a CERT Course	6.3%	1
Join Youthreach	0.0%	0
Go to College	0.0%	0
Other (sp	12.5%	2
Responded		16

Note:
50% finished school before age 18, 43% before age 16, leaving mainly to get a job.

Other (After leaving school)
'Nothing'
'Locked up immediately'

Are you currently in employed		
Yes	12.5%	2
No	87.5%	14
Responded		16

Note:
87% are unemployed.

Which of the following categories best describes your present employment status?		
1.Full time permanent	6.3%	1
3.Part time permanent	6.3%	1
5.Self Employed	6.3%	1
6.Student	6.3%	1
10.Other	18.8%	3
Responded		7

Other (present status)
'Prison'
'Prison'

From the four options below, indicate the categories that apply to you since the age of 15:		
1. Education	56.3%	9
2. Employment	75.0%	12
3. Unemployment	68.8%	11
4. Prison	31.3%	5

Note:
Since age 15, 11 have experienced unemployment and 5 experienced prison for a year or less. 12 were employed at some time.

Education - indicate how many years you spent in each, since the age of 15		
<1	6.3%	1
3	6.3%	1
14	6.3%	1
15+	37.5%	6

Employment- indicate how many years you spent in each, since the age of 15		
1	6.3%	1
2	6.3%	1
4	12.5%	2
5	12.5%	2
6	6.3%	1
7	6.3%	1
10	18.8%	3
15+	6.3%	1

Unemployment- indicate how many years you spent in each, since the age of 15		
2	12.5%	2
3	12.5%	2
4	6.3%	1
8	6.3%	1
10	6.3%	1
15+	25.0%	4

Prison - indicate how many years you spent in each, since the age of 15		
<1	12.5%	2
1	18.8%	3

Which of the following options best describes your present type of accommodation		
Parents' home	18.8%	3
Privately rented	25.0%	4
Local authority rented	37.5%	6
Homeless	6.3%	1
Other	12.5%	2
Responded		16

Other (accommodation)
'Prison'
'Prison'

Note:
62% are renting with 1 homeless and 2 in prison.

Is it:		
Detached	25.0%	4
Semi-detached	25.0%	4
Terraced	18.8%	3
Flat/Bed sit	12.5%	2
Other	6.3%	1
Responded		14

Other
'Prison'

Do you have children		
Yes	62.5%	10
No	37.5%	6
Responded		16

Pilot Comparison:

Yes 68.80%

No 18.80%

Note:
16 respondents have 20 children under the age of 18 years.

Please indicate how many of your children are in the following age group	
Age 1	1
3	1
4	1
5	1
6	3
7	3
8	2
9	2
10	2
11	1
15	3
18	1

Pilot Comparison:

0-1	*1*
2	*1*
4	*2*
5	*2*
6	*1*
7	*1*
8	*1*
10	*3*
11	*1*
12	*3*
16	*2*
18	*1*

4. Drug taking – Smoking/Alcohol

Do you smoke		
Yes	62.5%	10
No	37.5%	6
Responded		16

How often do you smoke		
Every Day	62.5%	10

Note:
10 respondents smoke every day, 9 drink alcohol irregularly, 40% have drank on two or more succesive days less than 3 times a year.

Do you drink alcohol		
Yes	56.3%	9
No	43.8%	7
Responded		16

If no, please specify a reason
'Illness so go on drugs'

How often do you drink		
One to three times a week	12.5%	2
One to three times a month	31.3%	5
One to three times a year	18.8%	3

The last time you had an alcoholic drink, whom did you drink it with		
3.With brother(s)/Sister(s	6.3%	1
5.With friends	18.8%	3
6.With my boyfriend/girlfriend	25.0%	4
7.With my husband/wife	12.5%	2

Have you drank for two or more successive days in the past year?		
Yes	43.8%	7
No	25.0%	4

How many times has this occurred in the last year		
1-2 times in the year	12.5%	2
3-5 times in the year	12.5%	2
2-3 times a month	12.5%	2
4 or more times a month	6.3%	1

How many occasions, if any, have you been drunk from drinking alcoholic beverages?

	Base	*Missing*	*Grid Table*						
		No reply	None	1-5	6-10	11-15	16-20	21-25	26 or more
Base	48	23	10	4	1	-	3	2	5
		47.90%	20.80%	8.30%	2.10%	-	6.30%	4.20%	10.40%
1. In your lifetime	16	6	2	1	-	-	2	2	3
		37.50%	12.50%	6.30%	-	-	12.50%	12.50%	18.80%
2. In the last 3 months	16	9	3	2	1	-	-	-	1
		56.30%	18.80%	12.50%	6.30%	-	-	-	6.30%
3. In the last 30 days	16	8	5	1	-	-	1	-	1
		50.00%	31.30%	6.30%	-	-	6.30%	-	6.30%

How much would each of the following people disapprove if you were drunk?

	Base	*Missing*	*Grid Table*			
		No reply	Strongly Disapprove	Disapprove	Would not disapprove	No such Person
Base	112	72	11	15	9	5
		64.30%	9.80%	13.40%	8.00%	4.50%
1.Mother/ Stepmother	16	12	2	2	-	-
		75.00%	12.50%	12.50%	-	-
2. Father/ Stepfather	16	9	3	2	2	-
		56.30%	18.80%	12.50%	12.50%	-
3.Grandparents	16	14	1	-	-	1
		87.50%	6.30%	-	-	6.30%
4. Best friend	16	11	1	2	1	1
		68.80%	6.30%	12.50%	6.30%	6.30%
5.Other good friends	16	9	-	3	3	1
		56.30%	-	18.80%	18.80%	6.30%
6.Other family members	16	10	2	3	1	-
		62.50%	12.50%	18.80%	6.30%	-
7.Wife/Husband	16	7	2	3	2	2
		43.80%	12.50%	18.80%	12.50%	12.50%

5. Drug taking – availability

At what age did you see your first drug		
11	6.3%	1
13	12.5%	2
14	12.5%	2
15	12.5%	2
16	12.5%	2
18	6.3%	1
19	12.5%	2
20	6.3%	1
35	6.3%	1
Responded		14

Pilot Comparison:

8	*12.50%*
10	*6.30%*
12	*25.00%*
13	*6.30%*
15	*18.80%*
16	*6.30%*
17	*6.30%*
20	*6.30%*
24	*6.30%*
28	*6.30%*

Where did this occur		
Home	12.5%	2
School	18.8%	3
Disco/Rave	25.0%	4
Street	18.8%	3
Local area	6.3%	1
Other	12.5%	2

Note:
9 saw their first drug under the age of 18, main location being a disco or street, 9 indicating that drugs were available in their area at the time.

Other (where it occurred)
'friends house'
'birthday party'

Were drugs widely available in your area at that time		
Yes	56.3%	9
No	12.5%	2
Dont Know	31.3%	5
Responded		16

Have you ever used drugs? (apart from cigarettes and alcohol)		
Yes	93.8%	15
No	6.3%	1
Responded		16

Note:
The majority have used drugs, mainly cannabis, LSD, cocaine and tranquillisers.

Which of the following drugs have you used		
1. Tranquillisers or sedatives	62.5%	10
2. Marijuana, cannabis, hashish, pot, grass	93.8%	15
3. LSD	62.5%	10
4. Amphetamines	50.0%	8
5. Crack	25.0%	4
6. Cocaine	62.5%	10
9. Methadone	50.0%	8
10. Magic Mushrooms	56.3%	9

Are you currently using any drugs (other than heroin)		
Yes	31.3%	5
No	68.8%	11
Responded		16

If yes
A few joints
Cannabis
Cannabis
Hash
Methadone program

Note:
11 are no longer on drugs, and those that are used mainly cannabis and hash.

6. Drug Taking – heroin

Have you ever used heroin		
Yes	87.5%	14
No	6.3%	1
Responded		15

Note:
The majority have used heroin with 56% being 18 and over when started, with 6 still using.

What age were you when you first used heroin		
15	12.5%	2
16	12.5%	2
18	18.8%	3
20	6.3%	1
21	12.5%	2
24	6.3%	1
26	6.3%	1
27	6.3%	1
Responded		13

Pilot Comparison Age:

13	*6.30%*
14	*6.30%*
15	*6.30%*
16	*6.30%*
17	*6.30%*
19	*12.50%*
21	*6.30%*
23	*6.30%*
27	*6.30%*
28	*12.50%*
33	*6.30%*
35+	*6.30%*

Do you still use heroin		
Yes	37.5%	6
No	50.0%	8
Responded		14

Pilot Comparison Use:

Yes	*31.30%*
No	*56.30%*

How often do you use heroin		
Every Day	25.0%	4
One to three times a month	6.3%	1
One to three times a year	6.3%	1

What method do you normally use to take heroin		
Snort	12.5%	2
Smoke	31.3%	5
Inject	31.3%	5

What methods have you used in the past to take heroin		
Snort	18.8%	3
Smoke	50.0%	8
Inject	37.5%	6

Why do you use heroin		
Boost how you feel	31.3%	5
To overcome family problems	31.3%	5
Problems in life	31.3%	5
The Buzz	31.3%	5
To experiment	12.5%	2
Other	6.3%	1

Other
'Cant seem to get out'

Note:
Respondents using heroin 4 used it every day, with injection and smoking being the main methods. In the past there was more smoking than injecting. The reasons for taking are equally disributed as per table. Taking it at home or open area in the main with a dealer being the main supplier.

Where did you take heroin the last time		
Your own house	25.0%	4
Friend's house	6.3%	1
Park, beach, other open space	18.8%	3
Other place	6.3%	1

Other
'sisters house'

From whom did you obtain heroin the LAST TIME		
A Friend	12.5%	2
Brother/Sister	6.3%	1
Dealer/Supplier	31.3%	5

How do you think each of the following people would feel about you using heroin?

	Base	*Missing*	*Grid Table*			
		No reply	Strongly Disapprove	Disapprove	Would approve	Don't know
Base	112	73	30	7	1	1
		65.20%	26.80%	6.30%	0.90%	0.90%
1.Mother/Step mother/foster mother	16	9	7	-	-	-
		56.30%	43.80%	-	-	-

... continued on next page

2.Father/ Stepfather/ Foster Father	16	9	7	-	-	-
		56.30%	43.80%	-	-	-
3.Grandparents	16	10	5	1	-	-
		62.50%	31.30%	6.30%	-	-
4.Best friend	16	11	3	2	-	-
		68.80%	18.80%	12.50%	-	-
5.Other good friends	16	11	1	3	1	-
		68.80%	6.30%	18.80%	6.30%	-
6.Other family members	16	10	6	-	-	-
		62.50%	37.50%	-	-	-
7.Wife/Family	16	13	1	1	-	1
		81.30%	6.30%	6.30%	-	6.30%

Would you say that "The use of Heroin is a problem in your area"?		
Yes	93.8%	15

If "Yes", how serious a problem is it		
Very Serious	31.3%	5
Serious	37.5%	6
Don't Know	25.0%	4
Responded		15

Note:
Heroin is a problem in the respondents area with 11 suggesting it is a very serious problem. All respondents in the sample indicated all of their friends use drugs with all indicating that most or some of their friends use herion.

Do any of your friends use illegal drugs		
Yes	100.0%	16

How many, if any, of your friends do you think use heroin		
A Few	31.3%	5
Some	18.8%	3
Most	43.8%	7
All	6.3%	1
Responded		16

How satisfied are you that you could discuss issues relating to alcohol and drugs, with the following people

	Base	*Missing*	*Grid Table*				
		No reply	Very Satisfied	Satisfied	Don't Know	Not Satisfied	Not Satisfied at all
Base	80	34	9	7	15	9	6
		42.50%	11.30%	8.80%	18.80%	11.30%	7.50%
1.Your Mother	16	5	-	3	1	4	3
		31.30%	-	18.80%	6.30%	25.00%	18.80%
2.Your Father	16	6	1	2	1	3	3
		37.50%	6.30%	12.50%	6.30%	18.80%	18.80%
3.Your Wife/ Husband	16	7	5	-	4	-	-
		43.80%	31.30%	-	25.00%	-	-
4. Your Friends	16	4	3	1	6	2	-
		25.00%	18.80%	6.30%	37.50%	12.50%	-
5. Counsellor	16	12	-	1	3	-	-
		75.00%	-	6.30%	18.80%	-	-

7. Treatments

How satisfied are you with the level of support available in Athlone/Portlaoise for people who use Heroin?		
Don't Know	6.3%	1
Not Satisfied	56.3%	9
Not Satisfied at all	25.0%	4

Note:
Of those who responded, 13 are not satisfied with support available with 9 having received drug treatment and 3 having received treatment before.

Have you ever received treatment for Drugs		
Yes	56.3%	9
No	43.8%	7
Responded		16

If so, please indicate how much you agree with the following statements

	Base	*Missing*	*Grid Table*				
		No reply	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
Base	160	95	8	37	3	13	4
1.The staff have not always understood the kind of help I want.	16	10	2	2	-	2	-
2.The staff and I have had different ideas about my treatment objectives.	16	10	1	4	-	1	-
3.There has always been a member of staff available when I have wanted to talk	16	10	-	3	-	2	1
4.The staff have helped to motivate me to sort out my problems.	16	9	2	3	-	1	1
5.I think the staff have been good at their jobs.	16	9	-	4	2	1	-
6.I have been well informed about decisions made about my treatment.	16	10	-	6	-	-	-
7.I have received the help that I was looking for.	16	10	3	2	-	1	-
8.I have not liked all of the counselling sessions I have attended.	16	9	-	4	1	2	-
9.I have not had enough time to sort out my problems.	16	9	-	4	-	2	1
10.I have not liked some of the treatment rules or regulations.	16	9	-	5	-	1	1

Note:
The majority agreed with the above statements.

Where did you receive the treatment?	
St Martin Centre	1
Dublin	5
Hospital	1

What type of treatment did you receive here?
Counselling, therapy
Detoxify
Detoxify and release
Methadone
Methadone
Methadone
Methadone
Prescribed drugs to methadone
Residential

How long did your treatment last for		
Up to a week	6.3%	1
More than a month	6.3%	1
Up to six months	12.5%	2
Presently on Methadone	25.0%	4
Methadone	6.3%	1

If you are on Methadone Maintenance please specify your current mls
'Took when coming off coke'
'Never on it'
'GP, Athlone, 9 mths '
'60ml'
'50 mc but got 25'
'45mls'
'100mls'

Have you received treatment previously		
Yes	18.8%	3
No	12.5%	2

Do you have any other addictions e.g. psychological addictions		
Yes	18.8%	3
No	31.3%	5

If Yes - please specify if possible and approx length of time of addiction
'Sleeping tablets and relaxes'
'Sex'

How much do you think people risk harming themselves if they do the following:

	Base	*Missing*	*Grid Table*			
		No reply	No Risk	Slight Risk	Moderate	Great Risk
Base	96	25	3	9	4	55
		26.00%	3.10%	9.40%	4.20%	57.30%
1. Smoking 20 cigarettes or more per day	16	4	-	1	1	10
		25.00%	-	6.30%	6.30%	62.50%
2. Taking 4-5 drinks nearly everyday	16	4	-	1	1	10
		25.00%	-	6.30%	6.30%	62.50%
3. Smoking cannabis regularly	16	4	3	7	2	-
		25.00%	18.80%	43.80%	12.50%	-
4. Taking cocaine regularly	16	4	-	-	-	12
		25.00%	-	-	-	75.00%
5. Smoking heroin	16	4	-	-	-	12
		25.00%	-	-	-	75.00%
6. Injecting heroin	16	5	-	-	-	11
		31.30%	-	-	-	68.80%

Note:
12 are of the opinion that heroin and cocaine are a great risk, 10 consider smoking and drinking of the same level risk.

Do you have regular/annual health checks		
Yes	56.3%	9
No	31.3%	5
Responded		14

Note:
50% of sample have regular check ups, 62% of sample suffering drug related illness, mainly Hep C.

Have you suffered other illness from drug related activities		
Yes	62.5%	10
No	31.3%	5
Responded		15

If yes can you please specify the illness and length of time suffering?
'Taking fits, hep C'
'Hep C'
'Hep C'
'Hep C'
'Hep C'
'Hep C'
'Hep C'
'Head melted'

In the past 12 months I ...		
... found that using [named drug: e.g. heroin] has led me to neglect things, or cause problems socially, or at home, or work?		
Yes	43.8%	7
No	37.5%	6
... used heroin in a risky or dangerous situation? (e.g. driving a car when under the effects).		
Yes	50.0%	8
No	37.5%	6
... have had problems with the law resulting from my heroin use?		
Yes	18.8%	3
No	68.8%	11
... continued to use heroin despite having problems with it in my social life or with my relationships		
Yes	37.5%	6
No	43.8%	7
... needed to use more (named substance, e.g. heroin) to get the desired effect, or has continued use of the same amount which had less of an effect than it used to?		
Yes	37.5%	6
No	37.5%	6
... felt sick or unwell when the effects of heroin have worn off, or I have taken more heroin or a similar drug to relieve or avoid feeling unwell?		
Yes	31.3%	5
No	50.0%	8

... used heroin in larger amounts, or for a longer period of time than I intended?		
Yes	43.8%	7
No	37.5%	6
... had a persistent or strong desire to take heroin or have had problems cutting down or controlling my use?		
Yes	62.5%	10
No	25.0%	4
... take a great deal of time either obtaining, or using, or recovering from the effects of heroin?		
Yes	50.0%	8
No	37.5%	6
... gave up or reduced important work, recreational or social activities as a result of my heroin use?		
Yes	43.8%	7
No	43.8%	7
... continued to use heroin despite having physical or psychological problems with it?		
Yes	37.5%	6
No	50.0%	8

8. Contact with Gardai

Would you see the Gardai as a source of information		
Yes	6.3%	1
No	68.8%	11

Would you see the Gardai as a source of help		
Yes	6.3%	1
No	75.0%	12
Responded		13

Has your use of illegal drugs brought you in contact with the Gardai		
Yes	50.0%	8
No	37.5%	6
Responded		14

If yes, how many times in the last two years		
1	25.0%	4
3	6.3%	1

Note:
The majority would not see the Gardai as a source of help or information with 50% having been in contact as a result of drug use. 5 have been to court.

Have any of these contacts resulted in court appearances		
Yes	31.3%	5
No	12.5%	2

Did any of this contact with Gardai result in you being directed to a support service		
Yes	12.5%	2
No	25.0%	4

Did this contact make you aware of the trouble/damage illegal drug use can bring to yourself?		
Yes	37.5%	6
No	6.3%	1

Pilot Comparison:

The Gardai would have referred some to treatment services and would have been seen as a source of assistance to some.

9. Contact with Services

How did you find out about the service you are currently using?	
When transferred from a Dublin clinic	(1)
Not on any service	(1)
GP	(5)
Friends	(4)

How helpful do you think this service is		
Extremely Helpful	25.0%	4
Very Helpful	31.3%	5
Not Sure	12.5%	2
Not Very Helpful	6.3%	1

What does this service provide for you?
Usual prescription, someone else to meet, no initiative to get clean, no one seems to be moving on
Steady life, happiness, being alive
My life, my family and able to see my kids
Medication counselling
Keeps my sons away from drugs
Keep my friends away from drugs
I can get up with out being sick
Got my mom and dad back in my life
Going to ring, would like to be working as getting older
Don't know
Change, second chance in life
Best friend is on the program

Pilot Comparison — what does this service provide?

Stabilizations	*81.30%*
Skills/Learning	*25.00%*
Someone to talk to	*62.50%*
Counselling	*37.50%*
Food	*62.50%*
Shower and shave	*56.30%*
Friendship/Support	*43.80%*
Advice on staying off drugs	*12.50%*
C. E. Scheme	*18.80%*
On Methadone	*6.30%*
Structure on the day	*6.30%*
I would miss it if closed	*6.30%*
Social	*12.50%*
Open Door/Drop in	*43.80%*
Part of a group of non users/Inclusion	*43.80%*
Relax/Clear Head/Helpful	*25.00%*
Wash Clothes	*25.00%*
Housing Needs	*6.30%*
Medical Card	*6.30%*
Privacy	*6.30%*
keeping me of drug	*6.30%*
keep out of trouble	*6.30%*
understanding addiction	*6.30%*

In your opinion what would be the best way to help people find out about the service?		
How did you locate information about help/assistance		
Newspaper	12.5%	2
Posters	6.3%	1
Friends	50.0%	8
Other	25.0%	4

Other
Through other people that have been there
Poster and gp
Person to go out
People to talk about
People to go out
People to get out and talk
More education, leaflets, drop in
More clinics
gp (5)

Are there other sources that could be helpful		
News paper	43.8%	7
Posters	12.5%	2
Confidential telephone line	18.8%	3
Other	18.8%	3

How often do you use the current service		
First visit in this week	12.5%	2
Every Day	12.5%	2
Every week	43.8%	7
Every Month	6.3%	1

Have you advised anyone else of this service?		
Yes	50.0%	8
No	25.0%	4
Responded		12

Who did you first talk to in relation to your drug use		
1. Doctor	31.3%	5
2. Partner	12.5%	2
3. Friend	31.3%	5
5. Service agent	6.3%	1
6. Other	25.0%	4

Other
The person doing these forms
Mother
Mother
Family

Note:
9 of the 12 service users find it helpful, with various benefits and uses. The majority found the service through friend using it every week. 50 % have advised others of the service and the doctor or friend being the first person they talked to about the addiction. The majority suggest that the service should be located away from local areas. The majority using the service to stop taking drugs.

Had you used any other related service before this		
Yes	25.0%	4
No	62.5%	10

If so, which ones (specify)		
Where should services be located (private/away from)		
1. Large towns/cities	6.3%	1
2. Private locations	12.5%	2
4. Hospitals	6.3%	1
5. Local areas	62.5%	10
6. Near to homes	6.3%	1

Why did you use the service		
Needed Support	31.3%	5
Needed a substitute	6.3%	1
Needed to stop using	56.3%	9
Other	12.5%	2

Other
get advice
for my sons

What else would you like this service to provide? (Specify)
Some one to talk to when needed
Proper urine samples in the programs, brought in Tuesdays and Thursdays
More help for homeless drug users
I hope it will help me
Hope for will power to stop
Help for me
Easy to get to
Easily located
Easier access
Drop in advice, needle exchange, encourage people to use clean equip, education
Clean up family
Better counsellors
A bit of hope

When would you prefer to use this service (specify)
Whenever. Should be open every day
When needed, like to pick up phone
When needed
When needed
When I look for it
When ever I need to
Mornings
Hope to visit every day
As needed
As needed

What other services are you aware of for drug use assistance (specify)
Prescribed drugs
Only my gp
None
None
None
No others
I am not aware
Don't know

Do you have a contact number for a support service on you		
Yes	50.0%	8
No	43.8%	7
Responded		15

How do you normally contact the service		
Drop/Arrive in anytime	37.5%	6
Ring before hand	31.3%	5
By appointment	31.3%	5
Responded		16

How long do you spend in the service building		
<1	43.8%	7

What ways do you think these services could reach others		
Getting someone to go out	43.8%	7
Re-ensure privacy	6.3%	1
Gets others who are past users to help	75.0%	12
Other	6.3%	1

How do you travel to this service		
Walk	25.0%	4
Cycle	6.3%	1
Bus	25.0%	4
Train	6.3%	1
Car	25.0%	4
Responded		14

Note:
The majority have a contact number on them and usually drop in spending less than a full day. They suggest that getting an ex-addict out to talk is the best way. The majority walked, drove or took the bus to the centre.

10. Limitations

Low rate of return:

The return sample was expected to be 60. This target was not satisfied due to the following limitations:

- People did not turn up to return questionnaires to the research team
- People did not turn up at appointed times
- Some agencies did not distribute the questionnaires
- In some instances the respondents were unable to read the questionnaires or get assistance in filling them out

Answers:

All respondents did not answer all questions that they were asked.

Elements Present:

Elements within questions that did not receive a response value are not presented. The full questionnaire and question elements can be viewed in the appendix.

SUMMARY INTRODUCTION

Sample

The sample consisted of 16 respondents. This number of respondents is similar to the pilot study. These respondents were presented and /or assisted in answering the questionnaire. The questionnaire consists of five primary data gathering categories. The respondents were classified by gender, age, and location. The next main category is background family and family reaction is gathered in various relevant section of the questionnaire in relation to drug taking and alcohol. The background also includes their education and employment history, accommodation and children. The data on drug taking is introduced with questions relating to smoking and drinking habits of the respondents. The drug taking habits are approached from the first sight of drugs to heroin taking and habits as the element for primary exploration of the survey.

This section leads into the treatments that respondents are receiving or have received, and include a question to ascertain their general understanding and approach to drug taking. The second last section deals with the respondents view of the Gardai in terms of how often the respondents have been in contact, how often and whether or not they view the Gardai as agents of help or information. Finally, results are presented on the use of treatment services, in terms of usage time, resources used and referrals to these services, in addition to identifying ways to extend the services to others.

Classification

In this there were sixteen surveys returned from the respondent providing a gender balance as a result. The age category ranged from 15 to 55 with 62 % being below 30 years and the majority between 15 and 30. The respondents mainly lived from the age of ten in Athlone with other locations included. The majority currently reside in Athlone.

Background

The majority of the parents of the respondents were employed; for the fathers 8 were employees, 2 self employed and 2 unemployed while the majority of mothers were housewives. 62% of respondents are married or in a relationship. The majority did not complete second level education. Only 25% completed second education. The schools attended were convents and priests/brother schools. 50% of those who responded finished school at or before the age of 15. The main reason stated for leaving was to get a job, with a further 12% outlining non-socially productive reasons, one respondent being 'locked up immediately'. 87% are currently unemployed. 75% report that they were employed and for various lengths of time. Since the age of 15, 37% were in employment for 6 or more years. However 37% have been unemployed for more than 5 years with 31% unemployed for 10 years. 31% have been to prison spending 1 year or less in prison. The respondent's accommodation consists of mainly privately rented terraced houses, local authority rented houses with one respondent reporting sleeping on the street. 62% have children ranging from 1 to 18, 4 under then age of 6, 12 between 6 and 10 with 5 over 11 years old.

Drug taking – Smoking/Alcohol

In this study the aim of the drugs section is to focus on heroin intake. The other drugs dealt with initially consist of alcohol and cigarettes. 62% smoke, with all of these smoking every day. 56% drink with 12% drinking one to three times a week, 43% have drank for two or more successive days in the last year with 25% reporting that this has occurred up to five times a year. The majority drank the last time with partners or friends. 18% have been drunk on 26 or more occasions in the respondent's lifetime. In addition, during the last three months 18% have been drunk 6 or less times, during the last 30 days 31% have not been drunk. 24% report that their mother/step mother would disapprove of them being drunk. 32% suggest that their father would disapprove. Their friends would equally disapprove 30% of their partners would disapprove. 50% report that their other friends would equally approve and disapprove.

Drug taking – availability

The respondents report that 50% were 15 or younger when they saw their first drug. This happened mainly on the street, disco/rave or school. According to 56%, drugs were available in their area at the time. 93% used drugs other than cigarettes and alcohol (the balance relating to a parent who was reporting for her children who were using the service). The drugs used by all of the respondents consisted of marijuana, cannabis, grass, and cocaine. All other drugs were also used to a lesser degree.

Drug Taking – heroin

87% have used heroin with 56% using for the first time above the age of 18 or over. However 50% no longer used heroin but 37% still use it. 25% use it every day with smoking and injecting being the primary usage methods. The main reasons stated for using heroin are to boost feelings, overcome life and family problems. The last time the relevant respondents took heroin, 25% were in their own house and 18% at a park or open space, obtaining it from a dealer/supplier. The majority of respondents indicated that mothers, fathers, family would strongly disapprove and 25% suggest that their wife/husband would strongly

disapprove. All respondent agree that heroin is a problem in their area with 31% stating it as a very serious problem. All of the respondents also have friends who use the drug, with 43% having most of their friends using. 18% would discuss drug issues with their mother and 18% would with their father. 25% would discuss it with friends and 6% with counsellors.

Treatments

On the basis that 56% of respondents have received treatment for drugs, 81% of the sample are not satisfied with the support in Athlone although the majority agree with the statement as follows the "staff helped me to motivate me to sort out my problems". The length of treatment received was up to six months. In an exploration of the respondent's view of harm with regard to smoking drinking and drugs the following indicate their understanding. They deemed that smoking and drinking were of equally great risk as cocaine and heroin.

Contact with Gardai

The respondents were asked their view of the Gardai and their level of contact with them. The average of 71% would not see them as a source of help or assistance and 50% of the sample have had occasion to have contact through their drug use with the majority of these in contact only once with the Gardai. 31% of those have had court appearances. 12% have been directed to services by the Gardai and 37% have realised thought the contact with the Gardai the trouble that can result from their drug taking.

Contact with Services

The majority suggest outreach as a favourable method. Friends are seen to be the best method of being attracted into services. 56% think the service they use is helpful or very helpful, with 56% using the service every week. The greatest suggested benefit is 'steadiness', kids, second chances and family back in lives. 50% have advised others to use the service with the friend and doctor being the major referral source. 62% suggest that the services should be located away from local areas with 37% preferring the drop-in method to use the service. The main

reason they use the service is to stop using drugs. There are many other uses outlined in the tables above. The majority were satisfied with accessibility to the service. They were not aware of various services available in the area. 50% had the number of the service on their person and 25% normally travel to the service by walking, 25% by bus and 25% by car. The respondents suggest getting others who were drug users to help while getting someone to go out. The majority use the service for stabilisation, personal and social needs.

CHAPTER 5 (a)

Stories from the Service Providers: Athlone

Niall C. McElwee

The extent of heroin misuse in Athlone Town

"Well it's hard for the people that live in the communities they're trying to raise their families and, you know, want to try and bring up their families in a kind of a decent place and they don't want this on their doorstep."

We have already detailed in chapter 4 our methods of undertaking this research, noting that we would speak to as many service providers as possible within the constraints of our budget and time. A primary question that readers will, no doubt, want to know is how many heroin misusers are there in Athlone and Portlaoise towns? We have sought to clarify figures for heroin experimentation, use and misuse, but have found it extremely difficult to do so as we were consistently provided with varying figures from a number of service providers who are entrusted with 'expert' opinion on such matters. One figure given, for example, was as high as 500 persons whilst another figure was 120 persons, whilst a third figure was 60/70 persons in relation to Athlone – with an average of about 100. This obviously presents us with a problem in that we can only guess at figures, even after nine months of active research.

There is, then, the official world comprised of Gardai, treatment and intervention programme statistics, housing, social work, youth work, etc., where we were able to collate and compare figures and the

anecdotal world based on individual contacts and hearsay even within these services. The Gardai suggested, "*I'm looking at a list I did… in which there is about 130 on it and out of that there is 46 either stable or some are in custody or some are serving sentences because of dealing, right. So, in having taken account for new people coming in that I wouldn't know of and then allowing an x factor of people I don't know, I would say there is a rolling figure of possibly between 80 and 110 which is sizeable enough for the population. In relation to Athlone, compared to say the mid to late 1990's and possibly 2001, I'd imagine that it is a little bit more stable than it was…Most people that were on heroin that were from the town in 1997, 1998 right up to 2001, a lot of them are kind of stabilised now and they have maintained that kind of stable position. Some of them are employed and some of them are on courses. We have of course got a new age of people coming through that have gone down the road of heroin abuse but I would imagine numbers wise we are probably less that what they were in 2001*." This sounds reasonable.

Another one of our interviewees use, instead, a hard data set from his service, "*Well, my own evidence is that there are twenty people. Twenty to twenty-two people attending ourselves. There are another eighteen to twenty people on the waiting list and there would be ten to fifteen people that we would know of through the grapevine of users that are out there and haven't sought help yet, like you're talking, I think statistically you talk about measuring the existing people that you encounter and you would usually multiply by a factor of about five or six to give a rough estimate of the actual numbers that are out there. It wouldn't surprise me to discover that there's maybe two hundred people out there who are developing problems around heroin or using heroin.*"

Accessing heroin in Athlone Town

> "*The availability of it? Well, I think it's quite easy to get if people want to get it you know. People don't have to go to the end of the earth and people would know where to get it and who to get it from as well, yes.*"

All of the service providers we interviewed agreed that heroin is easy to access, "*It's very hard to judge that and then again the word that I'm getting back is that it's very freely available at present, again there's no shortage of supply currently." Another service provider commented, "Apart from some short term shortages of heroin, heroin is freely available in Athlone, again*

depending on the sort of Garda enforcement. It can dry up occasionally, it would be scarce but, by and large, in my experience from listening to people is that it's freely available and gets cheaper as it's more available."

The army was also mentioned consistently in this study. As with the college, this is no surprise as there is some 1,000 personnel based in Athlone and a high percentage of families in Athlone have connections with, and to, the army. The army has high visibility in the town. In our quantitative section of this study, we note the high numbers of respondents mentioning 'Army' as father's occupation. This is not, of course, to suggest that the army barracks is a location for obtaining heroin.

We interviewed a representative from the army command structure who pointed out that Athlone is part of the national random drugs testing policy within the military and that they have participated in this programme since early 2002. In fact, between 1.11.2001 and 31.10.2003 1086 army personnel were randomly tested nationwide with only 4 testing for banned substances. The sanction for testing positive is automatic discharge for an enlisted soldier complusory retirement for an Officer, so the stakes are high if one is detected. Preventative work is also undertaken by the Military Police in Athlone whereby searches are completed on a random basis. Thus, there is a matter of perception and fact in simply stating *"Athlone is a Garrison town and this explains the heroin problem"* as we have heard several times in this study.

There have been occasions when drug dealers have attempted to access services pretending to be addicts but with a view to selling heroin on site. A service provider comments, "*There have been pushers here under the guise of looking for help. Wolves in sheep's clothing coming in crying help or crying wolf and looking for help from ourselves.*" The dealing is not overt directly on site, but both the dealers and the clients are familiar with the elaborate codes of behaviour in drug taking behaviours and the service providers are realistic in their outlook. *"In fact, looking at the list where the lads sign in… you know it's done with a nod of the head and an 'I'll see you down the road'. The actual game doesn't take place here but it can you know but then again I would say you know that's reality, I can't stop that so I've got to work with that you know, and I'm sure there has been heroin deals done here under my nose that I didn't see but that's reality you know and I've got to be able to accept that.*"

Having said the above, the Gardai have been very active in attempting to move heroin off the streets and have met with a good deal of success, "*… We were focussing on the town as it is with users… if you could think back to the Summer of 2000/2001, there was open dealing going around in XXX, YYY, ZZZ. There was what I would probably describe as a wandering tribe, you could see them outside the XXX. There was certain street dealers that we targeted, you know, and we ran successful operations against them… and you had this gathering of people that, you know, persons were kind of wary of. We don't have that anymore, you don't have this big gathering of ten, fifteen, twenty users at any one time coming to XXX which we had before where we targeted the dealer there and that's since stopped. The person who was responsible for meeting at the YYY and ZZZ,, he's doing a six year sentence…it's driven it more covertly you know underground.*"

Where do the clients come from?

We were informed that clients came from both the Leinster side and Connacht sides of Athlone town but also from Dublin, Portlaoise, Mullingar, Birr, Longford, Cork and Limerick. All service providers agreed that, "*There are a number of areas that traditionally have all of the disadvantage. I'm thinking of xxx, I'm thinking of xxxx and they traditionally have leakages where one generation and the next generation gets housing and move out of xxxx over to xxxxx and so it is family related. There's lots of linkages, there's maybe four or five links in one family with heroin problems and then, first cousins and partners of, that kind of background.*"

The fact that Athlone serves as a hub to other geographical regions was noted. Particular areas and streets were mentioned by all providers, but we do not feel it would be useful to reproduce their names here as it would only serve to further polarise people from these communities from the wider communities in Athlone. A difficulty mentioned by the Gardai was that they sometimes hear about heroin misusers, from any area of town, relatively late in their cycle of use, "*But we are primarily focussed obviously on people who are dealing more so than the users but what I'm saying is that it is possible for someone to maintain a heroin addiction and not come to light if they're able to maintain a job if they're able to source their heroin without actually dealing.*"

Age profile of heroin misusers in Athlone Town

Whilst we heard of children as young as thirteen that were starting to experiment with smoking heroin, this was not considered to be widespread. An agency commented, "*In relation to ages, I was trying to figure that out at one stage, I was. I thought with what we had was we had kind of a group that were early 20's and then we had a group that were kind of say mid to late 30's. We didn't have a huge amount of teenagers and I was kind of happy about that. I thought maybe the difference of issues that kicked off around looking to expect about and…I thought the message would go out and maybe we'd be able to just deal with the crowd that had already been caught up in the heroin abuse before there was any help out there for them. But now I see that I think we do have a younger age we have certainly got, I would say 17, 18 year olds that may be on the fringes of heroin abuse that may either be in contact with people who are using or maybe not using themselves just yet they're in contact. It's either their family or it's possibly a boyfriend or girlfriend that's using and I would say it won't be too long, they'd normally come to our attention when they're in their late teens or so, you know. I'm not really aware of anybody that would be we'd say 15 or 14 or 16.*"

How did a heroin problem come to Athlone Town?

> "*I don't know that it's becoming a problem I'd say that it was there for a while, it is there, and it is a problem and it's probably not becoming a problem in so far as other things are becoming problems in Athlone, you know what I mean.*"

All of the service providers have made a clear link between what is described as 'the Dublin connection' and the influx of heroin into Athlone. One of the service providers noted, "*There are now some Dublin people being treated here and their extended families. The history of it is that people have for a variety of reasons, left Dublin, some to seek a better way of life, some selling their homes in Dublin, buying homes down the country having money saved on the purchase of the two houses and going on a spree and others because they've been hunted out of Dublin. Yeah, there is a Dublin influence if you want to put it in that sort of language. An increasing Dublin influence.*"

There is a strong feeling from many service providers that the location of a treatment centre in the town with an overwhelmingly Dublin client base has contributed very significantly to heroin in Athlone. This is not to say that the clients there were dealing heroin in town, but their friends and families and contacts came down to visit and stay in town. "*I think one of the correlations, and it's not a popular one to mention, but I mean the treatment centre that we have in the town didn't help because that is a treatment centre predominantly was for alcohol and it changed in the nineties to heroin abuse, so that has probably given us at least 50% of our problem in the sense that obviously there was people that were already involved in the criminal process had gone through jail, had already been heroin addicts. Any chance they ever had of giving up at times if they had made independent decisions the next thing they bump into these fellas who'd fallen off the treatment programme in the treatment centre….*" This is also reported to us having affected girls in Athlone very badly and one interviewee had a list in his possession, "*Here is about ten girls that have all gone through Dublin boyfriends and are all heroin addicts as a result of them.*"

Other midlands and western areas feature prominently in terms of traffic moving back and forth, as seen from the following extract, "*I know it was mentioned about Galway and all that, there isn't a huge influx from outside Athlone coming in here. For a time we had a few people from Birr coming over but they tend to kind of be intermittent. They'll be here now and again or they'll go to Portlaoise. People in Portlaoise can have access to their own heroin now from Dublin. There are enough Dublin families that have been involved in drug dealing moving down to Portlaoise. There's enough contacts between Portlaoise and Dublin now that they have their own supply network, they don't have to come up here. Galway likewise, would have their own supply networks, possibly Limerick I'd say more so than Dublin you know. But at the same time we did have an incidence where stuff was coming from Dublin through to people in Athlone and some of it was going on to Galway, only some of it. I'd say that there may be an interconnection between we'll say Longford or Mullingar on an exchange basis where somebody might want gear and want to swop it for hash or e's you know but there's people from Mullingar likewise. It would take them nearly as long to go to Dublin as it would for Athlone to get their gear and they can do that they can go up on the train from Mullingar. I've been in we worked in Mullingar and I' aware that most of the addicts there are*

getting it from Dublin there are going to Dublin. They're coming up and down on the train the very same as what we had here in Athlone."

When did heroin come to Athlone?

There is considerable divergence on when heroin first appeared in Athlone or, indeed, when 'addicts' first came to notice either in a criminal or a health/treatment context again ranging from the early 1980's to the mid 1990's. When asked if heroin is becoming a problem one service provider noted, "*Not alone is it becoming a problem, it is a problem, and has been a problem for the last six years. It's about six years ago since heroin, six or seven years ago heroin started to raise its head in Athlone and since that it has been an ongoing and developing problem for a lot of people.*"

Another service provider commented, "*Well what I believed happened over I suppose a ten year period, Dublin got their act together around heroin and around addiction and particularly in the housing estates and initially that was dealt with, with baseball bats and I believe that the heroin pushers and people on heroin were forced out of Dublin and looked for refuge in other large provincial towns.*" Other commentators felt that heroin was a problem dating back many years with one noting, "*Well heroin has been a problem for a long time now, it isn't just in the last few years I've had people who've been on heroin for maybe the best part of fifteen, twenty years at different times, and most of those would be people kind of coming in from either coming in from England or coming in from other places where they were using heroin.*"

The fact that Athlone had a rehabilitation centre which closed during the life of this study is also seen as problematic and inviting to dealers and to recovering users, "*There's also treatment centre here and that's putting a negative slant on it because treatment centres they're fine and they work fine and a lot of them work from the abstinence model. But there is a failure rate after a period and I don't mean this in any negative way but men tend to drop out from treatment in Athlone and then they tend to be on the streets then and they put their lives together in Athlone rather than moving back to Dublin and there's this very strong link in that respect.*"

Still others encountered heroin immediately on their arrival into Athlone. "*My experience I suppose of the issue has been since around the beginning of 1997… and some of the women that were on that project had*

young people who were heroin users. One lady she has lost two children since then, who died from abuse."

Are women using heroin in Athlone Town?

> "*I think that women prevalence is on the increase. I mean that family that I spoke about there was a lad and two girls in that family and they both the girls were heroin addicts and the lad as well in the one family, and the mother had an alcohol problem.*"

All of the service providers and people we interviewed suggested that there is a real problem with heroin amongst a female population, but that the current services target only males which has a number of negative consequences. "*That again is another huge dimension that, in fact, it's very hard to quantify for that very reason, that you know a lot of girls are certainly using because their partners or other people that they're associated with were using and they got into it in that particular way, but that is a really difficult situation to try and…. They're even more difficult. As you know, quite a number of them we actually have had to take out of Athlone and we sent them to different centres in Dublin and we sent them to other places as well as a way of at least getting them treatment and getting them away from the type of people…and they worked out quite well.*"

One project has dealt with ten women of whom six were suspected of heroin misuse, "*I don't know exactly but I would say that six out of that ten were heroin users as well and indeed you know some of the lads have girlfriends, their girlfriends use as well but we because of the aims and objectives and because of focus here you know general we don't deal with females." Another service provider commented that, "Initially, it was more male dominated, more males, but now there and, again this is from my head, I think it's mostly females*."

All agreed that more females are using heroin than was the case in the past really the divergence was just around percentages with another service agency noting, "*Well, what I would say is if you get a fella that's using heroin, the girlfriend would be using heroin. Very rare that you'll have one using and one not, it doesn't work out for them because the heroin user gets up and that's all they get up for that's all they have they need it to keep*

themselves right…So from that point of view I see it as it's not 50/50, I'd say it would be 65/35 predominantly men. What you have is 35% possibly you'd have a kind of a group of women there I used to see them there are a lot of the local people have kind of as I said stabilised but, there is a smaller group and they are actually younger. As I said they are in their late teens early twenties now and they would be going with possibly they maybe going with one heroin user and that relationship falls out but they're in a circle of numbered male heroin users like as in a normal group that age where you go out with one girl and next thing you go out with another girl from the group of friends you might have a smaller circle of girls a larger circle of fellas they are all predominantly heroin users and the girls are heroin users and relationships change but predominantly you will get male/female most of them being on the heroin…I don't know any of the girls around here that didn't go on to heroin or made the decision to go on to heroin without being with a boyfriend that was using it, you know, that's the only way, I can't give you figures. I'd say 99.9% who went on it because they were with a boyfriend that was using it."

To 'chase' or to 'spike'?

> "*Well Gregory's Court (name has been changed to protect anonymity) they were injecting it because syringes were found. Now in terms of whether they're I wouldn't know after that, whether they're smoking it or injecting it but they were definitely injecting it in Gregory's Court.*"

There is an entirely mixed cohort in Athlone in terms of smoking and injecting prevelancies. It is clear that once a person is addicted, the desperate physiological and psychological urge to obtain as much of a 'fix' as is possible is paramount with habits costing as much as €200 per day. In one project we were informed that the majority of clients started their opiate addiction by smoking heroin and then progressed to injecting.[1] One service provider commented, "*…Majority of them won't*

1 Intravenous injection or 'mainlining' provides the greatest intensity and most rapid onset of euphoria (7 to 8 seconds) while intramuscular injection produces a relatively slow onset of euphoria (5 to 8 minutes). 'Skin-popping' is where the heroin is injected just under the skin getting into the blood through tiny blood vessels and is often used prior to full injection into muscle or veins. When heroin is sniffed or smoked, peak effects are usually felt within 10 to 15 minutes so it can be used in public environments and the desired effect is speedy.

last very long smoking it. Any GP will tell you the facts that some people might last 3 to 4 years and that's being very, very, dedicated maintaining everything else being stable they'd want to be working and trying to keep everything together you know, but most of them would eventually go on the needle. Some things can precipitate going on the needle as in they might have to they might get very bad quality gear and if they are sick enough they won't get the actual lift or they won't take the pain away from sickness, withdrawals from smoking it. Then they'd have to use the needle and they realise that straight away when they taste the gear they'd say, 'look I'm going to have to go back on the needle', and I've spoken to people who've said, 'I only went back on the needle because the gear was terrible the quality of the gear was terrible. There wasn't enough in it to maintain me by smoking so I had to go back on the needle'. That's the sad thing about it, but overall most of them end up on the needle."

Even when the interviewees we have spoken with have come forward for treatment or intervention of some kind, there remains a stated reluctance to diminish, in any way, the buzz they acquire from injecting heroin. Alan noted, "*But what I'm finding with some of the men is that they start out smoking and they eventually come to using syringes then you know. Now I couldn't put a time on that but I know I hear them talking about all the heroin 'going up in smoke' in front of them when they're smoking it and I often heard of other another friend of the guys smoking heroin and he's waiting for the smoke to rise up and he'll inhale that you know, because I suppose it's so precious to them and it's effective enough that they find that if they inject that you get every last thing you pay for and it's a bigger hit from the syringe as well..."*

Another service provider commented that, "*Some people don't move on to injecting they make that conscious decision that they're not going to go there, but the majority of people who were on the methadone and in touch with this service here have ended up injecting. There's a huge problem with DFII8 medication and it has been described by GP's as an alternative to heroin or as a sort of detox, and it is quite a problematic issue in Athlone where people are introduced to heroin through the DFII8's…."*

Funding a heroin addiction

There is no doubt that a heroin addiction is expensive to maintain. We have spoken with people who spend less than €50 a week and to

others who say they spend over €1,000 weekly. Thus, it is extremely difficult to support such a habit given the chaotic lifestyle that many users have. One service provider informed us, *"I've known men who would've have…used six, eight bags a day. You know, at €25 that's what it roughly is on the streets, so when there's a drought for it, it will move up a little bit in price or if there's too much then you get it for €12 so they kind of have their own system or their own culture around that and it's kind of it's all black market stuff…."* Another service agency reported, *"I suppose if two people went together on an eighth half an eighth would cost them possibly €200. That would do the two of them maybe two days three days and twice that would be €400 roughly. Split between the two that would be €200. Now that's if they're accessing and being able to go to Dublin and buy it in weight, but if they're buying on the street, they might need maybe an average two to three bags you're talking maybe €50 to €75 a day. What they might do is they might get away with a bag in the morning and they might get, depending on the quality of the bag, they might get a bag that evening they can take a smoke off and have a bit for the next morning. Or, they might supplement it that is if they haven't got the money you know, but a very bad user would possibly use up to four bags a day you know which would be €100 a day."*

Criminal activity to fund an addiction was mentioned by all sources, *"We'd have guys here most of them have spent time in prison, around petty crime and around, I suppose, looking for money – jumpovers in shops."* One service provider noted the range of crimes typically engaged in by heroin misusers in Athlone, *"Stealing, dealing… bag snatching, robbing houses, robbing from the cruisers all of that is used as a means of financing and dealing. Those would be the major ways in our experience."*

Prostitution in Athlone

Prostitution in Athlone is not seen as a serious problem, although most of the service providers are aware that it takes place – but to a limited degree. 'Alan' states, *"I know in the past I've dealt with three men, three young men who would have travelled to Dublin at the weekend and would've sold themselves on the streets for money for heroin."* When pressed about this, he further elaborates, *"Yes, and one of them is a pimp, he brings his girlfriend as well, he'd sell his girlfriend as well he'd sell his girlfriend on the*

street and sell himself as well."

Another service provider commented that, "*Prostitution is a minority, it does happen in my experience and on peoples own telling me that they have prostituted themselves in the past as a means of resourcing….*" He then went on to elaborate, "*That would be in Athlone, but it would be on an individual basis in a sense that two that I know of, two males have made their bodies available to other males as a means towards an end to get finances for drugs have been paid financially or paid with drugs. I know of one woman who has been a long-term prostitute in Athlone and in Galway as a means of financing her drug use and that there are one or two others who have used prostitution on occasions as a means of getting finances for drugs.*"

Interestingly, at the time of researching this study, a brothel was discovered operating in Athlone Town so there is at least a certain degree of organisation.

Money lending and heroin addiction

Money lending often accompanies heroin addiction. "*There are loans that can be got from people who very dubious… there's a lot of fear in a heroin addicts life, there's a lot of 'he'll kneecap me' or 'I'll be beaten up' or I'll be, you know, dodging and hiding and different names. A mobile phone rings you can feel the fear yourself there's tension.*"

Extracting monies owed and heroin addiction – threat of violence/risk/strain

It is not uncommon for violence to accompany heroin misuse. "*Yes, not that it's common but we have experienced injuries and we have experienced terrible fear around that and we've actually had one incident here last year where a Dublin man came the whole way from Dublin down to extort money that he was owed from a client and smashed up the drop in centre here and well he came in he was looking for the lads prescriptions for benzoes and stuff like that*."

There is an issue of personal safety for service providers "*I've been attacked once or twice here in the early stages for money and you know for talking to somebody – trying to explain what the service was about and the lads got him to stop*." Sensibly staff in one agency have tangible preventative measures. "*We have safety stuff we work with…We work with alarm systems*

around our necks (it's not necessary at the moment because the centre has stabilised and what's going on here has moved on along way from that but at the very beginning that was certainly part of it)."

A central focus: The effect of heroin on individual lives

> "*Well I mean if you're addicted it's going to have an effect on your attendance in work at school and you know like the whole family situation if people are in a family situation. I mean it has a knock on effect on everything. I mean that woman who lost her two children through it… that's going to effect her for the rest of her life, you know. I mean it must have huge implications.*"

The one word that springs to our minds throughout this study is devastation as seen in the following quote, "*There's another girl I knew who was addicted to heroin. Her mother used to work here. She ended up in Mountjoy and the reason she was in Mountjoy is she was stealing to feed her heroin habit so it was like revolving syndrome the whole time and she must have been getting heroin in Mountjoy because when she was coming out she was back to the same thing again. So, I think she's out at the moment but I mean how long will she stay and I mean that particular family would have huge issues in terms of their brother died and the mother struggled to bring up three children and… three of them ended up on drugs. Now that girl was only seventeen and she was in prison.*"

Health status

Interestingly, the majority of our interviewees understood health as in their immediate physical health and symptoms. Many of the interviewees were in contact with GP's in relation to presenting sicknesses as observed by a provider, "*Very, very prevalent, most of the guys that use heroin have are at the advanced stage of Hep C and indeed some of them are attending Dublin at the moment St. James in Dublin...*" In relation to a specific cohort of misusers, one of the service providers observed, "*I think it's safe to say that not that I'm aware of, none of them have Aids or HIV, I think all ninety per cent if not all have Hepatitis C.*" There are also issues of co-addiction which effects heroin misusers health as noted, "*Oh yeah, all of the people were, most of the people who were on methadone are also addicted*

to benzers and that again nationwide that's the norm, ninety per cent of people who are on methadone have valium problems."

Perception

> "*I don't think they've any value on themselves to a certain extent because… the girl who was in Mountjoy at that young age and she was after being in care. She was in care in a house in XXXX for a couple of years and, like, she had psychological issues from whatever experience she had been through and she was kind of more or less purposely stealing to get back into prison…She probably felt safer in there than she'd have done outside, and she was stealing to get drugs you know just a vicious circle and I know she tried to commit suicide a couple of times. You know, she nearly didn't feel that she has anything to offer any society.*"

Reasons offered by service providers for heroin misuse

When asked for background reasons as to why people might start to experiment with heroin, Alan answered, "*Okay, well it's my belief around all addiction that addiction itself is only the symptom and heroin might appear to be a symptom of a problem a greater problem. I tell each novice that comes here…that the addiction I see presenting a problem is a symptom of the mans life and, in reality, there's hopelessness and there's a social thing of what class they belong to, where they come from. We have men here who, you know, their fathers have never worked – or their grandfathers have never worked and they were caught in that cycle you know and it's kind of an answer to stresses in society…It's not that these people are flawed by any means but it's all to take away the psychological pain of being marginalised or caught up in a rat trap.*"

Another service provider considered, "*In my own practice and the evidence would suggest that it's around disadvantage. It's around poverty, it's about lack of opportunity, it's about maybe second, third generation unemployed people, and that's where heroin has found a niche in Athlone. So it is about disadvantaged people it is about poverty, it is about lack of opportunity and that's where heroin got hold in Athlone….*" This is supported by another service agency which commented, "*The issues, they're your typical issues I suppose ones that everybody like poverty, bad social, economic circumstances, bad family circumstances.*"

Are services working together?

There was a feeling articulated that there are too many services in Athlone that held competing agendas, but this was rationalised in terms of the historical development of the voluntary and statutory sector as somewhat piecemeal and reactionary. "*They're not co-ordinating together at all. We're all working separately, we're all gone off our own tangents and we're all doing great work but we're not tying in.*" Social work services came in for criticism from some providers and one gets a sense of the personal struggle in this. "*Ah, what do I do with someone who arrives at 4.55pm? I'd have boundaries around that and I need to go home to my own life and my own family.*" At the same time, the social work services were frustrated with other services and agencies in town who were perceived as supplying what was seen to be key information too late or, indeed, not at all.

The Regional Drugs Task Force

All of the service providers interviewed agreed that the Regional Drugs Task Force was a positive development mainly as a collective forum where people could network and a venue where information could be obtained, clarified and shared. Opinion varied, however, as to its effectiveness. One service provider suggested, "*I find it a brilliant forum, first of all for education for learning for myself and secondly to move things on*", whilst another provider felt little is really accomplished, "*It's a talking shop, well meaning people, at the end of the day I think it's just a facility to bring you together to get you to talk and it is my experience having been on a range of committees it's going to change nothing.*"

Negative comments centred on the aspiration to ensure that progress was made "*But again, I'd be a little sceptical I'd like to see them in action.*" It was also expressed that the funding allocated to the RGTF's is wholly inadequate.

Thoughts on the methadone programme in Athlone

The methadone clinic raised diverse comments. One commentator felt it was very useful but was "a crisis and medial response" which took from other potentially more useful and effective approaches, "*After five years it's still a crisis response you know and I feel that there's a terrible lot of work that needs to be done around that.*" Funding and staffing the clinic

were mentioned, "*I know there's issues of funding and I know there's issues of staff and all that I'm very aware of that, but I'm also very, very aware of the client out on the street that's looking for these non existent services and services that are acting from a crisis response and I think it all needs to be developed.*"

There was also the feeling that methadone maintenance could be moved from a clinic environment and placed within a defined project, "*Certainly I would be looking at all of that and indeed you know and I'd say this and I don't mind saying this, I don't believe that the Health Boards should have their arm around methadone maintenance, I believe that methadone maintenance and that kind of service… can be used in a project like this and it's something I will explore at the moment.*"

Other comments centred around the perceived lack of co-ordination between professionals. "*I'm finding working with heroin addicts is…where a GP prescribes in isolation and he leaves the prescription at the reception for the client and the client keeps going back every week to collect and this can be very heavy addictive stuff that the client is using…There's methadone that's on the streets….*"

A particular problem with waiting to access methadone is that clients have to have dirty urines so some of themkeep taking heroin which places them at risk as identified by a service provider, "*…From what I have seen we have a number of people as I've said that will travel to Dublin and they'll get half a gram, half an eighth. It's really to tide them over for two or three days. Some of them will tell you they are doing this because they're waiting to get on the methadone programme they have to have dirty urine before they can get on the methadone programme, so they continue to use the heroin.*" In addition to placing misusers further at risk, it also puts an emphasis back onto the addict who then has to try to access other services or get clean by himself/herself, "*Well I suppose it's a bit ironic you know, but at the same time you want to make sure that you're obviously they probably feel that spaces are so limited in a way that they want to get the most chronic people to deal with rather than somebody who may be able to get through the withdrawal with other forms of help and may not need to go on methadone. Because if somebody, we'll say, has clear urine then you know what I mean they'd be able to um possibly get some other form of help even try cold turkey or go through counselling without having to go on methadone.*"

Hope for the future?

The service providers and agencies all suggested that there were more services in place than a decade ago and that these services were, in the main, less difficult to access than just five years ago. One agency personnel commented, "*I think the last six years especially the last four years there has been a number of agencies trying to address the problem from different angles and that stopped it I think from becoming a bigger problem.*"

CHAPTER 5 (b)

Stories from the Service Providers: Portlaoise

Niall C. McElwee

The extent of heroin misuse in Portlaoise Town

"Like all the kids know about it down there. Even my five-year-old could tell you about a joint you know, because they hear it out there on the road you know. And it's all around us. That's why I've tried several times and hopefully I'm moving out…"

Estimates for heroin misuse in Portlaoise vary from between 70 and 250 persons. All the service providers we interviewed felt that (a) heroin misuse is increasing across both genders and (b) that the age profile for first use is lowering significantly. One service provider had noted increased visibility over the past couple of years, "*Yes, I'd say that it has been a problem in Portlaoise for a while and it's becoming more and more of a problem, and that it's becoming more of an issue for young people as well. And it seems to be that young people are able to access it at a younger, and younger age and are experimenting with it at a younger age.*" We asked another service provider what his thoughts were in relation to the figures that were being discussed at various meetings and in the media. "*Well, in the level of reaction that we've been hearing in the last year in relation to Portlaoise it doesn't really. And, like, I think also being aware of some of the family contexts in Portlaoise and some of the extended families that really if you look at those numbers alone it would justify the number that you're actually talking about.*"

Service agencies were keen to provide a balanced account of the

heroin terrain. "*I think we have a problem with it, and we haven't big amounts, but we have a problem… but we have an estimated user base of about seventy, seventy to eighty, some of those might have only used it once or twice but a number of them use it fairly regular. That's all I know seventy-five to eighty people...*" Another service provider corroborated this statement by suggesting, "*It's readily available, to anybody who wants it*."

A problem we soon encountered in relation to obtaining accurate data was that several agencies were collating their figures independently of each other, "*Well I suppose there's different figures being given. Like, comparing different figures one would be twenty young people under eighteen and then another is one hundred young people under twenty. So, I don't think there's any accurate figure. There's a lot of, I suppose, different professions in contact with these young people who try to gather their own figures but there's two extremes there it's hard to know*."

Attempts to estimate misuse amongst younger populations presents many difficulties because there is a mismatch between those young persons known, in any context, to services and those reputed to be smoking or experimenting. "*I would say there would be probably about seven or eight young people that I could name that would be around sixteen, seventeen, but having spoken to them they would estimate the number themselves at close to thirty to forty in terms of young people*."

Accessing heroin in Portlaoise Town

> "*I think it's available for the last couple of years in Portlaoise, but it wasn't really known I'd say, until there about two year ago, you know*."

All interviewees agreed that heroin is not difficult to access in Portlaoise. One service provider suggested, "*Apparently it's very available. Nearly everybody seems to know where they could get it from, or seems to think they know who's dealing it….*"

A feeling was expressed by service providers that heroin was not dealt in pubs or nightclubs in the town, but deals were done mainly in housing areas, "*No, I'd say not, I'm not saying that heroin couldn't be got in pubs or nightclubs. Probably not, it's probably got direct from the door of the supplier*."

As with Athlone, the majority of heroin in Portloaise is said to come from Dublin. A specific problem was noted in relation to the location of the prison(s) in Portlaoise with people from Dublin coming down not only with the intention of dealing, per se, but to supply their partners or family members, "*… The other side of the heroin detection here in Portlaoise is a lot of those convicted, charged and convicted with supplying heroin is in relation to prison visits. You know, that somebody comes down visits their fella, generally their fella inside in the prison, and tries to slip him a small deal or two deals of heroin*." It was suggested that this is well known to the relevant authorities and that efforts were being put in place to limit this.

We sought information in relation to those dealing heroin in Portlaoise. Several families remain the main sources for distribution for some years. "*There's one extended family that still accounts for a lot of it, accounts for a lot of the crime in relation to drug misuse. A number of others on a smaller scale… only five or six*."

The Gardai are continually frustrated in their efforts to move heroin off the streets because dealers and suppliers use a multitude of tactics to evade capture, "*The trail we have at the moment that the suppliers get the bus and train or car go off to Dublin. They have their sources in the city and they come back and to beat us. We have number one. They don't come back the normal way, they come back, they're picked up. Another one may come back on the train, throw it out somewhere near where they live to someone else. That they try to beat us in everyway they can*."

Where do the clients come from?

It is felt that heroin misuse was very much confined to certain housing areas, but this has changed in the past three years. One service provider commented on the change, "*Again it would've been very much confined at one stage to one small estate it's now all over the place, it's much more widespread around the council estates and even outside of those to private estates as well, so it's changed*."

A housing area where we spent significant time has a particular problem with dealers. There is serious difficulty in attempting to house people with heroin addictions as pointed out in the following excerpt, "*No, there's no emergency facility we've had great difficulty but, we rely on the good will of the hostels and adjoining counties and they're fast running out of*

patience with us really, and anyway they don't want anyone that has an addiction problem be it alcohol, heroin or anything else. They want people that are on the dry and drugs free so it's very difficult to place people when you run out of the hostels. We have a B&B, nobody in a B&B wants a drug user nor do you want to be placing anyone. It's not suitable anyway to place them in a B&B, so then you rely on your own housing stock. At any given time you might not have anything vacant and invariably then it's probably back on the estate where there's the drug problem in the first place so you're putting them back into the vicious cycle anyway."

How did a heroin problem come to Portlaoise Town?

The geographical proximity to Dublin was seen as the main reason heroin has come into the town. Simply put, Portlaoise is well within a two hour drive from Dublin and there are several people who have moved out of Dublin and down to Portlaoise who have brought their criminal contacts and credentials with them.

Are women using heroin in Portlaoise Town?

"They kind of came in with lads that were on the fringe of crime."

There is no doubt that women are experimenting with heroin in Portlaoise. The Addiction Service, alone, sees fifteen women on a regular basis who are addicted to opiates (50% of the client base) and we have interviewed several misusers, their families and service providers who have suggested that young female teens are also experimenting. One of the service providers commented, "*It's balanced boys and girls. I don't think particular people, you know, that I'd be told are taking heroin. There would be a lot of girls mentioned in the names now that's in the under eighteens.*" We interviewed one young woman who was regularly using heroin with several of her female friends who, she claims, are unknown to Gardai or service agencies.

To 'chase' or to 'spike'?

There was mixed opinion on this and one has to be careful in cross-referencing information. A service provider pointed to the fact

that there is only a fairly recent understanding of heroin being a problem in the first instance, "*I think heroin has been a problem… Portlaoise for the past number of years. It's more highlighted in the last numbers of years but I believe that it's probably been there on a smaller level for a longer period. I believe it's mainly to the population within the lower socio-economic groups in Portlaoise and I believe that it's still at an early stage of development and that there's increasing numbers.*"

One might have thought that simply coming across discarded syringes was proof of a heroin injecting population in a town, but this is not the case. "*We don't think we have any injectors, but I mean I'm not going to say we don't. I mean, I had a complaint from one section of the town about needles being left around but we were able to trace that one back to insulin needles from the hospital.*"

Age profile of heroin misusers

> "*Predominantly you'd be talking about kind of maybe fifteen to sixteen, but you're probably going down as young as fourteen as well.*"

Portlaoise was identified in the media as problematic particularly as a result of several juveniles appearing in court. Towards the end of this study, a midlands based judge admitted at a conference that the use of heroin by teenagers had "caused her to weep with frustration." This was widely reported in the media.

There are mixed views as to whether or not juveniles were actually experimenting with heroin or using other drugs. "*Well there was one children's court sitting which precipitated the local Judge, Judge Martin, which I suppose it was noteworthy in the sense that there were nine juveniles in court that day and six of them claimed that they were using heroin to the police. Maybe seven or eight of them have given that as their reason, and out of those there were at least five of them were fifteen, five of them were under sixteen. That was just the fact that they all appeared in court the same day just highlighted the problem, because I had heard about one of those people referred to the service before and through him I heard about some of the others, so I knew that was happening. A group of three of them who were living out of home and using drugs of various sorts experimenting with heroin.*" Another service

provider was aware of one young teenager who had informed her of peer involvement but she could not substantiate this from her own work, "*I think from probably fifteen upwards. I would be aware of one particular young person who's using and he maintains he would know about ten more around his age group so, but whether that's accurate or not…*" and a third service provider commented, "*They're anything from about fifteen to about eighteen might be seventeen we'll say… They are no doubt, you can see it. I mean what a heroin user looks like as against somebody else. Well, I mean they say they're using and they're getting the deals and they've got to have a deal per day or whatever it happens to be but that's their way of doing it*." One of our interviewees admitted that he was only thirteen when he first started to use heroin in Portlaoise, which we will see in a later chapter.

Funding a heroin addiction

It would be misleading to suggest that all heroin misusers resort to crime to fund their habits as we heard several times that there were many people holding down their jobs who had not come to the attention of service providers or the Gardai. We also heard that there are some individuals who are stabilised on methadone but who engage in criminal activity anyway.

Criminal activity to fund heroin misuse in Portlaoise appears to be a recent phenomenon with mixed views as to its level of seriousness and regularity. One service provider noted, "*It's becoming an increasing problem, yes. Heroin misuse was spoken of when I came… they were talking about a heroin problem. In my opinion, at that stage, there wasn't a heroin problem there were a few heroin users, but certainly from our perspective…, it wasn't a problem in the sense that it hadn't exploded into criminal activity to fund that heroin use. I would think that they were either dealing to fund their habit or a small number of people were committing a number of crimes but it hadn't been out of control. That has changed and it's getting worse. It's still not completely exploded into a problem but…, the high number of house burglaries and robberies and so on, would indicate to me probably in terms of the criminal aspect of it, it was a problem*."

The stealing of mobile phones and cars directly linked among a younger population with another service provider noting "*I'd say they're robbing or whatever way, thefts from cars used to be a big one if we could trace*

it back to it, other than that they sell it, as I say some of the people that are actually selling it are addicts themselves. If they take the chance they go up and get four or five hundred euros worth they can double that the next batch of it you know. We have a number of other drug suppliers around the place, I suppose to be fair I wouldn't like to say that they supply heroin but they might. They'd supply anything that's cash and their not people that are addicts themselves now they have used a bit." This was corroborated in our interviews with heroin addicts where one interviewee had just stolen a mobile phone prior to an interview with us and we were told that the going rate for a mobile phone was around €20. Another service provider pointed out that many people in the town are probably unaware of the extent of criminal activity around heroin misuse, "*Well I suppose a lot of the crime that I would hear of in relation to heroin use is smashing cars, and taking things out of cars, shoplifting those kind of things you know. Other than that, I'd say there's probably a huge proportion of people in Portlaoise that wouldn't even be aware of the problems that are there.*"

Prostitution in Portlaoise

It is not thought by any of the service providers that prostitution is a significant problem in Portlaoise. One service provider thought that it was a possibility but had no evidence, "*Stealing things or dealing is the most common…Prostitution's the other way. I'm not aware of it… prostitution cases don't appear in court so I don't know to what extent that's going on but I presume that's a possibility, certainly….*" Another service agency also felt there was little organised prostitution, "*Don't know that I'd say no. That's not that we wouldn't have any bit of it, but not a big problem. The few, that would be the few girls that might be possible prostitution, they're not on the game on the street.*"

Perception of heroin misusers

It was felt by service providers that there was little sympathy for heroin misusers. One service agency noted, "*Every user is afraid of the heroin… you know. That's the one they look on as a dirty drug really. At the moment it's kind of put down as, it's a bit unfair as drugs for the lower classes, you know. If you had plenty of money you might be on the coke or something like that. Well, no one minds the cannabis too much now that's the way they're*

looking at things everywhere but the heroin is looked upon as a drug that drives them scatty really. They have to get on to the business they have to feel they have it and they must go at it right away."

Of course, one has to take into account the individual experiences of service providers who have been at the end of violent and problematic behaviour such as needle stick incidents, "*…There's been one or two that they threatened to have it alright, and there's been a few with people that don't live here. Car chases and that into a corner and they produce needles with infected blood or something like that, but I don't know whether it was infected or not. But I mean, guys that were squirted with the blood or occasionally pricked with needles you know they've a worrying time.*" Having said that, it appears that communities in Portlaoise are very reluctant to have known heroin addicts placed near them. When asked about attempts to rehouse addicts, a service agency noted, "*It's not for want of trying to be honest it's a very political hotcake. Every time you go for an emergency facility nobody wants a place beside them, you know. So we've had several locations identified and every time because of the perception of the drug dealers that these are the people that are going to be using it and obviously people don't want that beside them.*"

Media profiling of heroin problem in Portlaoise

As was the situation in Athlone, service providers and agencies acknowledged that the media had been less than helpful in its portrayal of heroin addiction in Portlaoise. One agency commented, "*About a year ago we made big headlines which was a little bit unfair, because, I mean, there's no point in saying that Portlaoise is worse that Athlone. You can't say Portlaoise is worse than Athlone, and it's an awful lot worse that Carlow because it's in them all*" .

Media profiling is a double edged sword as explained, "*A lot of the problem with drugs is what happens is the seizures often give you an idea of the problem you have. But the seizures from our point of view is success. We are successful if we make the seizures but on the other side if we make them it shows that we've a big, big problem. So, if you make no seizures it doesn't mean that you haven't got a problem but it's not as high profile. We made the news for a day or two a few years ago and I think we made the Sunday World or something a few months ago there. That nine young people were sent away the previous day, now that was true, they were all on the fringe. I couldn't say that they were*

all on heroin but they were all on the fringe of that you know. And they had been through the hoops a good few times."

A central focus: The effect of heroin on individual lives

Not all heroin misusers are "unsalvageable" to use a word from one of our interviews. One young person was in contact with a range of agencies and appears to have come through his addiction as explained by a service agency thus, "*I suppose the youngest is about fourteen, fifteen. We've had a few of them in and around that age you know that got in on it very quickly. But one young lad, he's had a very bad year, year and a half of heroin and he does crime all over the place. The strange thing is he seems to have turned the corner he went down, after all the trouble. He looked for a little bit of help from his own people, they brought him to Ashling and he now heads a little group that he's kind of encouraging others to do the same and we'll see how it goes. There's no point in kind of making a saint of him yet. He's still facing a few things from before but, but at least he's a young man that didn't look salvageable a year ago, but it looks like he is now.*"

Another service provider pointed to the problem of young people, in particular, and heroin addiction in terms of the lack of services, "*Well obviously we need services, you know and they're not there. Like, if somebody is discovered, even if an under age is discovered where does an under age person go on heroin? Most of them end up through the juvenile liaison system and then through the courts, which is not you know the appropriate way of dealing with it.*"

Reasons offered by service providers for heroin misuse

> "*I suppose their backgrounds, where they live, lack of parental support, poor education that goes in terms of attendance and liaising within the schools and I would say most of the young people that are on heroin and who'd fall out of the school system that I know of and they would fall out at a young age. I suppose the family members, whether close family members or distant family members I mean that are involved in some of the dealing in drugs.*"

Several reasons were offered as to why people might take heroin

including family involvement, peer involvement, availability of heroin in town and marginalisation. One service user commented "*I suppose there seems to be a few maybe significant families in the town and I don't know whether or not they're proactively going after young people or just the stuff is available and they've dragged people in, you know. Like I suppose once there are some people using you know, if they're nineteen or twenty and then there is younger people around they're going to start using as well. I'm not really sure as to the reason why, but it certainly I suppose that the family issues involved, and availability I suppose that would be the key issue. You know, that it is so available for them particularly in certain areas in the town like there'd be other young people that would be involved in drugs from middle class families but they don't seem to be going for the heroin.*"

Are services in Portlaoise working together?

> "*I suppose I'm twelve years here and, as I've said, I've identified the families that are at risk and I think if all the agencies got together and definitely identified from an early age I think we could put a stop on some of it you know.*"

It was felt by service agencies and service providers that there are not enough services in place in Portlaoise, they are under funded, nor can the existing services always be accessed in a timely fashion. It is also the case that services are not collaborating with each other to maximise delivery for clients as noted by one of our interviewees, "*I think there has been frictions for a period of time that has hindered the moving forward in relation to a number of key issues. I think that needs to be addressed, and although a lot of personnel have moved on, there is still an underlying factor there that seems to cause tension that needs to be considered.*"

There is also an issue of strategic management planning within the health board, "*I'm not sure that there has been an open and frank discussion in relation to the heroin issue at a strategic management level within the Health Board. I think there's certainly a recognition in the last twelve months, and I think that has been due to the change of appointments, that there is an urgency in getting key personnel….*"

Even with the best intentions of the health board it remains difficult

to obtain these key personnel and we provide below examples from psychiatry and GP services. "*The difficulty I suppose is, some psychiatrists don't want to work in isolation so, therefore, their expectation would be that there would be two appointed within the region, but that was never the Board's intention when they first advertised the post although it subsequently had another post approved. But, because of the current embargo hasn't been able to recruit into that*."

The Board now also feel that the utilisation of GP's needs to be rethought, "*There obviously, over the years, has been GP's contracted in relation to the methadone service and that hasn't necessarily been the most effective way and the Board has now decided to look for a full time GP which will increase the number of service days. One of the functions of that GP is to train GP's at level one in relation to methadone services which should mean that he or she is only dealing with the chaotic patient group and that those who are stable can be seen by their own GP's*."

This presents a challenge for the Board and individual GP's who may have both received conflicting messages from each other. "*One of the messages I suppose that has to be got out to GP's is that if you train as a level one, we are only asking that you look after your own patients. We are not asking you to take patients from every other practice in town or anything like that*."

The most 'at risk' category of misusers was seen to be youth, "*There are not enough services at all. There's a methadone clinic up the road here. Honestly, the Guards don't have any access to it, but still they would know certain people that are going to it making the effort to get off. But our concern is that people that might be anxious to get off and nowhere to go you know. And I'd say I've never been in the place, I know where it is but it's not possible to deal with anymore than a set number of people so and the biggest hole in the whole system is the young people, because I mentioned five or six in the last four or five months have gone through the system. They've been to courts, they've done the whole lot and eventually deciding that it's either Aisling or jail. Quite often it was jail for a week or two until they could get a place in Aisling. Now, a few of them okay, like the guy I was telling you about earlier, but some others just didn't work for them and they went back on heroin again. But supports that's all*."

Another service provider suggested, "*Access to detox facilities would be*

extremely useful for our client group because you look at it as a sort of window of opportunity in terms of they come to court at a crisis point they may have fear of going to prison or something like that may motivate them for a short period of time." Yet another service provider commented that meetings in town tend to be informal and that an ecological emphasis would be useful, "*We do but it's more it's an informal thing. But I think there's a lack of funding on the Health Board side and that's not a criticism, but obviously they've put a lot of funding into child protection, but to me this is a huge issue in child protection because children of the dealers and the users are now becoming the users and dealers themselves, and they're getting pregnant and you know the cycle follows on. Like if we can identify children at two and three now that we know are going to be in difficulties and that's where the attention should be*."

Lack of service provision: homeless populations

A particular concern raised was in relation to the paucity of services for homelessness or out-of-home which creates and maintains a cycle of hopelessness. "*No, there's no emergency facility we've had great difficulty but, we rely on the good will of the hostels and adjoining counties and they're fast running out of patience with us really. And anyway, they don't want anyone that has an addiction problem be it alcohol, heroin or anything else. They want people that are on the dry and drugs free so it's very difficult to place people when you run out of the hostels…Nobody in a B&B wants a drug user nor do you want to be placing anyone, it's not suitable anyway to place them in a B&B, so then you rely on your own housing stock. At any given time, you might not have anything vacant and invariably then it's probably back on the estate where there's the drug problem in the first place so you're putting them back into the vicious cycle anyway*."

The Regional Drugs Task Force

There was serious disappointment with the RDTF. One service provider commented acidly, "*Well, I don't believe that Task Force has served any function at this point in time. I think the task force has not been resourced as it was envisaged it would be in the National Drugs Strategy, and therefore has been limited in any type of response it has made, that it can make. I think that the very fact that there is an interim coordinator in post who has additional duties on top of his substantive post, separate to that of the Task Force which is*

complicating the situation even further. Therefore. if the Task Force is to move forward in any type of constructive way then it must employ a coordinator."

Thoughts on the methadone programme in Portlaoise

The methadone programme is situated in the same building as addiction services and more formal communication between the medical and counselling providers would be useful. Of course, there are mixed views on methadone, "*There is a methadone, whether it's a detoxification programme, or more of a maintenance programme has become more accessible except it's not, there is a difficulty with juveniles particularly if they're under sixteen, it's not accessible to them. One of the, there are rehabilitation programmes around the country that the information service would have access to but nearly everyone of them requires that you be drug free before you enter the programme and that's an obvious difficulty… I don't have great confidence in most of the programmes that are offered anyway, but you know then some do okay out of them, but to get them drug free at a time when they are motivated to do something, most of them, again methadone is not an answer, it's a small part of an answer but it's not an answer to it. It has a lot of problems in itself.*"

We interviewed the only dispensing Pharmacist in Portlaoise and uncovered many inconsistencies. We were informed that the Health Board wanted to attract Pharmacists into the methadone dispensing programme but was largely unsuccessful. Having made initial contact with the Board we were informed that, "*It took eighteen months to get back to me.*"

There is certainly a very real issue that Pharmacists may feel physically threatened by heroin misusers or addicts on methadone. The scene is complicated in Portlaoise by the fact that most of the Pharmacists are owned by females who are reluctant to have male addicts on their premises. This creates enormous issues of stigma as addicts have to consume their methadone at the side of open counters. The threat of recognition is always present.

There is little formal training given to the dispensing Pharmacists (only one relevant photocopied book on premises at the time of our interview). What little training takes place is generally located in Dublin. The dispensing Pharmacist also had clients 'landed' on him

with no discussion from the local Board which was a cause of considerable dissatisfaction. The dispensing Pharmacist noted that he "*feels a bit worn down*" and is "*afraid the addicts will fall off the wagon or rob the shop*."

Concern was expressed that, in effect, the Pharmacist is "*Letting out a tradable commodity in methadone*." This was supported by another service agency in the town, "*That service has to be extended some way. I'm not a hundred per cent sure on the medical side if someone went up and got methadone and would that keep them right. I don't know if that would or not. In actual fact, I forgot to mention it that I know that there would be some methadone for sale too. Not only would they buy heroin but they buy methadone in either Dublin or England that sell it to the abusers as well*." A mother of a heroin addict informed us that, "*A centre should be here for them in Portlaoise, or some kind of thing where they can get their fye and whatever, they all have to assessed and they have to be this and that, when the young fella goes out looking for his fye, Kevin had to buy the fye off somebody else. He didn't get it off the doctor, at the time he wanted to come off he was in a bad way he had to go and buy he paid nearly €60 for it, two small little things of fye, he had to go and buy it for €60*."

An interesting way to get around the alleged sales of methadone in Athlone and Portlaoise was suggested which included colouring the methadone with a special traceable dye which is particular to only these towns.

Reaction of the community to heroin misuse

There are enormous difficulties in relation to communities and substance misuse and, particularly, heroin. People are fearful of both dealers and addicts and often articulate that they don't want any services in their own area. This, of course, presents a challenge for service providers. "*It's not for want of trying to be honest it's a very political hotcake, every time you go for an emergency facility nobody wants a place beside them, you know. We've had several locations identified and every time because of the perception of the drug dealers that these are the people that are going to be using it and obviously people don't want that beside them*."

What to do?

The service providers all had detailed commentary on what might be done to improve access and provision in Portlaoise. These were wide ranging in orientation, particularly in relation to younger populations. "*I think there needs to be a more flexible approach in terms of young people…they find it difficult to engage young people until their parents bring them along and that might work for a couple of sessions, but after that if they're not motivated themselves to attend it's not going to work and that's I suppose you know if they're getting that service they're probably getting one hour support which isn't enough. So, I think it needs to be more creative and more flexible in terms of how it's engaging young people and engage them maybe individually and in groups. And also they need to be doing outreach work with them they need to be working with their parents and friends as well. I think it needs to be a whole package, and maybe that would after some kind of detox or residential programme and maybe the approach used within the residential units would need to be reviewed in relation to young people and maybe like there could be like some kind of links….*"

The creation of an Outreach Worker post with specific responsibilities and reporting structures was mentioned by several providers, "*I think it would. I think once their role is clarified and that there is a very specific job description for them. I think they could become a dog's body in relation to the drug services, so I think their role would have to be clarified, but I think that there is a role for outreach on a number of levels, one certainly liaising maybe with GP's and clients on the ground, the other is in relation to the rehabilitation process and making sure that when someone leaves the formal treatment services that there is a key link with other like FAS, other service providers and to make sure that the person actually engages in whatever process is out there for them, rather than them falling down and then coming back into the treatment services twelve months down the road or whatever, you know.*"

CHAPTER 6

Stories we could Tell

Gráinne Monaghan

*I have a sixteen year old son, and I have an eleven year old son and I'm in fear for them because they could pick it up (heroin) in **** straight away do you know what I mean. That's why I want something done for the likes of those people on heroin and that before it gets too late for my other children.* (Sarah, Portlaoise)

Many themes emerged as this research progressed. In the following chapter, we present these stories and the issues, real life experiences and visions for the future that were uncovered in the individual interviews. As outlined in the methodology, an array of people was interviewed with different levels of involvement in heroin use. We talked with parents of current heroin users, partners of heroin users, current heroin users themselves, people on methadone maintenance programmes and people who have detoxed from heroin. These stories and experiences offer rich insight into the daily lives of people in Athlone and Portlaoise. They offer service providers the opportunity to look from the inside out as they pave the path for future developments and they offer policy makers rich data from which they can plan.

We all have our own perceptions, moral values, life experiences, and personality traits that collectively feed in to how we understand and view our world. As we hear the voices in this chapter of people with their take on heroin use, we deepen the holistic pool of why, who, what, when and where people use heroin. To really open up and address issues we need to ask questions and develop our understanding but even more importantly the people at the centre of issues need to tell their stories to ensure that real needs and issues are addressed and not what we think is "the(ir) reality".

The themes that arose most frequently across all interviews will be presented in this chapter. Let us begin, then, with health as this is so important to our interviewees.

1. HEALTH

Throughout the study it was evident that the many of the interviewees had a very 'medicalised' view of health. Health was referred to again and again as a physical concept and this is reflective of where people are at in their lives and the reality of the presenting immediate issues that face them. This theme arose in several contexts and many of the interviewees were quick to identify health concerns as a perceived threat of heroin use.

The health issues discussed centered substantially on the medical model of health. Issues such as hospital stays, GP appointments, medication and withdrawal symptoms arose throughout the research. Much of the health commentary focused significantly on treatment of health issues as opposed to the prevention of health decline.

1.1 Medication

Medications such as valiums, DF118's and sleeping tablets were talked about frequently. A great sense of knowledge existed around their uses and, indeed, the drawbacks of taking prescribed medications. "*Benzers, tablets the likes of Valium, sleeping tablets they are serious addiction out here, and they're prescribed medication*" Others also talked about the uses of tranquillizers and other prescribed medications in dealing with withdrawals. "*Doing a bag and if you get your hands on D10's or that your gonna use them.*"

1.2 Hepatitis C

Injecting drug users are susceptible to acquiring viruses such as the Hepatitis Virus. Many of the interviewees during this research mentioned that they had the Hepatitis C virus and, as with the pilot study findings, they felt little time was given to discussions around it amongst their peers or families. "*I have hepatitis C yeah, but it's type three it's grand.*" Others mentioned that due the chaotic nature of their

lifestyles during their addictions they would have feared that they had much more than "just hepatitis C" as one man put it. "*I came out of it with Hepatitis C you know*." This man felt that he was lucky to come out of his addiction with hepatitis C alone as he feared for a long time that he had several other infections and diseases. "*I was so sure that I had them do the tests four or five times, and the social worker told me, she said, that's enough questions, just go out there and live your life…. You're one of the lucky ones*."

1.3 Withdrawal

The physical side effects experienced from heroin use were discussed and the hold that they have on the body as it yearns for its next fix of the drug was expressed and emotively described. "*I couldn't get out of bed in the mornings*", "*Mad withdrawals, your body is telling you what's wrong*" The need to use heroin to relieve these very acute symptoms causes much disruption in the day to day lives of the interviewees as their minds are full of thoughts of getting their next "fix."

"*They can't function their body will not function whatsoever like the pain the crippling pain the torture, that they go through, the sickness and the withdrawals, you need something just to take it away*." This interviewee felt that this explains why people inject heroin and need to inject so badly. Personally he felt he could never bring himself to inject heroin but then he reflected that he never thought he would ever use heroin at all.

Many of the interviewees expressed a shared opinion that addicted heroin users are no longer using to seek a "high." Much of their daily lives are focused on avoiding withdrawal symptoms from heroin. "*You could sit here all day and talk to addicts and tell them what's good and what's bad and the bad things about injecting at the end of the day they know themselves they're not stupid but all they want to do if for that pain to go away like the buzz is gone for them now half of them people out there now taking drugs they're not taking it for the buzz they're just taking drugs to make them feel normal*."

1.4 Hospitals

One male third level student in his mid thirties, who has used multiple drugs including heroin, talked about his ongoing struggle to stay away

from "street drugs" and the mental health difficulties that he experiences. He recounted four hospital stays in one academic year (2002-2003). *"The psychiatrist felt that I was putting too much stress and pressure on myself trying to keep college going and trying to work o my psychiatric illness as well which is manic."*

Another male, during the pilot focus group, discussed the many times he had spent in hospitals in the Midlands. His stays centered mainly on his alcohol related problems, which he perceived to be a greater health risk to him, then his heroin addiction. Other interviewees also touched on hospital visits and treatments as part and parcel of their lifestyles.

Sarah: A case study

Sarah has an eighteen-year-old son who has been using heroin for the past three years. During her interview she talked about the impact that this has had on her own mental health. *"It's just tore our life apart, tore my family apart and everything, I've been in Vincent's and all over it… St. Vincent's is a mental hospital in Portlaoise."* Sarah had been admitted to hospital at least four times that she could remember for depression all arising form her fears and worries for her son and other children. *"I do dream at night time that the Guards are going to come and say we found him, he overdosed on heroin because it happened in Portlaoise to a fella, overdosed and he died, and that's my fear and then there's the fear with the other children growing up and looking at him and thinking you know they can do the same."*

1.5 General health

"He pukes up everything, he's not even eating, he's like that, his trousers are falling off him, it's terrible, it's just unbelievable," (Marie, talking about her 20-year-old son from Portlaoise) Sarah, from Portlaoise, also talked about her son's physical decline over the past three years that he has been using heroin. *"He's gone so thin, so small from it."*

In September 2004 we interviewed a young man, Kevin from Portlaoise, who was aged 21 at the time. He was on the run from the gardai and he looked drawn, small for his age and malnourished. In November, we travelled to Mountjoy Prison to interview prisoners from

the Athlone and Portlaoise areas who have been involved in heroin use. Kevin was the first person we interviewed. He had been arrested just hours after we had met him in September. The difference in his appearance in just two months was startling. He looked more alert, he had put on weight and expressed that he was enjoying prison life. He felt safe there and secure that he had food and shelter.

2. RISKS

The lives of the interviewees are embedded with many risks due to their heroin use. At times the interviewees talked directly about the risky behaviors that they have engaged in and the consequence and fears that surround them. Some of the risky behaviors ranged from sharing needles and equipment, indulging in promiscuous sexual behaviour and dealing heroin to overdosing and being left homeless.

2.1 Homelessness

The risk of becoming homeless was an ongoing theme in this research. Many of the interviewees had spent time out of home – "*Ya lose everything, I put myself homeless*" – while others live with a fear that they are marginally away from losing a place to stay. "*If my family got a sniff of this I would be homeless*."

The accounts of times that people have spent out of home were stark features of fear and stress for the people who have had these experiences. "*I've slept on the streets*."

2.2 Overdose

Personal experience of overdosing from heroin was uncovered during this research. "*Indirectly done prison over it, I nearly lost my arm, I OD'd, I nearly lost my life*" (Mark, Athlone).

James, who now lives studies in Athlone, tried heroin for the first time with a prostitute in Dublin. He used crack and other drugs in America but on returning to Dublin two years ago the opportunity to try heroin presented itself to him. "*I didn't really think too much about it, it was more or less an impulsive thing. Jesus I'd love to do heroin but I can't inject myself*." He asked the girl to inject him into his left arm and he felt no

high from this so he asked her to inject some more. After this he immediately overdosed, fell to the ground unconscious and was brought to hospital. The following night he repeated this process and overdosed again and ended up in the same Dublin hospital. He decided following this that injecting just didn't suit him. "*That's the definition of insanity and I did, I went back doing the same thing expecting a different result*."

The risk of overdosing on heroin is ever present due to many different factors including tolerance levels, quality and personal health.

However, the more frequent discussions on overdose were in relation to fears that it could happen at some stage and from knowing friends or family members that had overdosed. "*There's an awful lot of my friends after dying, do you know what I mean, my brother died, my cousin died, two of my cousins died*" (Jay, Athlone).

3. PATTERN OF HEROIN USE IN ATHLONE AND PORTLAOISE TOWNS

3.1 When it all began

Heroin use was evident in Athlone since the early 1990's and, indeed, even before this but at this time is was a more secluded activity and involved only a few people who kept to themselves."*There was one time in the town when we were seventeen/eighteen, certain clientele that you knew were doing heroin, that was it, but they kept to themselves.*" Many of the interviewees in Athlone were aware of the heroin situation in the town from their youth. They were aware of the drug culture that existed and how it worked. "*I know for a fact I've been around the drug scene along time, since my youth, heroin has been around this town the last ten to fifteen years."*

The pattern over time seems to have changed with an increased availability of heroin and more people taking part in both experiential and dependent use. "*Was a certain amount that did it, but the last five years it's easier to get than any drug. Easier*."

In Portlaoise, the heroin issue seems to be more of an emerging trend. It has been a feature of the town for the at least the last seven years but, again, it was more hidden and pocketed use that was happening. In more recent times, it is more widely available and

touching a greater number of people and especially younger people in the area

3.2 Availability

The interviewees required little time to consider how available heroin is in Athlone and Portlaoise. On a number of occasions interviewees said things like … *"Give me twenty-five euros and I'll get you a bag if heroin now."* The interviewees all agreed that heroin is readily available whenever you want it in both towns. They felt that there is a supply of heroin in the towns to meet the demand – *"It's in ample supply."* The mobile phone is an extremely efficient tool in acquiring heroin in both provincial towns. *"It was simple for me to get heroin all I had to do was make a phone call."*

The availability of heroin has made the option of trying it out for the contemplators a realistic reality in recent times. It may even be said that its availability has sparked usage. *"So easy to get that's why so many are on it."*

Dealers are supplying heroin in different locations in the towns and for people who are aware of the general workings of the market-accessing heroin is not a problem. *"If I wanted heroin now like there's a fist full of people I could score from."*

A young woman in Athlone talked to us about the community that she lives in and when we asked her how available heroin is in that community, she told us that it is always available. *So you think there's always a supply – whenever you went out in the community it's there is it? "It's there all the time, do you know what I mean?"*

It was also interesting to hear the views from a man in his mid twenties from Dublin who had recently settled in Athlone. He had first come to Athlone for treatment for his heroin addiction and he decided to stay. *"If I wanted to make a phone call now I'd get it, that's how easy it is, like I thought coming down from Dublin that the country, no disrespect to country people, but I didn't think I could get…I didn't think they had a clue about drugs but if I want it I can get it…so it is a big problem when it's that readily available like I thought it would be an issue where Dublin would have to come into the equation, that they'd have to travel, they do travel to Dublin to get it but there's that many people selling it."*

3.3 Numbers using heroin

Throughout the research the people we have met have cited widely varying figures in relation to the numbers of people using heroin in the towns. In Athlone it was generally recognised by the interviewees that there are at least one hundred heroin users in the town. "*A hundred, a hundred and fifty people, about a hundred people, yeah, at least that.*"

Others felt that it was extremely difficult to round off the figures of people using heroin. "*I wouldn't be able to put a figure on it like, I'd say it's in the hundreds, so it is, do you know what I mean, like they mightn't be regular users, but I mean regular users and dabblers.*" The differentiation between regular or dependent heroin users and the experimenters and dabblers came up on many occasions. It is believed that numbers of people are at the dabbling stages of heroin use in Athlone especially. "*Probably be around the hundred mark, definitely, you'd have people saying ah how is there, but I could sit back and think of who's smoking heroin now, probably a lot more just dabbling.*"

For people who are experiencing drug use and especially chaotic use around them, it can sometimes feel that this is the general way that things are. One's personal experience can override reality as the despair of coping with such immense difficulties. "*I think nearly one of them is drugged, yeah, everyone of them, there's loads.*" When we asked this interviewee about the exact numbers she felt that somewhere between seventy and three hundred people in Portlaoise town are using heroin. The reason she feels that it could be as high as three hundred is due to the amount of younger people using and perhaps not coming to the attention of the services just yet.

3.4 Age profiles of people using heroin

Portlaoise has a young population of heroin users and we know this from the interviews and other sources such as courts. 'Younger people' and 'smoking heroin' have emerged as common themes through engaging with people involved in heroin use in the town. This highlights how important that swift action is in addressing the heroin issue in Portlaoise. "*I know the youngest down there is twelve years old… has actually smoked heroin? Has actually smoked it, yeah and the hash*" (Sarah, Portlaoise).

The younger age group are also experimenting with heroin in Athlone. "*Seems to be getting younger, seventeen/eighteen, met a lad lately, he was fourteen, guinea pig for someone.*" On numerous occasions we heard of fourteen year olds in Athlone smoking heroin"*Fourteen is the youngest I know*." Again, the younger age groups seem to be smoking heroin as opposed to injecting. We did hear from an ex heroin dealer that she had sold and injected heroin with a young teenager but this does not seem to be the norm in terms of current trends.

The older generations of heroin users, especially in Athlone, tend to keep to themselves but talked to us about the growing numbers of younger users that they are aware of. "*I kind of stick to myself, you know like, because I'm like say the older generation and I mean, so like I don't, I know them all like, but I don't actually mix with them, if you know what I mean, the younger generation that's into heroin now like, I'd know them just to say 'howya' to and talk to about who's dealing and that, but I don't socialise with them as such.*"

3.5 To "chase" or to "spike"

In Athlone, people are choosing to inject heroin more than they seem to be in the Portlaoise area. It has been reflected that about half of the people smoke and half of the people inject heroin in Athlone. "*Half 'n half, a lot of people are injecting, I know a lot of people are injecting, a lot of my friends are injecting because they're not getting that high from smoking any more.*"

A recurrent view expressed was that people usually start smoking heroin and then progress to injecting for a greater high and also for economic purposes. "*I notice from experience, that people think that they won't, but invariably they do go into the needle. I'm twenty years on it. I started into speed, I smoked it for the first time in Mountjoy last year, I never even knew about the tin foil and all that.*" Once again, this comment really made me think about the current heroin situation in Portlaoise where younger people are smoking heroin. Could the situation look very different in five years time without speedy, effective interventions?

One man in Athlone gave a very emotive picture of why people decide to inject heroin and how close he, personally, is to taking this step. "*They say to themselves well I'm losing so much smoking so I might as*

well just inject, inject it into my veins, get the whole lot in one go, that's, that's what's happening, and I was on or am on the verge of using a needle and I don't want to go there that's why I'm trying to stay away, I don't want to use a needle."

Other people feel that the majority of people are smoking heroin and, although a lot of people are using needles, they are the minority. "*It's mostly smoking. Like there's a good few injecting but like the majority are smoking you know.*"

3.6 The provincial experience

Due to heroin use being an illegal activity and socially unacceptable for many in society most people tend to try heroin for the first time in the homes of other users. This pattern of "home using" is one, which stays with people through their involvement in taking heroin. Unlike in larger cities where people sometimes "shoot up" more publicly that would not be the experience in the provincial towns of Athlone and Portlaoise. Heroin usage is kept more behind closed doors. This will immediately present a dilemma for anyone trying to establish the extent of a heroin use in such towns. "*Very hidden, we all interact with one another we don't interact with other people.*" This hidden population of people using heroin find when and if they decide to try to get off and stay away from heroin in a provincial town a number of problems arise.

Not only are the physical side effects of withdrawal quite overbearing but also the services are far fewer in the areas outside of Dublin. It throws up lots of concerns and difficulties also when we think of the close-knit, secretive activities and the support that exists within the peer groups

4. PERCEPTIONS

4.1 How we view ourselves

Many times interviewees contradicted the perception of the stereotype that they felt society sometimes bestows on heroin users. It was expressed that not all heroin users fall into this supposed bracket. An interesting dynamic that was apparent was where the interviewees themselves in various discussions talked about the "typical junkie".

"*You'd be surprised people that actually use heroin and you wouldn't suspect it like they don't all look like the normal junky we'd say like, out of work and this kind of thing like, there's a lot of people that's using heroin and they're holding down jobs at the same time, but they are spending all their wages on heroin.*"

Their perceptions of themselves and their own identities seems to be swallowed up in a collective mind set that heroin users should be a certain type of person. It can often be the case that people "live out the label" and this may be the case for some people while others strive to re identify who they really are outside of their addictions.

It was recognised that through the course of addiction many changes can happen in ones life and that people can find themselves involved in activities that simply do not make them feel good about themselves. "*Well it changes your whole personality, it makes you greedy and it's selfish and like you're happy when you have the gear but you're not overall happy like, at the back of your mind, you still can have a guilty conscience about what you're doing because you know it's wrong like, do you know what I mean, well that's what I found over the past couple of years like.*" This guilt can form part of a vicious circle where people use heroin to block pain and such feelings as guilt. The words "selfish" and "guilt" surfaced on numerous occasions in the many conversations with people involved in heroin use. Given time to reflect on and recount stories people were very open and honest about how they see themselves and the addicted side of their personalities. "*A heroin addict is the most selfish person you are likely to meet. (Pause) Heroin addicts/ all addicts are selfish.*"

The level of self-awareness and self-analysis was very evident and people tended to lean more towards the negative aspects yet not in a self-pitying way but rather using very direct, reflective and emotive language. It was enlightening to see that many of the interviewees although they believe in on day at a time could visualise the future and had hope. "*I'm twenty-two now, hopefully another good few years left ahead in my life, if I had stuck on heroin, I'd probably be gone now, I'd probably be dead now, it's crazy isn't it, I never did think that much into it, I just take it and that was it, I didn't worry or think about it.*"

4.2 How others view us

In general, the interviewees felt that people do not look favourably on heroin users in either town. Some report that they feel misunderstood by the community at large and at times excluded from the mainstream workings of society. "*They see them as scum, do you know what I mean, they don't see them as any form of a person whatsoever, they believe that they're totally… absolutely bottom of the barrel, I believe that people believe that they should be just locked up and the key thrown away, like it's unbelievable like the way people judge and people are very judgemental of them, and I was like that myself until I judged addicts before I became an addict, going around slagging them and this, that and the other but it's very hard to understand that underneath it all like they were a nice person before they took the drugs.*" (Simon, Athlone).

Another emerging theme around the views others hold about people who use heroin was that even after overcoming the struggle with addiction some people still hold negative perceptions. "*You know I still get called that, ah there's the junkie they'd say.*"

Another perspective came from a father of a heroin user who from his own personal experience highlighted that it is not useful to label people who use heroin. "*Maybe we're blinded by the old story I suppose it'll never happen to me, and we hear about these things, also I think that there's an impression out there that the people who get involved in drugs are coming from very disadvantaged backgrounds and where as our son, he didn't get a brilliant leaving cert or anything and maybe drugs could've been responsible for that too, that he didn't fulfil his potential I don't know, but we just had no experience of anyone taking drugs, we came from a different era, we didn't want to believe.*"

4.3 Views on the dealers

Not all of the heroin dealers in the Midlands use heroin themselves but see dealing in more of a business sense as. This was quite frustrating for some people who expressed this to us on occasion. "*The one I use doesn't use at all, doesn't use at all.*" We asked this interviewee how he felt about his main dealer not using heroin and after a brief think on the question he sighed his answer – "*Ah, angry at times, he's making the money out of our misery but then we're, we're the fools that are giving it to him, you know.*"

Dealers are also seen as a crucial cog in the wheel of facilitating

people getting involved in heroin use. "*It is pretty bad here* (Portlaoise), *yeah, especially for young people they are trying to sell it to young people, and then start them on it, it's really very bad.*"

5. RELATIONSHIPS

5.1 Family

Heroin addiction causes much chaos in the lives of people who misuse and the family is often one area that really suffers. Time and again we heard stories of families torn apart from addiction. Interviewees described the turmoil that heroin use has caused in the dynamics of all of their families, from, parental inability to cope to the loneliness of isolation from family members."*It destroyed my relationship with my family for a long time, my mother disowned me, everything sort of fell apart on me, my sister didn't speak to me for two years… my mother wouldn't sit in the same room as me and basically I tore my father asunder.*"

A harsh reality from the interviewees was the pain of many losses that people have encountered through addiction. The loss of contact with children and, indeed, the realisation of the loss of time spent with children caused pain for many of the interviewees. "*I've lost communication with my daughter.*" "*I regret through addiction the family life that I didn't spend enough time with them that I missed out on my little sister growing up and even though I was there, I wasn't there, I was there in body not in mind and it was very hard, like you know, my mother wasn't she wasn't a very affectionate person even to this day she was just a very hard woman, she's never, I don't remember the last time that she told me that she loved me.*"

For other people the realisation of the pain that their heroin use and other activities has caused their families is a motivator to overcome their addiction. "*That incident where I overdosed, like that knocked a lot out of her like I mean they have stood behind me, so I want to be able to repay them, I want them to see me make something of myself, make a life for myself.*" Family support is viewed as crucial in the recovery process from addiction. Knowing that people care about you and will be there with you and understanding you on the road to recovery. "*I certainly attended every court session he was at and I think that also made a big difference because it communicated to the judge that the family was supportive.*"

Parents of heroin users in both towns expressed many concerns regarding other children in the family and their own difficulties experienced in coping with the practical and emotional strains. "*Questions I would ask would always revolve around our son who was involved in drugs and I'd be saying where is he and all this. Now, I didn't realise but our other children were saying to their mother, how come daddy is only concerned about the son… he was the person I felt that needed the attention.*"

Case study: Marie, Portlaoise

Marie's son is twenty and has been using heroin for the past three to four years. Marie has been finding her son's addiction a huge strain on her life and has attempted suicide in the past. She wonders how other parents cope in similar situations and tells us of her very real fears that her son may some day resort to physical violence in the house. "*A lot of effect, I'm not able to cope, I just want to pack up and, my own house the last sixteen years I'm living in my house, I just want to pack up and leave and go to a new town, I don't even want to know my son, I'm not able to cope, I'm not, I'm just not able to cope with a situation like that, I don't know how other parents are coping, I'm just not able…Some day he'll hit me but and I don't know how to handle that, especially my own.*"

So you're afraid that might actually happen to him?

"*That might happen at some stage, I've heard that some kids have done that to parents, because they're not giving them money for the heroin or whatever it is…. I hope David pull his socks up to get himself sorted out, I'm his mother and I'm just not able to cope, I have tried to commit suicide a couple of times.*"

You have?

"*I have yeah, that I'm just not able.*"

You just get so upset?

"*Yeah, breakdown and whatever I'm just not able, I might be strong outside but inside I'm not, I don't know how other parents are coping, I'm just not able to do it, I'm not able to cope with it, I don't even want him in my house.*"

5.2 Other siblings following the heroin Trail

This was a very real risk of heroin use expressed by mothers of young heroin users in Portlaoise. One mother discussed her concerns for the welfare of her other children "*I mean I have seven other children as well, and its so hard for them looking at him and saying he's able to do it, why can't I, because I need to get the help for him for the other children as well, to say well its wrong to do this, because they know about him robbing, they've seen the guards several times*."

Heroin users themselves in the Athlone area also talked about the impact of their using on the lives of their children. The realization exists among the interviewees that the heroin issue is not stand-alone as it is today but the cycle that can develop is also a concern and a perceived threat for the future.

5.3. Social exclusion and stigma

Feeling marginalized and cut off from mainstream society were experiences that many interviewees could identify with. "*People don't trust you, get bad press, some people are okay but some are as thick as stone walls*." The lack of understanding of why and how people get involved in addictive behaviour was reiterated throughout the research. Everyday activities that many people take for granted as they go about their daily lives could be skewed for people caught up in the addictive cycle. "*Little things like that, that I haven't experienced for years and they sort of mean more to me where like to other people they wouldn't blink an eye to it because they do it every day of the week, where I didn't experience them things for years because I was an outcast, they're things that weren't important for weren't part of my addiction*." At times, interviewees felt that not only did society push them to the margins but they too distanced themselves from experiences and activities not associated with their addiction to heroin.

6. INVOLVEMENT IN HEROIN USE

"*With this certain drug, once is too many and a thousand is never enough, you know what I mean, it takes time, but eventually it takes a grip, you think you have control but then it takes control of you…at the start it was fun but all*

good things have to come to an end and then you realise that it takes a grip on you but that's what you do your life is out of control."

6.1 Introductions to heroin

Friends are often the first people that will introduce new users to heroin. Many of the people interviewed had peers that were using heroin at the time at which the started into it. In the main, it was not heroin pushers or dealers that forced or persuaded people in the towns to take heroin for the first time but of course their presence in communities facilitates usage and uptake. *"I was introduced to it by a friend, I was just up in a heap one night and he says come here and try a bit of this and I was violently, violently sick like when I took it first and I was told that would pass, and I kept at it, and then I started getting a high from it."* Mostly people have tried heroin for the first time in the houses of friends. *"Well like they'd be introduced to it by their friends like and say people that's already using like, maybe it could be down in somebody's flat they could be calling to somebody's house, generally drinking and smoking hash or something, the next thing there's somebody there using gear and they try it and…."*

Family traumas such as relationship breakdowns were cited as a factor for initiating heroin use on many occasions. *"After the marriage broke up I found the perfect drug for me that took away everything the pain the whole lot."*

"Usually arrays of other drugs were used before people start into heroin. *"Like I first started when I was seventeen on drugs, like on heroin, my first drug was when I was eleven. It was hash, then I went to speed, acid, E, then I went to coke, crack, heroin, methadone, anything to everything."* Another interviewee was introduced to heroin in Amsterdam. *"I started in Amsterdam, I started on heroin in nineteen eighty-one, yeah, I'm on and off heroin since nineteen eighty-one. It was methadone tablets is what I started on."*

With the younger people in the town solvents and alcohol seem to be the first drugs of choice. *"He started relatively young, not on heroin, but it was the blowing the stuff through their nose first, he started that first."*

6.2 Why do people use heroin

A number of different reasons for choosing to use heroin were cited by

the interviewees. Family problems, lack of educational opportunities, peer use, pain relief, the availability of the drug and the ease at which it can be accessed were the most common reasons found. Many commented that they were unaware of the sickness that would follow from using heroin and the addictiveness of the drug. They feel that this is one area that service providers really need to work on with younger people who are in the contemplation phases of heroin use or indeed well before this phase. "*Didn't know what it was about, didn't know it was a sickness thought it was a drug just to take like a bit of hash.*"

The availability of heroin is a key factor in its rising use in a town. Once dealers establish themselves and the drug can be accessed with little difficulty people are more likely to try it out and of course this is a major complication as one interviewee described as follows: "*They get it if it's available and just try a different drug, they just get introduced to it and once you get the taste of it then you like it like.*" Once a taste is developed for heroin a person may be tempted to chase after this feeling and fall into a pattern of regular use. Heroin can block emotions and for some people this is major reason for using heroin in particular. "*I found it took away all the pain, all the worries, the whole lot I didn't care that I was separated, I didn't care about anything, all I wanted was this drug.*"

Simon from Dublin is in his 20's and has been living in Athlone for the past year. He decided to move to Athlone town after spending some time in a treatment centre in the town. He feels that this centre has a part to play in the Athlone heroin scene.

"*I'm not going blame people that are from Dublin but to a certain extent the Marist rehabilitation centre has a lot to play, and a big part to play for the problem in this town. I was in the Marist two years ago.*"

The lack of facilities for young people was also noted as a possible reason for the increasing numbers of younger users. "*There's nothing here* (Portlaoise), *there's nothing to keep the kids occupied like you know, kids are leaving school and they are just thrown at the side there's nothing.*"

6.3 Recreational heroin use

In general, it is accepted that some people do use heroin on a recreational basis. "*Like they mightn't be regular users, but I mean regular users and dabblers, do you know what I mean, weekend users or dole day users.*"

However, when further discussions took place on this people expanded to talk about how quickly heroin addiction takes hold. *"Well I could say I'm dabbling but I find it difficult not to use…. so that's addicted."*

In Portlaoise younger people are noted to be experimenting with heroin and are mostly smoking at this stage. A major influence around dabbling in heroin use comes down to financial restrictions. As the interviewee above stated, some people buy and use heroin only when they have their dole money or when money is available to them. "*There are a lot of dabblers in Athlone*" .

7. GENDER AND HEROIN MISUSE

7.1 Female heroin users

> *"It would be fifty-fifty, definitely yeah, no it would be, probably a few more lads than women."*

In both towns, women are almost as heavily involved in heroin as the men. This was surprising to us as generally there would be more male heroin users as opposed to female. "*Over the past couple of years there seems to be a lot of the girls using as well like, it was just men but lately like there seems to be a lot of girls after getting involved in heroin.*"

Many of the interviewees got involved in heroin use due to having a male partner who was using. The female population of heroin users also appear to be younger than the males at the time of initiating heroin use.

The risk of losing children due to addiction was more of a common theme and fear for the female interviewees. *"The older girls are kind of getting it together now, they're probably sick of losing their children like, so they get off them, it happens to an awful lot of them children get taken off them and they kind of they get their heads together when they hit their thirties.*"

8. ECONOMICS AND HEROIN

> *"Well, wheeling and dealing and different things like, you'd be doing runners people."*

8.1 On the tab!

"*Say I get a €130 on the Dole, they'll only let me go as far as 5 bags which is €125, but I can get them 5 bags if I want them*." This interviewee explained that he could buy up to five bags of heroin due to the fact the dealer knew that he had the money coming in from the social welfare. What this means in terms of owing nearly his entire dole is astounding. When we asked this interviewee about how he would manage for the rest of the week once he had all his dole money gone he replied "*Just, going around borrowing off this lad and the other trying to survive*."

The struggle to come up with the money for heroin each day is an ongoing feature of the lives of many addicted heroin users. Interviewees have told us of the great lengths they have gone to from holding back rent to criminal activity to come up with the money. "*A huge amount of money, like I've ended up selling things that I thought I'd never sell, you know, I've gone to the bottom now, I've nothing more to sell, and I'm trying to get off it, I've been off it now a couple of days, and it's good but it's not easy, it's not easy*."

Even those on a high income would feel the financial strain of a substantial heroin addiction in Irish society today. "*An average week, you're talking seven, eight hundred euros*."

8.2 Criminal activity

All of our interviewees that have used heroin have engaged in criminal activity at some stage from buying heroin to stealing to get money to buy heroin.

The courtroom is a familiar setting for those who have come to the attention of the Gardai for their various activities. "*There would be a number of court sessions, both in Dublin, down the country, in Moate, in Athlone, several of them, absolutely*."

Many other people recollected various accounts of crimes that they had committed in order to fund their addiction. The interviewees expressed that they would never have contemplated these crimes that they committed prior to the hold of an addiction. Feelings such as shame, guilt, embarrassment, tiredness and sheer frustration were reflected to us.

Case study: Marie's son faces the judge

"As far as I know it was one tiny bag, you know the tiny little bags? They have wrapped up in the plastic things, that one, and the brown stuff and some tablets."

Okay, and was he caught with a lot or just a bit?

"According to them, it's worth about a ten thousand, according to them."

Okay, and is he up for sentencing this morning?

"No, he's up for, this morning he is up for robbing a woman of three bars of chocolate plus he's been in court for hitting a woman in a shop, that's going through as well, he's up for a lot of things but today he's only up for while he was out on bail, he did a robbery and he shouldn't have done it."

8.2.1 Dealing

Dealing heroin to fund one's own addiction was a common theme arising from the interviewees. At times is was almost like the interviewees didn't quite see it as really dealing while others had things more organized in their minds."*Trying to come back and trying to make a few pound, trying to sell, trying to feed my habit, trying to get back up the money, try to double it again, sometimes it might work out other times not.*"

8.4 Competitive market forces

Heroin dealing is a lucrative business for some and as with any profit-orientated businesses certain tactics are used to draw in potential consumers. *"Say twenty-five euros, thirty euros and a dealer starts up or it could be fifteen euros and another dealer starts up, do you know what I mean, and the bags get bigger as every dealer comes along one dealer gets caught another three start up, do you know what I mean, Just your head wrecked like trying to get the money together.*"

8.5 Prison

Going to prison for incidents related to heroin misuse was reported more frequently than people going to prison directly due to buying or selling heroin. "*Gone to jail over heroin, not over being caught with heroin over being out robbing getting money for heroin.*"

Stealing was the most common reason that people had for being sent

to prison. "*I ended up in prison because I used to go around robbing.*"

During the interviews in Mountjoy Prison, two of the interviewees explained to us about the routines of prison life. One interviewee had spent most of his teenage years in prison and reported that whenever he gets out he really wants to party to make up for lost time and usually ends up going back in shortly after release.

Another interviewee joked about the fact that most of the males in his family had spent time in Mountjoy and that is was just his turn.

9. LIVING THE LIFE

The daily lives of people involved in heroin use is often quite chaotic. "*It's a nightmare, you're constantly never satisfied do you know what I mean, you're always looking for more.*"

Interviewees were forthcoming in giving us a glimpse of their daily routines much of which is spent trying to keep as private about activities as they possibly can. "*I'd be up early enough and waiting, if you haven't got any gear left from the night before you're cracking up waiting until the dealers like, the dealers don't start dealing until around dinner time, do you know what I mean, you won't get anybody dealing say until half twelve, one o'clock, so you're just sitting around, cracking up waiting to score like.*"

Heroin addiction is a time consuming activity for many. One interviewee talked about how heroin use can interfere with life activities that some people may take for granted. "*The drug comes first, if you want to go on a holiday you'll have to bring drugs with you, you know what I mean, no matter if you want to go to work, you have to have the drugs before you go to work, if you want to get up out of bed and have a shower, you have to have your drugs before you can wash yourself, you can't even eat before you have your drugs, because your stomach won't hold it down because you'll get sick, so like that's what I'm saying you lose total control of your life.*"

Interviewees discussed the long-term effect of heroin cravings on their lives and the feeling that they cannot become to secure about ever beating their habit. "*There's a lot of people like in this town* (Athlone) *that are off heroin and went back on it like you know, that's the thing about addiction you can never get complacent to where you are in life like, it's always there, that monkey is always on your back, he's always waiting to strike.*"

This lifestyle is obviously difficult lead with its constant risks, threats and much disruption. It's understandable that the following interviewee could feels as he describes:

"I'm sick of this lifestyle, you know, I'm sick of being sick, I don't want the… they say about aids and std's and all that, when I first went into treatment, I was so guilty and shameful doing these things, with men and women sexually, that I was sure I had written myself off."

10. SERVICES

"I don't think I'm that yet, but I will, but at the moment I just want him sorted out" Mother who expressed personal welfare concerns."

10.1 Access

In the main, people in the qualitative section of this study felt that there were not enough services and that what services there were, were difficult to access.

"I'd say it's bad, it's pretty bad here in Portlaoise and I think it's pretty bad that people here in Portlaoise are not getting off their arses and doing something about it for the kids that are on drugs, like there should be a clinic here for them in Portlaoise, now it's very hard to get into a clinic, that clinic down in Limerick, it's very hard to get into, it is very hard wherever the clinics are Tullamore, wherever they are, it is hard for them to go especially for parents who don't have transport for their kids you know to get there and here and there and turn up at the meetings and all, it's very hard, really there should be a centre in Portlaoise, but the people in Portlaoise aren't doing enough for them." These feelings related to a range of services. *"You go to the chemist with a prescription and everyone knows."*

Another theme raised was that of fear of access. Some interviewees were aware of services but were fearful to be seen accessing them. *"Like people say there could be forty people in the clinic in Athlone or whatever, but that's registered addicts on methadone, you know like there's a lot of people out there that are ashamed of what they are and what they've become, so they don't come forward so there's a lot of people in Athlone that are addicts that people don't know, so there's a big effect like it's not just people that are on methadone, there's a lot of people that want help and are afraid to ask for help."*

10.2 Methadone

Feelings on methadone differed within both towns. In the main, heroin addicts were very pleased to be on programmes because they were able to live close to normal lives. "*I'm stabilised, it keeps me away from heroin, because you're wasting twenty-five pound if I went and bought a bag of heroin but not now because the methadone is a blocker, able to do normal things yeah.*"

Methadone was understood to be one answer amongst several possible responses. "*Okay, yeah, I don't mind it at all, as long as I can get on the methadone like I'm very happy, but at the moment like I'm only starting like, but I'd like, I can't wait until I get built up enough until I can get off heroin completely like.*"

Interviewees did comment on access to methadone and random testing which was felt to be wholly inadequate. "*Lasts twenty-four hours in your system, but you can get away with not taking it for forty-eight hours, you could sell Sunday's dose and get away with it, feel a bit weird, but if you had a couple of beers take the edge of it.*"

10.3 Urine analysis

Perhaps ironically, heroin addicts wanted a more uniform system in place so that urines must be genuine. "*Like I could mess around if I want to even with the urine samples, I give one urine sample a week because I'm clean so long now you know, if I wanted I could've scored me a bag of heroin Thursday, Friday, Saturday, Sunday and Monday, use all them days and still be clean for a urine sample, so you really refine yourself.*"

10.4 Local community agencies

Local projects and agencies received praise from all interviewees. "*Got a lot of help (names changed} Angie helped me, Angie was there, John, Jen and Tracey do you know what I mean, they came up with me, I was going through withdrawal symptoms for about six months.*" Some parents chose to access services outside the midlands. "*Our son went through the Coolmine therapeutic programme and completed the programme and graduated from the programme and he's never looked back since then.*"

One of the most recurrent themes throughout this research was the need for confidential treatment which is a challenge in a local setting. "*More private, through the doctor, I couldn't line up.*" Many reasons for this

were given including fear of families uncovering use, shame and embarrassment if others in the community became aware of their addictions and generally wanting to remain anonymous in their community. "*You go to the chemist with a prescription and everyone knows.*"

A solution offered frequently was that treatment would be facilitated through ones own general practitioner. "*More private through the doctor, that's the only way I could do it.*"

11.Visions for the future

Let me end this chapter by quoting one of our interviewees.

> "*Well, I'm trying to stay away from it, but it's a struggle – it's a struggle staying away from it. Trying my best to get back into society and so-called normal people, and normal nine to five job and things like that, you know what I mean, and I'm grateful for what I have today, it's taken me a long time to get it but I'm grateful, but there's one thing I'll never be, I'll never be cocky for what I am, because I know that just like that I can just slip back on them, that's the difference, like you know what I mean, you can never get, you can never get too cocky, you always have to watch your back, that's the thing like.*"

CHAPTER 7

Guest Chapter: Brody Cameron & Alyssa Clements

The Story of Dilaudid and Goliath: Methadone users struggle to become drug-free

Section 1: Brody Cameron

Introduction

The issue of opiate addiction is not a new phenomenon, rather it is one dating back centuries. What is, however, a relatively new area is the emphasis on harm reduction under which remit methadone treatment programmes fall. At present, questions are being asked and concerns raised about both the appropriateness and effectiveness of methadone treatments programmes in Ireland. The same questions are being asked elsewhere, with Canada as an example. A look at issues facing one town in Eastern Canada is offered for the purpose of comparison.

The Purpose?

The purpose of this section is twofold. Firstly, to provide a forum in which methadone service users and those close to them had the opportunity to share their experiences, which they have lived and continue to live, thus providing an alternative to the common practice of considering this population as statistical representations, which are often devoid of any human aspect. These lived experiences do not know any geographical boundaries. The efforts one takes to become

drug-free are similar whether you live in New Brunswick, Canada or in Athlone or Portlaoise, Ireland.

A considerable amount of the research pertaining to heroin misuse and methadone treatment in Canada focuses geographically on the West Coast, for it here that we find the largest concentration of heroin issues due in part given it's location on the Pacific Coast, and also it was this area where opiates and their users have been researched at street level for a greater length of time (See Stoddart 1983).

In order to keep with the purpose of attempting to humanize what is often an abstract issue alien to most in the community, references of an academic or statistical nature are kept to a minimum. Instead, the reader finds information provided that is qualitative, in that it has been provided with those who know the topic best:

- the clients whose struggle with addiction saw them seek help and they who now present themselves each day at a methadone clinic.
- the families and loved ones of methadone patients whose drug taking affects them in some way.

History of methadone.

Methadone, a synthetic drug, was created during the Second World War by German scientists. When American troops were going through Germany after the war, they came across the factory where it was being made. In 1947, methadone's first clinical trials began. Originally intended to be a "super painkiller', it never reached the level of popularity predicted. Today, methadone is amongst one of the most heavily researched drugs on the market.

It's use in the treatment of heroin misuse can be traced back to the early 1960's and two New York doctors, Nyswander and Dole, who realized that with a tolerance slow to develop it was an effective treatment for heroin addiction.

In Canada, the harm reduction approach is responsible for the emergence of methadone treatment programmes. This shift first came about in 1987 when harm reduction was put forward to be the framework for Canada's national drug strategy (Hughes, 2004).

Dilaudid and Goliath

In Moncton, street grade heroin has always been scarce despite there being known users. It is not a drug that has ever been as widely available as other drugs such as cannabis, cocaine, ecstasy or PCP. However, like most things in life, for the right price it could be obtained. It certainly doesn't come cheap. Those I spoke with informed me when/if you could get it, a gram of heroin had a value of $450 (Canadian dollars). A gram divided up into 'points'[1] (ten 'points' per gram) each of which then selling for $50 each.

During the writing of this article, I spoke with a number of known problem drug users to enquire as to where one might purchase heroin in the area. Most of those I spoke to were unaware of any consistent local supplier and informed me that the majority of the time any heroin in the city was only for personal use or for sale amongst a very small group due to its scarcity; a co-operative if you like where resources, in this case heroin, are available only to members. Users who are arriving in either bring heroin into the city from other parts of Canada with a dependency, or else those using go to larger cities specifically in order to purchase it. Calgary and Vancouver were the two cities mentioned most frequently as the point of origin.

When I met with 'David' he had been on a programme just over a year. I asked when he, himself, thought that his drug using had become a problem. He said that it was when he started taking "Dillies" (Dilaudid). Dilaudid, an analgesic narcotic is similar to morphine, however it is roughly eight times more potent than morphine). Those using it commonly refer it to as 'designer heroin'. When purchased on the street, it can be quite expensive, resulting in addicts turning to crime in order to maintain their habit. In January 2003, Gerry Cameron (no relation) of Addiction Services Moncton, stated that "more than 100 of his clients are addicted to Dilaudid" (CBC Jan 30 2003).

It can be taken orally, crushed in order to snort or even injected. In January 2003, police in Fredericton, New Brunswick, following an investigation, seized 1500 tablets. When police searched the suspects'

1 Point refers to the decimal place such measurement occupies on the digital scales used by dealers

residence a further 300 pills were found along with $84,000 (See RCMP).

The drug has a street value of $25 upwards and is being obtained in many different ways. Thefts of prescription pads and doctoring legitimate prescriptions are but just two of the more common attempts to gain possession of the drug. In March 2003, a masked man brandishing a knife robbed Dilaudid from a Summerside palliative care unit. In April 2003, a Prince Edward Island woman was beaten up after she refused to provide more Dilaudid for a man known to her.

By far the most disturbing thing that I learned from 'David' was the extent to which some addicts will go for this 'synthetic heroin'. He told me the story of how cancer patients were being specifically targeted for their supply of Dilaudid. When it was learned that someone in the community had cancer, their home would become the target for a break and enter by addicts desperate to obtain drugs.

'David': A case study

David is a 30 year old father of two sons, both of whom live with him and his partner. David tells me that he has been using drugs for half of his life, since he was 15. He started using cannabis and then cocaine and prescription drugs such as OxyContin and, ultimately, Dilaudid. David says that it was when he started using Dilaudid that the serious problems began for him.

BC: How did you end up on the programme in the first place?

D: By luck, I figure. It was the Dillies. I was really running out of options at the time and getting awfully close to hitting rock bottom again. Feeling really shitty about myself and life in general. It was a cycle. Over the years I'd ground out, spend a while cleaning up and then somehow end up back in the same spot all over again. Like fucking deja-vu. This time I knew that I needed to get some sort of help. Knew of a few buddies who went on the programme, so decided to check it out.

BC: Where did you go to access the programme?

D: Went it to a doctor at one of the clinics first. Worried if I went in to our family doctor my family would find out somehow. They know I have a problem but it's not something we really talk about. Ended up at the family doc. Really nice about it but he

wasn't much help. Seemed a bit fucking clueless about the whole thing.
During our conversation I asked David how he felt the programme was being run, which is when he mentioned the "bell" system to me.
" A bit degrading to be honest. Degrading I guess, I mean everyone knows why you are there once you ring the bell or are just standing around. If you steal from them or have been abusive or violent you're not allowed into the store. You have to ring a door bell at the front of the building and they hand it to you"
Overall, David's experiences of being on the programme are positive. He considers himself to be lucky, in that he is on the programme, whereas there are some in his circle that are still on a waiting list.
"It keeps me clean and that's good so I can spend good time with my kids. Right now it's working for me. They're strict about following the rules. Some dudes are on the waiting list. Not really sure but I'd say there at least 75 people on the list. "

Those on the programme who have stolen from the store, or pose a physical threat, are not allowed into the store. They ring a doorbell and staff will bring out their dose to them at the front door, which they take there on the spot. Whilst fully appreciating this policy is in place for the protection of those working and shopping at the pharmacy, with a stigma in the community still surrounding drug use and treatment, there is concern about the level of dignity afforded to this client group.

'Jane'

Jane is 29. She met Roger 7 years ago and they have been married for the last 5. Roger has been on the methadone programme for 15 months. Jane has a good job whilst Roger is often between jobs and rarely manages to keep a job for any great period of time.
Jane did not know the extent of Roger's drug problem before they were married, believing him to be an infrequent user at most.
BC: What kind of difference has it made to you, Roger being on the programme?

J: "Some sort of relief I guess. Now I don't worry about him as much when he goes out. Used to always think that he was going to get grabbed by the cops for carrying dope. Least this stuff is legal. Hopefully he will stick with it"
BC: Had he ever been in trouble before with the police?
J: Nothing major. Got picked up a few times for bullshit stuff but never for dope. If he was shifty there was a greater chance that it would happen. A guy who is shifty will do anything, no thinking about it. They just don't use their heads at all. The only thing on their mind is getting right.
BC: How have things been going since Roger has been on the programme?
J: Restricting. We can't just pick up and go for the weekend, you know, spur of the moment. He needs to arrange for his dose.

Jane talks about why it is that she worried Roger would be arrested by the police. It was due to the fact that someone with an addiction to heroin's primary concern is where he or she are going to get their next fix. Regard for the law went out the window when he was "shifty", which Jane explained was when he was going through withdrawals. Her fear that someone suffering from opiate withdrawals is more likely to get caught committing a crime is not unfounded.

The programme

In the initial stages of starting on the programme one must present oneself each day to receive a prescribed dose. Once one have been deemed to be of low risk of abusing the treatment, one may be granted permission to receive "carry-overs" which means that one can bring one's dose(s) home thus reducing the frequency of one's visits to the dispensing site. This is an attempt to normalize the lives of those on the programme. As is common with the dispensing of methadone elsewhere, it is often dispensed in a liquid form. Distribution guidelines set out by the New Brunswick Pharmaceutical Society (NBPhS, 2004: 5) suggest that "Methadone should be dispensed in a vehicle that does not lend itself to injection" (can't be boiled down)".

Methadone, serving to satisfy the physical side of dependency, is not

prescribed on it's own as a means of breaking the dependence on drugs, rather it is part of a larger programme which includes counselling to treat the emotional aspect of dependency.

Conclusion

Methadone is a classified drug, with a great deal of safeguards regarding its administration and therefore its movements are heavily monitored. Despite the safeguards that exist in order to ensure it does not end up on the street (where its trade is lucrative), this failed Stephanie Reeve.

Fifteen-year-old Stephanie died in July 2003 after being given methadone by her mother. Ironically, it was given to her as a reward for staying off drugs. The methadone that killed Stephanie was legally in the house on prescription to her mother Mary (Health & Medicine Week, 2003). Deaths from methadone overdoses are few, however it is an area, which will require increased energies.

Section 2: Alyssa Clements

Introduction: A view from new brunswick

Methadone maintenance treatment (MMT) programmes are fairly new to New Brunswick, with treatment only becoming available to opiate/opioid addicts in the last couple of years. A highly contested topic in the Canadian media, methadone is seen by some as a 'wonder drug' and by others as merely one drug replacing another drug. As part of my College studies, I developed an informational programme to increase awareness about methadone in my community. The goal of the programme was to overcome some of the stigmas and misconceptions attached to methadone treatment and create awareness about this type of treatment.

From the research and presentation of my programme, I have developed a significant interest in MMT programmes and how they are used to treat opioid addictions, particularly those caused by the misuse of prescription narcotics.. I am very pleased to have this opportunity to share my information and findings in this publication.

Presenting a needs analysis

I present in this chapter a needs analysis which suggests there is a call for MMT programmes to exist throughout the province of New Brunswick. The areas of the province concentrated on for the analysis were the cities of Miramichi and Fredericton. I offer these findings for comparative analysis of the research being conducted in the Irish communities of Athlone and Portlaoise. To complete the needs analysis, primary and secondary research was completed. Primary research was completed through a series of interviews with 'clients' on methadone and 'experts' on the topic. Secondary research was completed through literature reviews, statistical reviews and documentary video reviews. A mentor was consulted for the development of the programme to assist with research sources, to review content accuracy, and to provide access to the Community Health Clinic, the location of a Methadone program, in Fredericton, New Brunswick.

Results of the primary and secondary research showed that there is a definite need for a methadone treatment programme in Miramichi. The City of Miramichi, including the surrounding areas of Northumberland County, has a population of 50,817 (Statistics Canada, 2001). The nearest MMT program is located 180Km south of Miramichi in Fredericton, the capital city of New Brunswick. The population of Fredericton is 47,560 (Statistics Canada, 2001). The Canadian Community Epidemiology Network on Drug Use (CCENDU) states, a large percentage of people using opiate drugs in the Fredericton area, could benefit from MMT and an educational programme on methadone (CCENDU, 2003).

The Community Health Clinic

Methadone treatment is an alternative to an in-patient detoxification programme, or it can be used in conjunction with an in-patient detox programme. From May 2002 to May 2003, there were 142 people admitted to the in-patient detox programme in Fredericton for addiction to prescription drugs (CCENDU, 2003). For patients addicted to opiates, methadone treatment could be a treatment option.

From January 2003 until September 2004 a methadone treatment

programme was offered in Fredericton in conjunction with the Community Health Clinic, which is managed by the Faculty of Nursing at the University of New Brunswick. During the time that the MMT programme was in operation at the Community Clinic, 109 people were admitted. Sixty clients were still in treatment when the programme was transferred to Addiction Services. There were a number of reasons for attrition, including incarceration, failure to comply with programme regulations, moving from the province, and the discontination of methadone treatment for personal reasons (Stewart-Taylor, personal communication, 2004). The clinic offers primary health care services, to the homeless and drug addicted populations living in the City. For the above period of time, services also included a MMT programme. The client base at the clinic is approximately 600 people, 60 of whom were in the MMT program. In addition to the 60 clients being provided with Methadone, there were approximately 200 more people waiting to enter the programme.

The clinic operates from funding derived from the University and grants from the Federal Government. The clinic is regularly staffed with a nurse, a nurse practitioner, a social worker, an office manager, a cleaning person and volunteers. There is a doctor on duty one day a week. In addition to providing health care services, the Clinic is a service-learning site. Students from nursing, medicine, massage therapy and a number of other health related disciplines are able to complete clinical placements at the Clinic.

In New Brunswick, many opioid addicts have various health problems. In addition to offering methadone treatment, the Community Health Clinic also provided the following services: individual, group and family counselling; full panel screening, including HIV and hepatitis testing; STI testing; wound care/dressing changes; physical assessments; immunizations; laundry facilities; outreach to those living on the streets and in shelters and healthcare for existing and new health problems (Stewart-Taylor, personal communication, 2004). Although the Clinic is no longer providing MMT, it is still providing all of the additional services.

In the handbook *Methadone Maintenance Treatment, Client Handbook* (2003), methadone is recommended for persons with opioid drug

addiction, including opioid addicts who are pregnant, HIV or Hepatitis C positive. Methadone treatment helps patients to stabilize their physical and psychosocial health, which, in turn, improves their quality of life to the extent that they can again become productive members of society (Stewart-Taylor, personal communication, 2004). During the time that MMT was provided in the Clinic, 109 people were admitted to the methadone programme. At the time of the transfer of the MMT programme to Addiction Services 60 clients were in treatment. There are many reasons for attrition in the methadone treatment, such as incarceration, failure to comply with programme regulations, moving from the province, or discontinuing methadone treatment for personal reasons (Stewart-Taylor, personal communication, 2004). It is very difficult to measure the success of MMT programmes, as success can be measured in many ways, such as a client being able to return to school, regaining custody of children, gaining employment or rebuilding relationships. Therefore it is difficult to define a success rate for methadone treatment. Considering the length of time the clinic has been operating and the changes it has gone through such as funding, programming alterations and basic growing pains, a great deal of success has been evidenced at the clinic.

A new and disturbing trend

The trend, of late, in the Province of New Brunswick, is the abuse of prescription narcotics such as Dilaudid and OxyContin. During interviews with 'clients' at the Community Health Clinic in Fredericton this was consistently identified. Dilaudid and OxyContin are rapidly becoming the drugs of choice for many people across the Maritime Provinces of Canada, especially in New Brunswick. It is not only young people who are addicted to these powerful opioid painkillers, but, parents with young children, seniors, and professionals. Some start out taking the drugs when prescribed for pain relief, and then end up addicted. When physician's prescriptions stop, the addiction does not end. Patients often seek pills to feed the addiction illegally or wait in hospital emergency rooms hoping to receive another prescription. A client of the Fredericton clinic explained her story in The Daily Gleaner (April 3, 2004). Her addiction started when she was prescribed

Dilaudid after a minor surgery. She became addicted to the drug and took whatever measures she had to in order to support her habit. This habit cost the client her marriage, her children, and her health and well-being.

In a recent newspaper article "Drug addicts find new hope" a woman from Shediac, New Brunswick, tells of her struggle with prescription drug abuse. The article states that in the Moncton area, there are 173 opiate addicts on the waiting list at Addiction Services (Times & Transcript, 2003). The population of the Moncton area in 2001 was 117,727 (Statistics Canada, 2001).

Most prescription drug abusers are looking for a quick, accessible and relatively inexpensive high that can be attained from prescription opioids. Although the drugs may start out as inexpensive, the addiction quickly becomes very expensive to feed with the addict spending $100 or more per day to sustain the addiction. As a child and youth care worker, I have worked with teenagers in a closed custody setting; many of these youth have used Dilaudid (D's) and/or OxyContin (Oxy's). The youth I have spoken with describe the high as quick, cheap and always available. The high is quick since most users will crush the pill and subsequently "snort" the powder intranasally or inject it intravenously. The high from these methods of use happens much faster than when the pills are ingested. The crushing will break up the time release components of the pill, if it is a slow release medication, so the high will hit almost at once.

According to my interviewees, at the time of their interviews, Dilaudid, OxyContin, Demerol and Codeine were more accessible in New Brunswick than other drugs such as heroin, methamphetamine and cocaine. Regardless of the problems associated with the drugs in question, the medical community still regularly prescribes these drugs because they are so effective in pain management. There was, for instance, a case of a man in New Brunswick, as told to me by a classmate, who had several prescriptions for Dilaudid and OxyContin. He would make trips to various doctors each week to have his prescriptions renewed, resulting in the accumulation of hundreds of pills, which he would then sell. The police are currently investigating him.

Public concern

Disturbingly, people are targeted for their prescriptions, especially the elderly and relatives of those who have passed away from terminal illnesses such as cancer, where there are often left over prescriptions. ATV News reported on June 4, 2004, 22 confirmed deaths from the abuse of OxyContin over 18 months in Cape Breton, Nova Scotia, a Province bordering New Brunswick (ATV News, 2004). These deaths have caused public concern in both provinces about the accessibility of OxyContin. They also have increased the debate concerning options for the treatment of addiction in the hopes of preventing more deaths from occurring. In an attempt to curb the problem of the availability of the drugs, people are speaking out about their concerns and suggesting stricter regulations for the dispensing of prescription narcotics. The suggestion has been made not to dispense OxyContin at pharmacies because addicts in search of a fix routinely break them into.

Methadone

Methadone treatment has demonstrated much success in the treatment of addictions to Dilaudid and OxyContin, particularly at the Community Health Clinic in Fredericton. Since methadone is proving to be effective, there is call from the public to have more comprehensive methadone programs available to help substance abusers overcome their addiction to opioid drugs. It is difficult to meet the needs of the addicts who are seeking help due to the long waiting lists, directly related to a lack of Government funding causing delay in the opening of new clinics and impending closures of clinics currently operating.

A small group of physicians in Miramichi hope to offer a methadone treatment programme in the near future, according to the Provincial Government of New Brunswick. This clinic will serve persons on a waiting list to receive methadone treatment in Miramichi.

Since the writing of this chapter, there have been changes to the way methadone treatment is provided in New Brunswick. In Miramichi, the small group of physicians opened a methadone clinic with their own funding in conjunction with money raised through fundraising. The clinic has been in operation since October 18th, 2004 (Jacobs, 2004). In Fredericton, the Community Health Clinic no longer offers MMT. The

60 clients from the Clinic programme now receive their Methadone through Addiction Services, as one of the services offered by the Regional Health Care Authority. However, the clinic continues to offer their other services along with screening clients for a local doctor who provides methadone treatment, who also sees her clients at the clinic once a week. (Stewart-Taylor, personal communication, 2004).

Statistics in context

CCENDU reports there is a significant problem with opiate abusers in Fredericton and the surrounding areas. Although there are few statistics concerning addiction in the overall population, data does exist for high school students in New Brunswick. In 1996 (3315 students), 1998 (3298 students), and 2001 (3854 students) respectively, 2.4%, 1,7% and 1.9% of students reported using heroin (CCENDU, 2003). In this research study, students were defined as youth attending high school, excluded any student who had prematurely dropped out of school. These findings are particularly worrisome as in New Brunswick, heroin is quite hard to obtain.

Heroin belongs to a class of drugs called opiates or opioids. There are a number of prescription drugs that fit into this classification, including OxyContin, Dilaudid, Morphine, Percocets, and Codeine. Since the prescription drug Dilaudid, which is basically a synthetic form of heroin, is very accessible in New Brunswick, it has become a drug of choice for many young people. In 1996, 9.3% of students reported using prescription drugs for non-medical use (CCENDU, 2003). In 1998, 8.4% reported using prescription drugs and in 2002, the number jumped to 13.4% (CCENDU, 2003). Clearly, these statistics show a rise in the use of prescription drugs in non-medical situations by high school students. It is critical that responsive treatment programmes, including MMT programmes, are implemented in the province to meet the needs of this expanding population.

Methadone in Canadian prisons

Methadone treatment has been used in the Canadian Federal Prison System since January 1st of 1998 (Johnson, 2001). An informational programme on methadone would be beneficial for Correctional Officers

to help the officers better understand what methadone is and what it does both physiologically and psychologically. This would enable officers to give information to inmates interested in receiving the treatment. An introductory informational methadone programme could be used at Atlantic Institution for both inmates as well as institution staff, as there is a methadone programme operating there.

The most recent statistics show that in Canadian Federal prisons, approximately 67% of offenders have substance abuse problems. Of this 67%, about 20% require intensive treatment for their addiction (CSC, 2003). Many opiate abusers inject drugs, thereby increasing the risk of HIV/AIDS and Hepatitis C. Canadian Federal prisons use methadone as a solution-oriented initiative. The rational for the use of Methadone in prisons is based on the principles of harm reduction; a person receiving methadone treatment is less likely to inject drugs If an offender is not injecting drugs, he/she is not sharing needles which can reduce the spread of HIV/AIDS and hepatitis C, thus, creating a safer environment for both inmates and correctional officers (CSC, 2003).

My study

A qualitative methodology was used to gather the data for my study. Participants who were interviewed were derived from a convenience sample. Interviews were conducted with my mentor, with methadone treatment clients and with an expert in the addictions field. Since I completed only five interviews in New Brunswick, I acknowledge this is a very small sample. Nonetheless, it does contribute to the debate.

Person-to-person interviews were used with my mentor, Dr. Dykeman, and with three clients of the Community Health Clinic methadone programme in Fredericton, clients at were also required to sign an informed consent form prior to the interview, so that I could include their information in my findings. The interview conducted with Lisa Watters, a community social worker with Region 7 Addictions Services was conducted through a written questionnaire.

When initially interviewing Dr. Dykeman and through further conversations with her, I learned about the need for MMT and about

the population that is in need of receiving treatment.[2] Dr. Dykeman stated that in her opinion, which was validated by research, methadone is only as good as the programme that delivers it. In addition to providing me with information for my study, Dr. Dykeman provided an opportunity to tour the clinic facility and conduct interviews with selected clients.

The measures used from my interviews are all qualitative, as all of the questions I asked the clients and Ms. Watters required a short answer. Also, both parties offered further information through conversations related to their experiences which was useful to my study. The design of the study consisted of primary and secondary research. The secondary research consisted of literature reviews of five research sources including: a television programme, brochure, newspaper article, statistics and government documents.

The primary information was gained through my interviews. I chose open-ended questions for my interviews with clients, thus providing them with the opportunity for further explanation of their stories. The questions I asked Ms. Watters were to gain specific information from her, which gave me a good baseline for developing programme content, as well as allowing for additional suggestions.

My literature review was limited to the use of Canadian sources. The statistics used in this study are the most recent and most of them were provided by the government of Canada.

Results

A 'life-changing experience'

The results of both the primary and secondary research have demonstrated that there is a need for MMT programmes in New Brunswick. Information from the interviews conducted with clients of the methadone program at the Community Health Clinic, suggests that there is also a need for continued services of methadone treatment, as

2 Dr. Margaret Dykeman holds a Doctorate of Nursing; she is also one of the clinics founders. Dr. Dykeman is involved with the community clinic as a nurse practitioner and nurse manager. She is also a nursing professor at the University of New Brunswick.

persons interviewed have experienced much success in their lives since beginning treatment, and continue to set new goals for themselves. All of the clients describe the methadone treatment programme as life changing for them. Clients interviewed did identify one draw back to the programme in place at the Fredericton clinic, in that they must go to the clinic daily to receive their dose of methadone. Two thirds of the clients acknowledged that going to the clinic daily was worth the hassle, as they gained needed support from the staff and other clients on a daily basis. Clients at the clinic also informed me that if their family and friends could better understand the process involved with methadone treatment they would get more support. This statement shows a definite need for an introductory information programme on methadone to be available to the public.

The need for education

Through an interview with Lisa Watters from Region 7 Addiction Services (personal communication, 2004), I found there is a need for education about methadone and methadone treatment. Region 7 Addiction Services is located at the Miramichi hospital where inpatient and outpatient services are provided to clients who have substance abuse issues as well as clients who have gambling addictions. A detox center is operated in the facility on an inpatient basis where a holistic approach is used with the clients when treating their addictions. Taken into consideration is the environment in which the person lives. Outpatient services include counselling and perhaps MMT in the near future. According to Ms. Watters there is an increase in clients seeking treatment for opiate dependency, leading to an increased amount of requests for methadone treatment (Watters, personal communication, 2004).

The information received from Ms. Watters at Addiction Services showed there is information available to people from the staff at Addiction Services about methadone programmes and methadone treatment. Ms. Watters did identify that there are other groups, which could benefit from a programme on Methadone. The groups she identified are: the Miramichi Police Force and students in the Correctional Techniques programme at New Brunswick Community

College Miramichi. These results suggest there is a need in Miramichi for education about methadone.

Along with the audiences mentioned above, an introductory informational programme on methadone should be available to the general public. Dr. Dykeman made this suggestion because she believes that the public is not well educated about methadone treatment and addiction programmes.

The case for a health promotion initiative

Methadone will always be debated as a positive or negative treatment for opioid addictions. This is mainly related to the belief that methadone treatment is a substitution of one drug for another or one addiction for another. As with any addiction treatment, some clients will find success in methadone while others will not. In any case, public awareness and understanding is needed for methadone treatment to be understood as a harm reduction measure and means of assistance to persons addicted to opioids, be it heroin or prescription drugs. There are still many people who do not have an understanding of how methadone treatment will benefit not only addicts, but the community as a whole, through the decline of crime committed by opioid addicts for example.

With the trend of more and more persons becoming addicted to prescription opioids, through medical and recreational use, the case for methadone treatment is becoming even greater. This disturbing new pattern of prescription opioid addiction is causing youth to die, crime rates to rise, and doctors and pharmacists to be terrorized by those seeking prescription opioids. Receiving government funding for methadone clinics in New Brunswick can be extremely challenging. The provincial government has chosen to fund the service of providing a dose of the methadone drug, but does not chose to fund the health promotion aspect of MMT programme along with the medical services required for a comprehensive treatment program. It is unfortunate for clients who have improved their lifestyles to now face the danger of losing some of the tools that have helped them to better manage their addiction, have enabled them to regain custody of their children and prepared them to become employable persons again.

Methadone treatment is proving to be beneficial for those in New Brunswick who are able to access it. The local newspapers are filled with testimonials of clients who have gotten their lives back on track with the help of methadone treatment. These clients are begging for the continuing availability of existing programs not to be shut down in their communities, as well as for much needed services to become available in other areas of the province. The question remains whether or not those who govern us are seeing the clear benefits of Methadone programmes.

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CHAPTER 8

"Maybe its Time for a Change": Exploring the Emerging Data

Niall C. McElwee & Gráinne Monaghan

A tangle of thoughts

"I never seen no one get that before like, none of my family ever done anything good for themselves like, good jobs or good this or good that so, hopefully one of me kids grow up to be something. I could be supporting them, if I get me claim and I leave them all the money and I die young or whatever, and leave them loads of money they'd be alright won't they".

I'm sitting in a backroom to a conference hall in Glasgow reading a copy of the Irish Times that I brought over with me from Dublin and perusing a headline that reads 'Open Verdict on Man Found Hanged in Park" (24.11.2004). On a further read down through the article I see that there are actually a couple of reports on Coroners findings. One alludes to the inquest into the death of a man found lying face up on the steps of a Franciscan Chapel in Merchants Quay in Dublin. The man was originally from Athlone and died from "a lethal mix of drugs and alcohol". He was just 26 when he died. The Coroner suggested that he was in poor general health with liver and lung problems prior to his death.

How tragic that anyone would die in such lonely and pathetic

circumstances. What must that young man have felt prior to his death as he lay there on the cold steps of a Church alone in his final moments? How does one person's life disintegrate to such a level? What more could have been done to intervene?

Such deaths are not uncommon. During this study another young man from Galway was found dead in a locked public toilet in Amsterdam. He was a heroin addict. We hope that the reader has a sense of moral outrage at such occurrences. These men could have been your brother, your son, your boyfriend, your nephew, your friend. They could have been your work colleagues. They could have done you a kindness in the past. They could have brought some joy into your life. But, not anymore.

— Niall C. McElwee (December 2004)

How cool is that: A child & youth care approach

As we complete this study we note that New Musical Express, the teen music magazine has just released its 'cool icon' listing for 2004 (Times, 24.11.2004). Pete Doherty from a band called the Libertines, topped the writers' list despite the fact that he is known as a 'crack cocaine and heroin addict'. A headline in the Times newspaper reads 'He's been jailed, sacked by his band and he's a junkie. How cool is that?' These are the confused messages our youth receive and ones we must confront.

Many times in this study we have heard of children and their parents being placed at risk because of chronic heroin addictions in their families. We state this not to blame parents, per se, but to raise attention to the fact that children are at risk from all sorts of things such as neglect, needle stick injuries, gas being left on in the home if a parent is 'goofing off' and so on.

We believe that one has to think of heroin addiction as a familial problem rather than just focussing on the 'addict'. Chronic addiction is really the end of the problem drug misuse spectrum and the return would be much better if we were in a position to intervene earlier than

is the norm in the midlands at the moment.[1] All of the interviewees from the Social Work Department in Athlone, for example, reported that they had families with heroin problems on their individual caseloads and those families were being devastated by heroin misuse.

A culture of blame

The 1980's and 1990s were marked out as decades where blame became the norm and the human services working landscape became highly proceduralised and legalized. We take the view that there is nothing constructive in simply attempting to blame the health board or, indeed, voluntary service agencies in Athlone and Portlaoise for failing to provide adequate services in this area. This would, in any case, be overly simplistic and unfair to the many individuals and agencies that have attempted to respond to heroin misuse in both towns, because heroin addicts, in general, receive little sympathy and the public needs to be convinced that there is some tangible return on treatment and investment of their taxes. We see heroin raised time and again at local level by politicians who try to keep the issue in the public eye and witnessed, first hand, the dedication which these individuals bring to marginalized people.

The unpalatable truth is that, for many, heroin misuse is not just an individual problem for individual agencies to respond to, but also a wider community problem and this is where we must focus efforts. Thus, the wider community needs to listen more courageously to potential solutions. We cannot, nor should we, locate services outside towns which are inaccessible to the very people that need them most.

Past reports

A number of reports have been published looking at various aspects of opiate addiction in Athlone. These include Keenan and Fitzpatrick's (2001) Review of Drug and Alcohol Services in the Midland Health Board, which was commissioned by the Midland Health Board. These

1 One concerned parent whose son had been through the Courts for drugs misuse just did not realise his son was in so much trouble and commented, "No, there were a few incidences when we look back and we'd say to ourselves weren't we very foolish we didn't see the symptoms or see the signs, you know".

authors examined reports from Ireland and the UK and attempted to provide an overview and analysis of best models of interventions for substance misuse. The authors discuss a range of approaches including motivational interviewing, cognitive behavioural therapy, motivational enhancement therapy, relapse prevention, behavioural therapy, matrix models, counselling, supportive-expressive psychotherapy, 12-step interventions and standardised manualised interventions.

This report noted that heroin misuse in the midlands was a serious issue with "little room for complacency" (2001: 5). The authors recommended a multidisciplanry approach with the addiction service having a budget that is ringfenced. It proposed that an overall management team with responsibility for service planning, delivery and evaluation would report to the management structure of the mental health care group through the General Manager of the Mental Health Service. It was also suggested that each individual team would have access to the Consultant for advice and support in technical matters.

This report has been criticized by a number of our research participants of being skewed towards a 'medicalised' model and for its authors not having consulted with enough stakeholders. We have attempted to address this by interviewing nominees from over thirty service agencies/providers in Athlone and Portlaoise.

A report on the Marist Rehabilitation Centre was also produced (Reddy, 2003) which noted that the service provides gender specific treatment for male residents based on an abstinence model which incorporates the 12 step programme of Alcoholics Anonymous/Narcotics Anonymous and a cognitive therapeutic understanding for a fourteen week period. Interestingly, between 1996-2002, 75% of the clients were from the Eastern Regional Health Authority Area with only 5% from the Westmeath area. Some 40% of the clients were in the age range 21-25 with only 8% over the age of 40. Some 51% of clients had court cases pending at the time of accessing treatment, 39% of clients had previous criminal convictions at the time of entering treatment.

The self-reporting questionnaire used by Reddy yielded 90% of respondents stating that the programme had addressed their addiction issues with only 10% stating that that programme had not done so. 99%

of respondents stated that they would recommend the programme to others. In relation to staying drug free after the programme, 73% of respondents stated they had done so for a combined period of some 669 months. It noted that a number of ex-residents have elected to stay in Athlone after their treatment has concluded, something which is seen as entirely problematic by a number of our interviewees as we saw earlier in this study.

A number of student dissertations at the Athlone Institute of Technology have also looked at various aspects of drug culture with one recently engaging in a small amount of qualitative interviews (Fallon, 2004). Fallon suggests that there have been dramatic changes in the prevalence of heroin use in Athlone, in the structure of treatment services and in the rise of heroin use. Of her five interviews with service providers, four felt "the government could be doing more to provide adequate services", two of the five respondents were positively disposed to the introduction of a needle exchange programme whilst three were unsure and four of the five welcomed drug courts as a positive development (Fallon, 2004: 44-46).

Our findings

A brief reading through our questionnaires illustrates that polydrug use is the norm rather than the exception, that people coming from certain areas in both towns are disproportionately represented and that children and youth are being exposed to drugs in a variety of environments. Two mothers we interviewed had both attempted suicide and spent time as in-patients in psychiatric hospitals due to their sons' heroin addictions and the chaos in their families this had wreaked. One father accessed services outside the region for his son who was a problem drug user. This should not be the case and there is much to reflect on in the data we have gathered.

Of course, there were limitations in this study in terms of time constraints, funding and the actual research brief. We quickly got the sense that several agency providers would have liked us to concentrate on other areas with more or, indeed, less specific aims and all interviewees had their own agendas, which is to be expected.

We have also learned that it takes some considerable time to get

access to a diverse population such as heroin misusers. In one of the earliest publications we came across on drugs in Ireland, a challenge was put down by the author that researchers should go out amongst the drug abusing population and get to know them (Macken, 1975). We feel that we have accomplished this.

This study commenced in April and concluded in December 2004. Despite the fact that we scheduled many interviews in both towns that did not take place, we balanced this by spending hundreds of hours in projects, houses and in the community, 'hanging out' and talking informally with heroin misusers, their families, friends and service providers. On three full days of scheduled meetings in Portlaoise, for example, no one showed for interviews and we had to spend the rest of time phoning providers and contacts and in various communities in an effort to locate additional people. [2]

From the literature review, we see that the age for initiating use of heroin and cocaine in Ireland is usually between the ages of 20 and 29 years, which is in line with our general findings. However, in Athlone and Portlaoise, younger people of both sexes are starting to experiment with heroin. This can be seen from the focus group and in-depth individual interviews for this research, but also from data held with the Midland Health Board who concur that young people under the age of eighteen are now presenting at the methadone clinic. It appears that teens no longer regard heroin with the kind of suspicion and stigma that prevented previous generations experimenting on a large scale and this is serious cause for concern.

Profile of heroin misuse in Athlone and Portlaoise Towns

The pilot quantitative data (n=16) taken from just one service revealed that the majority of the parents of the respondents were employed; the primary occupation of the majority of fathers was the army while the majority of mothers were housewives. 75% of respondents never married, nor did the majority complete second level education. 70% of respondents finished school at, or before, the age of 15. The main reason stated for leaving was to get a job, with a further

2 This was despite the fact that two different agencies had scheduled interviews for us.

25% outlining what might be termed 'non-socially productive' reasons. 81% are currently unemployed. 75% report that they were employed for various lengths of time. Since the age of 15, 42% were in employment for 12 or more years. However, 55% have been unemployed for more than 5 years with 25% unemployed for 10 years. 56% have been to prison and of those 25% have spent less than 1 year in prison, 30% have spent between 2 and 6 years in prison. The respondent's accommodation consists of mainly parent or privately rented terraced houses with one respondent reporting sleeping on the street. Almost 70% have children ranging from 1 to 18, 6 under then age of 5, 6 between 6 and 10 with 7 over 11 years old. The pilot respondents report that 50% were younger than 13 when they saw their first drug, *with 2 being 8 years old and under*. 87% of the pilot sample have used heroin with 56% using for the first time above the age of 18.

We noted earlier that there were, literally, dozens of themes emanating from the interview materials. We have chosen to focus our analysis on just some of these and present below examples of themes that were g overleaf refers.enerated from three agencies, chosen randomly from our interview datasets, in this study.

Table 7:1 overleaf refers.

Table 7:1 Themes from Agencies

Agency A

Methadone
Exploring issues/options with users
Addiction
Understanding the addiction
Employment
Generational usage
Marginalisation
Devastation
Homelessness
Access to facilities
Desire for Hostels
Judgementmentalism
Stigma
Service provision
Interagency approaches
Emergency response
Availability of heroin in Athlone
When heroin 'took hold'
How people start taking heroin
Treatment drop out
Home grown heroin users
Secrecy
Shame
Negative feelings
Perceptions (self and public)
Area specific heroin misuse
Dealing heroin
Peer pressure
Mobile phone useage
Gardai
Reality of working with users
Age
Funding an addiction
Prison
Crime
Prostitution
Money lending
Violence
Medication
Polydrug use
Alcohol misuse
GP's & medical model
Hep C infection
Hiv infection
Injecting practices
Smoking heroin
Youth smoking heroin
Numbers of people using heroin
Overdose risks
Women & heroin
Service provision
Crisis response
Social models
Unemployment
Engaging users in recreational pursuits
Environment
Homelessness
Housing
Needs of the clients

Agency B

Polydrug use
Aggression
Getting started
Gateway drugs
Availability of heroin
Perceptions (self and public)
Marist Rehab Centre
Numbers through the service
Women & heroin misuse
Funding an addiction
Crime
Interagency approaches
Service provision

Agency C

Availability of heroin
Third level college & heroin
Getting started
Health Board Response
Interagency approaches
Information disclosure
Medical model
Numbers using heroin
Marist Rehab Centre
Drop out of treatment
Cocaine use
Reasons for starting
Holistic response
Age of persons using heroin
Smoking heroin
Injecting heroin
Relationships and using heroin
Communities & heroin
Treatment centres
Peers & heroin
Availability of heroin
Dealing- community
Relapse
Methadone
Supply trail
Generational useage
Lifestyle & heroin
Funding an addiction
Links in the Midlands
Service Provision
Rock bottom crisis-action
Harm reduction
Detox
Health Board response
'Medicalised' response
Resources available
Urine analysis
Deception
Access and appropriate opening times of services
Themes in lives incl.; family chaos/early school leaving, abuse, hopelessness
Interagency working

In terms of the data generated from those using heroin, we found the following to be common themes:

Heroin misusers in the midlands were likely to:

- Use a wide range of other drugs also
- Have been arrested
- Have had court appearances
- Have spent time in hospital either as a result of their heroin misuse or directly related to this
- Have contracted Hepatitis C
- Be significantly 'at risk' of homelessness
- Have used methadone
- Have used df118's
- Have used amphetamines
- Have used ecstasy
- Have drunk alcohol
- Have used cannabis
- Have used cocaine
- Have experience of overdosing themselves or know people who have overdosed
- Have sold or supplied drugs
- Have stolen from a shop or vehicle
- Have experienced social exclusion and stigma
- Have experienced unemployment
- Have experienced educational disadvantage
- Have experienced major crises in their lives
- Have experienced major family problems
- Have come into contact with social services

Risks associated with heroin misuse

Having stated the above, it is interesting that Corrigan (2003) notes the purity of heroin in Ireland degraded from 45% in 1995 to 33% in 1999. The interviewees in this study highlighted that they, too, have experienced this and the knock on effects of impure heroin certainly pose a real threat to heroin users. Concerns arose about the purity of heroin mainly on two fronts; the 'buzz' is sometimes not as good with

impure heroin, but also interviewees were troubled by the fact that they are unsure of what they are injecting into their bodies and what the effects might be.

Many times the heroin misuser does not even know what he or she is taking into their bodies and there are serious dangers associated with heroin use.[3] Imagine going to a bar and asking for a particular drink with which one is familiar but getting instead a frothy substance which looks nothing like what one is used to drinking. Often, the heroin user is, in fact, smoking or injecting substances such as sugar, starch, powdered milk, brick dust, quinine, rat poison and a range of other mixers with the heroin which ranges very significantly in purity. And yet, the addiction is powerful and the high sought compensates for the risks involved. All three forms of heroin administration into the body can be addictive and the central danger is that one can never be sure how quickly one might become addicted. One person we interviewed for this study claims that he became addicted after just one session with a peer.

Needle sharing is, unfortunately, the norm amongst heroin users – as is the case in our study, particularly with heroin users in Athlone. In the mid 1990s, the World Health Organisation estimated that 40% of recent Aids cases internationally had been caused by drug users sharing injecting equipment. Of course, the sharing of injection equipment or fluids can lead to some of the most severe consequences of heroin abuse–infections with hepatitis B and C, HIV, and a host of other blood-borne viruses, which drug abusers can then pass on to their sexual partners and children (Lois Jorda, 2004 web).

The EMCDDA (2003) suggest that between 40% and 90% of intravenous drug users in the European Union have the Hepatitis C Virus. The European Monitoring Centre for Drugs has grave concerns about the health risks of using heroin. The spread of Hepatitis C and HIV as well as the numbers of drug related deaths present a real health

3 Dr Russell Newcombe, senior lecturer in addiction studies at John Moore's University in Liverpool, has found the purity of street heroin varies from 20% to 90% (Guardian, 14.6.2001). In 1999, fourteen heroin addicts died in Bristol and Manchester from heroin that was too pure for their systems to ingest

challenge for societies in the European Union and, indeed, elsewhere.

There is an emerging body of research in Ireland into the epidemiology of Hepatitis C amongst drug users in Ireland (Brennan et al, 2004; Smyth et al, 2003; Fitzergerald et al, 2001; Long et al, 2001). Study findings indicate that infection levels of between 51% and 85% of populations in prisons amongst persons injecting over a defined period. This is serious cause for concern.

Health, then, is often affected very badly amongst heroin misusing populations, not alone due to the effects of heroin, but also because of the ingesting practices and the risks of overdosing concerned with the drug.

Acquiring Hepatitis C from injecting heroin was considered an acceptable risk and, indeed, a likelihood, amongst several of our interviewees. Sharing of 'works' (needles) was not uncommon and one interviewee explained that the desire to use the heroin once it had been set up was so great for him that he would use "anybody's equipment" to inject himself. This is, of course, high-risk activity. A comment of relief of "only" having Hepatitis C and not AIDS was expressed when asked about the effects of heroin use.

In our study, smoking was perceived as the safest method of using heroin, as through the process of preparing and smoking some impurities are burnt off. When injecting, the interviewees were aware that they were getting all of the impurities directly into their bloodstreams.

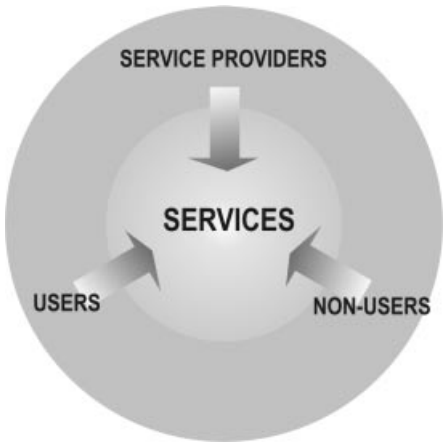
A focus on loss

One of the most dominant themes for us was around loss. A focus on 'Loss' may allow for recommendations which touch on how all service providers might 'revisit' clients/addicts and their interactions with them, thus developing ideas for treatment focus in counselling, a preparation for loss reaction in the Gardai, etc.

It seems to us that the current triangulation focus in many studies on heroin and problem drug misuse is often on 'Addiction'. An interesting perspective, which emerged in our phenomenological approach with heroin misusers, is the possibility of organizing the focus on needs. An example of this may be seen in the following quote, which involves

several persons; the heroin addict, his girlfriend, his family of origin, his baby girl and social services. "*Yeah, she supposed to have it the whole time but that's not the truth. It goes back to them at night time, but they are not supposed to have it at all, and I tried to get in contact with the social worker over it but she's out sick. Because it's not fair like. That child was in the detox unit when it was born so it was and she got it I think a week after.*"

This may be expressed in the following figure 7:1:



Initial involvement in heroin: Heroin misusers' stories

We heard that there were many points of access into heroin. 'Seamus', for example, had spent time in prison and he talked about smoking heroin for the first time there. His preference now is injecting and during the research he explained how he was still trying to inject into a shoulder that had an abscess from injecting, but the overwhelming need to use the heroin once it was 'cooked up' was too great for him.

One interviewee started smoking heroin because his father and some of his brothers and extended family were using it whilst another interviewee started smoking heroin in her late teens because some of her friends were experimenting with it. We learned of so-called 'party packs' with an e tab and a 'free' heroin tester being sold to get young

people interested in heroin.

Interviewees felt that, although people may start out smoking heroin, most people will progress to injecting the drug. Reasons proffered for most people going on to inject the drug were cited as both financial (it's cheaper to inject) and psychological (the hit form injecting is better than from smoking). The knock-on effects of injecting such as the spread of infections, abscesses and concerns about the risk of overdose were uncovered.

Relationship destruction (loss)

> "*Oh yeah, because there was a few times I went to commit suicide, over that. It's just I was getting hassle from Mike's girlfriend's family. It's going on a while. If I went down to the shop there'd be names called to me, I just couldn't take it. Now we did have a row one night and the two of us took at it, the girlfriend and myself and the mother came over and the brothers you know and I just couldn't put up with it anymore.*"

From a child and youth care perspective, the area of relationship is core. We were disturbed at the level of relationship disintegration that has obviously occurred in the lives of those misusing heroin and this is a tragedy in itself. We saw at the beginning of this chapter that this can lead to a very lonely death.

The relationships that the interviewees have, or have had, are in the majority of cases deeply affected by their heroin use. Some interviewees feared that their families would discover their heroin use and this would lead to them being isolated and abandoned. This is a real risk. Two mothers of addicts reported that they were "going to disown" their sons due to the criminal behaviour and affect of heroin misuse on siblings.

Loss of contact with children was a harsh reality for several interviewees, both male and female, who talked movingly about this loss and with deep anger and frustration.

The effects on the families of heroin users are seen as very significant. One interviewee, for example, talked about the selfishness of the addiction and how he felt that his children had a difficult time in

school and in the community trying to keep up due to his partners and his own addiction to heroin.

Parents of addicts are devastated. One mother commented, *"It's so hard seeing him with them, and he goes up the town and he puffing it away, up the town. He doesn't care if the Guards see him or not, because I seen him going up the town one day and I seen this joint they call it in his hand and I just looked and I said 'my God he doesn't care', you know. And even my son came into me, Stephen and he said to me, 'Mammy, they're making a joint over there'. I said how do you know about joints? Because I seen Justin making them he said*." Again and again we heard that the heroin addiction affects a much wider circle than just the addict.

Table 7:2: The Impact of Heroin on Relationship Dynamics
Damages relationships
Destroys relationships
Secrecy and shame become dominant
Trust issues
Issues of poor/non communication
Issues of co-dependency
Lying becomes a norm
Sense of self

Relationships and the wider community (loss)

The relationship that heroin users have with society is often quite difficult with many experiencing profound social exclusion and stigma. Getting jobs, keeping a job, getting a house or even building trusting relationships can be difficult - even when they try to overcome their heroin use. It is very common for heroin users to be barred from shops, pubs, hotels and restaurants. The Gardai stop and detain known heroin users and their peers and houses are raided. Thus, relationships are broken at every level of intercourse. This affects the individual and the community.

Accessing heroin in Athlone and Portlaoise

As mentioned earlier in this study, the *Athlone Voice* cited Athlone as the heroin supply centre for the Midlands and this has been carried in several other papers. Portlaoise also came in for some very negative publicity which was carried in national newspapers such as the *Star*.

We were told several times that no more than twenty established dealers have large quantities of the drug for sale and that people are coming in from other Midland towns such as Mullingar, Birr, Longford and Tullamore to buy heroin. There appears to be fairly frequent movement back and forth between Athlone and Portlaoise to sell and buy heroin and our interviewees from both towns claim that they know exactly where to "get gear" in the other town.

Tullamore was named as being "almost heroin free", Birr was identified as having significant pockets of heroin misuse, whilst Mullingar was thought to have a rapidly increasing heroin problem and "*be where Athlone was four years ago.*" This is reflected in court reports and local media records and a later comparison of these towns might reveal some interesting points explaining why this might be the case.

So, how easy or difficult is heroin to obtain in Athlone or Portlaoise? We do not wish to be alarmist or sensationalist, but we have learned that heroin remains easy to access – to those who are involved in heroin misuse generally. Anecdotally, we have enquired with people who smoke only cannabis and they report that they would not know where to access heroin.

One Athlone interviewee commented that heroin was "*the easiest drug of all to get in the town*" and we heard this from other interviewees again and again. We also heard that crack and cocaine were becoming much more popular than was the case in the past. This is also verified in the separate quantitative data.

Several interviewees mentioned that they were very familiar with the locations that one would buy heroin with many of the interviewees living close by and socialising in and around these areas. We heard about dealers in Portlaoise from one interviewee, "*Oh there's more than that, as well, there's actually two across the road from me. I see them going in there every night. You know what they're going for straight away. Around the corner then there's more, there's about three or four round there. Then they all*

link together and meet in this one place, one house, so I know the minute I see them I know. Even XXXX goes to this house, I know what he's going for. And then there's a house just down the road from me where this fella sells the heroin."

There are many anecdotal stories we could recount, but we will cite just two:

A community activist in Portlaoise

A community activist in Portlaoise recounted something seen by her son over a three night period where a taxi arrived into her housing area, a young male got out and purchased what she is sure was heroin because a powdered substance in a bag was taken out of a woman's bra and handed over. The nineteen year old woman selling the goods is a known heroin addict. Whether this was heroin, we cannot be sure but the perception is that it was.

A concerned mother in Portlaoise

One mother recounted how her son was able to purchase heroin from any one of three houses in her estate at any time of the day or night. One simply goes around the back of the houses, uses a particular knock which is known to the occupants of these houses and gains entry. We were also told that heroin is very easy to obtain from named sites (we do not reproduce these names in this study due to ethical considerations).

Supplying heroin: A competitive market

Heroin supply has a competitive market in most locations and Athlone and Portlaoise do not differ in this regard. In both towns, we learned that dealers use variable prices to first attract buyers and then the price is raised (we heard this from dealers as well as addicts). It was also noted that large quantities of the drug are available to buy from established dealers and that people no longer have to travel to Dublin or the UK to purchase heroin as was the case in the 1980's and 1990's. All of this indicates a lucrative market of buying and selling heroin as

pointed out by one interviewee, "*Easy, you can buy eighths, you can buy it in quarters, you can buy half grams, bags, whatever you have the money for you can buy it*."

Those affected by heroin misuse are deeply upset at the many anomalies in the system. One mother spoke at length of the inter-relationships between drug-taking couples. She mentioned that her son's involvement in heroin use has resulted in many family members being brought into contact with social services and the Gardai and court system.

Why are people in Athlone and Portlaoise taking heroin?

We might ask why are people continuing to take heroin and why are others experimenting with it when there has been so much media profiling of the dangers of addiction. As we mentioned earlier, teens have several examples of musicians and actors that have died from overdoses, or have been strung out on addictions that robbed them of their creative talent and, ultimately, their lives.[4] The most common reasons cited for taking heroin by our interviewees included:

Table 7:3 Why Use Heroin?
Escape
Pain in life
To help cope
Experimentation
Peer involvement
Family involvement
Feels good/why not?
Nothing else to do

4 At the time of completing this study, the Irish movie star Colin Farrell admitted to smoking heroin when he was eighteen (and quite liking it) which caused a furore in the media.

The financial costs of maintaining a heroin addiction

We learned that in both towns, there are very serious heroin addictions with some misusers needing between six and eight bags of heroin a day to maintain their habits. This translates into a cost of some €150 and €200 a day. Over a month, then, if the user is not buying in quantity and storing heroin for use the cost is roughly €4,200 and €5,600. One of our interviewees in Portlaoise reported using ten to eleven bags a day at a daily cost of some €250. He reported that he was rarely able to buy in bulk and normally had to scrounge or steal money on a daily basis to get 'gear'. There are very few ways to support this serious an addiction.

Again, one source in Portlaoise stated that she was aware of one couple both of whom were users where the woman was "robbing in practically every shop in town" and the male was "dealing himself to get by". We did check with some shops and heroin addicts stealing items were considered a serious issue with one owner in Athlone and one owner in Portlaoise commenting that they took every theft "personally" no matter the value of the goods pilfered.

A common theme for our interviewees was the expense of a heroin addiction and the financial tight spots they had frequently found themselves in. Mounting bills that resulted from falling behind with rent and other responsibilities were chronic stressors.

Funding an addiction: Prostitution

Prostitution is the selling of sexual favours for monetary or material gain. We found little evidence of organised prostitution in terms of established pimps controlling a group of women (or, indeed, men) in either Athlone or Portlaoise towns. Nonetheless, there is some prostitution as evidenced from the following quote from Athlone, "*Well put it this way, there's not a xxxxx too far down that road there, not too far away from xxxxx, there's a young one in there, her father owns the xxxxx and she sells herself when she hasn't got enough of money for her gear, or when there's no gear in the town she'll go with that dealer. I often seen her asking, do you know what I mean? I wouldn't mind but she's a good looking girl like, but*

she's destroyed, but her father thinks she's a saint." Also, during this study, a brothel was uncovered in Athlone town which resulted in a court case.[5]

We can report that episodic prostitution goes on in both towns when users are desperate for a fix. We were told of dealers sometimes trading bags of heroin for sexual favours, sometimes getting their partners to engage in prostitution and both males and females travelling to Dublin for prostitution.

Dealing drugs

Dealing drugs was a significant factor for some of the interviewees, both males and females, in order to maintain their own heroin addictions. Consequences of dealing heroin can lead to difficulties with the law, which several interviewees in the study had experienced. We frequently heard of 'runners', persons who were employed by more established dealers to run heroin between locations in Athlone and Portlaoise towns. There was significant resentment at the fact that the 'runners' were the ones caught by the Gardai and the main players were left to run their businesses. This may not be the case at all, but it is a widespread perception in both towns and illustrates the complexity involved in gathering evidence that will stick in court. We interviewed one person, for example, who claimed to have dealt heroin in Athlone for five months unimpeded by authorities. Interestingly, he was another individual to have come down from Dublin to relocate with a family member.

In terms of access in the two towns, it was confirmed by all interviewees that the majority of heroin dealing takes place over mobile phones and in selected houses. A mobile number is called, a deal is done and then a runner delivers the heroin for an agreed price.

Robbing

As one might expect, robberies are engaged in to fund serious

5 We contacted Ruhama (an organisation working with women in prostitution in Dublin), and asked if the organisation was aware of any young females from Athlone or Portlaoise travelling to Dublin specifically to engage in prostitution. We were informed that Ruhama does not distinguish between areas of origin, thus, having no figures for Athlone or Portlaoise girls. This organisation has some 600 women on its record base.

addictions, a point confirmed by all service providers and users. One of our service providers noted, "*Yeah, there's an awful lot of robberies. Even handbags. Do you know the bus station? You go into the bus station take a bag out of the underneath the bus and walk off, or they get on the bus and pick someone's pocket and walk off, or then they go into the train station get on to the train, before the train pulls off snap a handbag and jump off the train and walk down the line, and into the station and off you go.*" We also heard frequently of addicts who had done 'jumpovers' in shops which caused a great deal of distress to workers. A further point of note is the disregard of violence on victims when users are 'strung out' and beyond caring for themselves and others in terms of injury. We were surprised at the lack of visibility of heroin related criminal activity in both towns.

Female heroin misuse

It is commonly reported that men using heroin outnumber women by three to one. A number of studies have commented on the fact that girls are starting to experiment with drugs at earlier ages than heretofore (Flanagan et al, 2003; Kelleher et al, 2003), so it is not surprising to find this to be the case in both Athlone and Portlaoise.

A strong message emerging from existing research here and abroad is that women problem drug users have specific experiences and needs which are not always recognised or met and it is crucial to factor these into the way future services are developed for women within the midlands area. Our experience from this study is that women face particular challenges associated with their drug use such as pregnancy, birth and childcare and mental health needs.

We might express surprise that girls are reported to be smoking heroin in addition to cannabis, which, along with alcohol, is the drug of choice for most teens involved in drug culture. It is also of note that the findings in both the mid western and north eastern health board areas pointed to peers exerting a strong influence on first use of drugs. This is also the case in Athlone and Portlaoise where family and peers were consistently mentioned by our interviewees as points of contact into heroin misuse. The effects of this can be disastrous. One nineteen year-old female in Portlaoise we interviewed told us that she was introduced to heroin by her female friends just a year ago. At the time

of interview, she reported sharing up to ten bags of heroin a day with her partner. Two months later, we interviewed her partner in Mountjoy Prison. She is now pregnant with his baby.

Girls were reported by several interviewees in Athlone to be starting to smoke heroin as young as aged thirteen, but fifteen, sixteen and seventeen were more frequently mentioned. The youngest girl identified in Portlaoise alleged to be smoking heroin was twelve years old. It has also been suggested that teenage girls smoking heroin is confined to just a few geographical areas and is not widespread throughout either of the towns, although all feel concerned about a perceived increase. An ex-dealer did inform us that she had both sold to and injected heroin with a thirteen year old some two years ago.[6]

Somewhat ironically, there appears to be an unwritten 'code of ethics' amongst some of the older male heroin users who do not like to see and, in some cases, actively try to stop teenage girls from experimenting with heroin. One of our interviewees went so far as to confiscate heroin off two girls in a particular incident. *"Actually I ripped the tinfoil out of their hands to tell you the truth. I ripped it out of their hands because they didn't know how to smoke it in the first place to tell you the truth…and something said to me just snap it out of their hands…"*.

Concerns of the interviewees: Polydrug use

Alcohol was viewed by interviewees as a real health concern with one interviewee stating that, on occasions when he spent time in hospital, "*It was for this purpose as opposed to the heroin addiction.*" 'Seamus' also commented that he felt that he was more in control of his life in terms of grooming and working when he uses heroin than when he is drinking. 'Seamus' also suggested that using heroin would help him through the first day if he were trying to get off alcohol and identified himself firstly as an alcoholic even though he has been using heroin for many years. In this way his justification for heroin use has real rational roots for him. Another one of our interviewees noted that crack was actually his drug of choice and that he only turned to heroin because he

6 We checked to ensure that this girl is known to social services and in receipt of intervention.

was always in search of a greater high. A greater way to dim the emotional pain he was in and sense of loss he carried with him. In all of our interviews, respondents cited polydrug use as the norm rather than the exception.

Getting a conviction and going to prison

> *"Yeah, it's not that bad of a place, I heard a lot of stories about it but, one of my uncles done ten years in here, so it's not bad like he's always telling me it's sound enough and it is though. I was looking forward to coming here and keeping it in the family I was".*

Unfortunately, many of our interviewees had spent time in prison for drug related activities. There is serious risk in terms of health and well-being in going to prison, particularly because of the availability of drugs both in the UK and Irish systems. A survey of 57 inmates at Glenochil prison in Scotland, showed a complete reversal in the numbers of prisoners using either cannabis or heroin. Before coming to prison, 43 had used cannabis, 21 had used heroin. Once in custody, the number of cannabis users dropped to 27, while the number of prisoners using heroin rose to 48 (Observer, 4.10.2002). Most ex-prisoners attest to the fact that heroin is not difficult to access whilst 'inside' and come out of prison with their addiction as bad, if not worse, than when they entered.

We visited Mountjoy Prison in Dublin as part of this study and some seventeen prisoners from around and Portlaoise were identified by the

Governor's office in early November.[7] We interviewed three prisoners at length who reported that heroin was still easy to get - should they really want it and that the status of prisoners "remained the same on the inside as on the outside".

Mountjoy Prison has methadone maintenance, a slow detox unit, a drug treatment unit, a drug free area and a relapse area with waiting lists for most of these facilities (Murphy, 2004). A prisoner who arrives up to Dublin from the midlands who is addicted to heroin is interviewed by a medical doctor and is offered a detox straight away. If he elects to go for methadone maintenance he is put on a waiting list. A serious problem is that the prisoner must locate a clinic outside the prison, as the Prison has a policy that an addict must be formally linked with a clinic before he can be put on methadone maintenance.

Can prisons eradicate the drugs problem? This is a contentious question. Perhaps a more pertinent question might be what types of prisons are society willing to construct and run? What regimes are too strict? Is mandatory testing for banned substances really useful in the long run? We were informed in Mountjoy that the problem of drugs in prisons first begins outside the prison. This is important to remember.

There is also the issue of blood borne infections amongst prison populations. The HIV infection rate amongst prisoners is more than ten times greater than outside prisons and that of Hepatitis C is more than one hundred times (Lines, 2002).

Perhaps unsurprisingly, not all interviewees reported that going to prison was an entirely negative experience. One Portlaoise mother reported that her son actually asked to be sent back to prison for two reasons: (a) he got three meals a day and (b) he could access methadone and attempt to get off heroin. Another one of our interviewees ended up in Prison where he immediately put on weight, received three meals a day and a roof over his head and was celled with his cousin. For him, prison was, quite literally, a home away from home. Simply put, some of the prisoners felt safe in prison and that their immediate needs were being met (such as access to methadone, relationships). As one of our interviewees commented, *"Well I know, yeah, my cousin and another fella*

7 Particular thanks to Governor Lonergan and Governor Murphy.

and a few of my mates is coming in, this Friday, tomorrow, tomorrow's Friday isn't it?"

Homelessness

Several of the interviewees in this study had spent time living on the streets of Athlone, Portlaoise, Dublin, Amsterdam and London due directly to their heroin misuse. There is also the issue of secondary homelessness where interviewees in both towns rotate between friends and family for space on spare beds and on couches. Thus, whilst they are not out on the streets on a nightly basis, they are at constant risk of being so. Neither Athlone nor Portlaoise, as yet, have dedicated homeless accommodation and often the staff of various projects have to mediate between services to find accommodation for people.

Dealing with withdrawal

Several interviewees also recounted that because they could either not access services or found the services too difficult that they went into voluntary withdrawal in their own homes. We were informed that this took, in some cases, a couple of days and, in other cases, up to three weeks.

Types of medication to deal with withdrawal arose from time to time. Medications such as D10's and methadone were discussed and then, interestingly, the use of orange juice to cure hangovers and coming down of ecstasy was discussed. Orange juice, which is almost a mascot of good health, was discussed as an alternative healthy option by interviewees (we had some animated discussions where interviewees expressed interest in this concept inquiring if the orange juice should be of the pure or the concentrated type). One interviewee described the withdrawals as "*mad*".

Interviewees seemed to have access to other medications with relative ease. This shows a type of cycle or lifestyle surrounding their drug use, which centres often on getting drugs, getting high and dealing with pain later.

The media and heroin misuse

In reading the regional newspapers, one notices that a perceived

heroin problem in Portlaoise surfaced only in 1996 and this is reported as a key date more than once in, for example, the *Laois Nationalist*. In fact, in July 2000, it was reported that local Gardai were suggesting that the amount of people using heroin in Portlaoise town was as low as two persons.

This seems to be a serious under estimation. In the same year, the European Monitoring Centre for Drugs and Drug Addiction had claimed that Irish teens were twice as likely as to have sampled heroin than most young Europeans (EMCDDA, 2000). Are the youth in Portlaoise and Athlone any different to their urban peers?

Just two years later the *Laois Nationalist* (7.5.2002) reported Gardai sources acknowledging that in the years 2000 and 2001, fifty people had used heroin with approximately twenty people addicted to it. This is confusing to the reader, as the figures do not tally. There is no doubt that by 2002, heroin was causing serious concern in Portlaoise amongst local politicians with one suggesting, "This is the most serious problem facing Portlaoise at the moment" (Cllr Stanley, in LN, 16.4.2002).

There is little doubting that the majority of service providers that we interviewed felt that the media tended to sensationalise their stories around heroin and that this caused stress to all concerned; providers, heroin addicts and their families. A general sentiment expressed was that the media need to exercise restraint, ensure that their figures are correct and that stories are written up in a manner that is not offensive.

What to do?

Practically all the service personnel we interviewed acknowledged that there was a significant problem around effective co-ordination of services in both towns. Different reasons ranging from personal to professional differences, inadequate resources, a culture of mistrust and management issues, to name but some, were provided for this.

We would suggest that service agencies do have some work to do in coordinating their approaches so that the most marginalized heroin misusers actually access and stay with services. There are issues of organizational structure in both Athlone and Portlaoise that could be addressed, which would make ease of access and service delivery more attainable.

There are issues of funding. The Midland health board, for example, received €50,000 this year but this was a response to the increased use of the methadone services and is not seen by any of the providers to be adequate.

There is significant room for debate about heroin use/misuse and the strategies one might attempt to either reduce harm or create a culture of abstinence. Responses to the European 'heroin epidemic' vary significantly. The Netherlands, for example, has begun to follow the Swiss approach where heroin has been available to a limited group of addicts since 1998. Germany is currently undertaking nationwide heroin trials. [8]

Ireland, and the midlands, faces many difficult questions. Should legalised drugs be made available through GPs, specialist clinics, or pharmacists? Should opiate substitutes, such as methadone, continue to be supplied? Should needle exchange programmes be made available? Should safe houses be purchased and run by authorities? Should the supply of heroin be made entirely free of charge to users in an attempt to guarantee an extinction of the ever-flourishing black market? How can professionals be brought on board? How can the public be convinced that options should be made available? These are difficult questions.[9] Let us explore a few options starting with methadone as this is currently dispensed in Athlone and Portlaoise.

Methadone

In 1912, in the USA the idea of maintaining heroin addicts using morphine was established. By the 1960's, methadone maintenance was being actively researched. The purpose of methadone was to eliminate the need to use heroin (Fernandez, 1998:144). We have provided a guest

8 Until the late 1950's, the British Medical lobby had a policy called maintenance and believed in prescribing heroin to patients to eliminate the black market trade. However, this was not a success as addicts began to sell the heroin on the street (Walton, 2001:114).

9 It is ironic that the model for the European heroin programmes is the old British prescription-based system, which was close to being abandoned after some doctors were found to be prescribing too liberally in the mid-60s. Today about 310 patients in the UK are prescribed heroin although the total number of heroin addicts is estimated to be 270,000.

chapter from Canada on methadone.

Methadone in the UK

The extent of methadone prescribing in England has increased three fold in just a short period. Community pharmacies across England now dispense over 1.25 million NHS prescriptions for methadone. These are massive figures.

Since the mid 1990's, there has been a profound change regarding methadone prescribing. Over six years (1996 compared with 2001) the proportions prescribed as tablets (from 9.8% to 4.0%) and as injectable ampoules (from 8.7% to 3.9%) have halved, contrasting with the predominantly steady state of the preceding six-year period.

Methadone in the Netherlands

The Netherlands is frequently cited as having one of the most innovative responses to drugs misuse and heroin. In Amsterdam, for example, it is estimated that there are just over 5,000 hard drug misusers out of a population of approximately 720,000, which is statistically less that Dublin City. Unlike Dublin, however, the numbers of hard drug misusers is falling over the past five years due to a change in policing, strategy and health gain emphasis. A range of interventions has been developed for hard drug users, which are imaginative, but reality based – the reality of the daily heroin user.

Under the existing programme in Amsterdam, heroin addicts receive a daily dose of methadone from mobile units (called methadone buses), or other care units, and 200 GPs (around half the GPs in Amsterdam). The methadone buses operate seven days a week from four regular locations in the city. The methadone programme brings the City Health Department into daily contact with some 1,000 hard drugs users. This enables provision of a basic health package to the users, while informing them on aspects like infectious diseases (HIV/AIDS and hepatitis).

Methadone in Ireland

"Yeah, like today was my first day without the methadone and my

stomach is killing me I feel like just giving up to the whole lot of it I do, but I have another kid on the way now so I can't."

The National Drugs Strategy 2001-2008, comments that the number of people availing of methadone treatment in Ireland is rising with just fewer than 2% availing of the service outside of Dublin - widely confining its use to the Eastern Regional Health Authority area (NDS, 2001:38).

In December 2000, 469 clients were waiting to avail of methadone maintenance in Ireland. Of this number three-quarters were male adults of which 45% were in the age bracket 20-24 (NDS, 2001: 39). Due to the physical and psychologically addictive nature of heroin, users demanding treatment would usually have been taking the drug daily (NDS, 2001:39).

Between 1990 and 1999, 7,559 Irish people sought treatment for the first time for heroin or other opiate-related problems mostly in the Dublin area (Corrigan, 2003: 65). Merchant Quay Ireland, (2003), points out that treatment options for drug users include methadone maintenance and detoxification drug free treatment. Approximately 5,000 drug users in Dublin are engaged in methadone treatment and the remaining 8,000 are not receiving treatment for their heroin addiction (Merchant Quay Ireland, 2003).

Research is divided on what works best for the majority of addicts. When medication treatment is integrated with other supportive services, patients are often able to stop heroin (or other opiate) use and return to more stable and productive lives. What is at issue is the range and depth of support services available to people in the midlands region of Ireland.

There are other issues as we saw in the service providers' chapter from Portlaoise. The Irish Pharmaceutical Union claimed in May 2004 that almost 20% of Pharmacists participating in the methadone treatment programmes for drug addicts have been subjected to threats or intimidation in the past twelve months, 33% considered their patients unstable and it was generally felt amongst members that the Department of Health and Children was not taking their grievances seriously (Irish Independent, 15.5.2004). This was also the case in our

study.

Needle exchange as a potential harm reduction strategy

Needle exchange programmes are used to provide sterile injecting equipment and a safe place to dispose of used needles. Needle exchange programmes attempt to reduce harm and are not a treatment method. Ireland has had a harm-reduction policy of methadone maintenance and needle exchange since 1992 (Fitzgerald et al, 2001: 32-34).

We visited the needle exchange programme in Merchants Quay in Dublin where people from the midlands access services. We found that in the period 01.01.2004 to 30.09.2004, there were 30 visits from the Westmeath area, 17 from Longford, 20 from Offaly and 2 from Laois (Merchants Quay, 2004). We held an informal conversation with one of the project workers there who informed us that she knew many people in Athlone who would very much like and benefit from a needle exchange programme in their locality.

To date, no needle exchange programme exists in the Midlands to alleviate any of the concerns surrounding injecting practices, despite the fact that disposal of used needles is an emerging threat to the communities raised through this research. In a position paper, Armstrong (2004) points out that needle and syringe exchanges are aimed at bringing about behavioural change whereby people are provided with the information about the changes that are needed and are given the means to bring about this change. Thus, the emphasis remains with the user. This is felt to be empowering.

Syringe exchanges are also believed to be successful in reaching users who otherwise would not come in contact with services. 48% of attendees at the Merchants Quay syringe exchange programme in Dublin, for example, had never previously been in contact with any drugs service. Contact allows workers in syringe exchange programmes the opportunity to offer advice and support to users about safer injecting practices, safer sex and condom use and accessing drug treatment and other services (Armstrong, 2004). Syringe exchange programmes can be offered on an outreach basis where a peer outreach method is used. Injecting drug users are trained and make contact with

other injecting drug users and offer support and advice. This can be both monitored and evaluated.

Drug consumption rooms and tolerance areas

Drug consumption rooms are an innovative approach to harm reduction, which is increasing in popularity in several European cities and Australia. The rooms are also known as health rooms, injection rooms and contact centres. These facilities provide drug users with clean injection equipment, condoms, advice, and medical attention. Drug consumption rooms are often confused with "shooting galleries" which are operated illegally by drug dealers. One example of a drug consumption room is at Indro, Munster, Germany. The centre operates a low-threshold drop in centre for drug users. They offer a wide range of services aimed at addressing various needs in the drug users lives. They operate a syringe and needle exchange, offer medical and psychosocial assistance, provide food, washing facilities and recreational facilities and offer advice on housing and legal issues all alongside the drug consumption rooms. The aim of the centre is to improve the users quality of life and reduce their health risks (Armstrong, 2004).

As with needle exchange programmes, the public are very wary of such facilities, particularly if they are located in the community and it is thought that they will, by their very nature, attract users and pushers. In fact, there is little evidence of this. The EMCDDA (2004) examined 15 studies of consumption rooms and found that there was no evidence of this. These facilities allow for education to be provided on site and have encouraged changes in risk-taking behaviours. This is crucial. Because the rooms are operated alongside other services, clients are more likely to access services they might not have accessed otherwise.

Are Athlone and Portlaoise ready for such a revolutionary and controversial approach? Evidence suggests not at the moment, but we would urge that all potential solutions be investigated.

Addiction services

"The near death experiences didn't work for me you know, just because I was

close to death, doesn't mean that I should stop using heroin or crack, and it doesn't mean, it didn't work that with me anyway. And I don't think it works for other addicts either, they have to be ready themselves to say well, I'm sick of this lifestyle, you know, I'm sick of being sick, you know" (James).

Addiction services are well developed in both towns with formal teams and recognition. The original focus was more on alcohol than opiates. The Addiction Services in both locations report that they have very heavy caseloads and operate in a medicalised and bureaucratic landscape.

The Addiction Teams, themselves, were unhappy with organisational structures in which they operate with one comment, *"Well, I think… it's very complicated, the system is very complicated. From our point of view, the way it's kind of fragmented like as counsellors we are kind of, we're part of the Midland Health Board, we're part of the Mental Health Services that's our kind of link. The methadone clinic is separate, it's a separate service you know. The structure isn't very clear and the management structure isn't very clear".* This causes both dis-satisfaction and confusion in terms of co-ordination. Perhaps one of the more worrying aspects is around clinical responsibility for follow-up of clients as mentioned in one interview, *"…but the services should all be together and then we'd facilitate better communication between people, and it would be clearer then how it works, who takes clinical responsibility, it's very unclear".* Even when persons meet in multi-disciplinary team environments, it is not always clear to all present that a particular client has been accessed again for aftercare.

Interviewees reported various levels of satisfaction with counselling and several stated that they really wanted methadone as this was their primary motivation in attending services. Others stated that they did talk about things with their counsellors that they would not have with either family or peers. Interviewees found it hard to differentiate between counselling services and medical services as they are based in both towns in the same premises and on the same floors. We heard many times from our interviewees that the individual 'addict' has to be "in the right place in his head" before undertaking any form of counselling or therapy. To do otherwise is to doom the intervention to failure. As one interviewee stated, "*You can offer treatment but unless they*

really want to tackle the problem themselves, they must want to become drug free."

Outreach work

Outreach youth work is a particular method of work that supports and compliments new and existing centre/project based work or Health Board services. Skilled workers contact and inform a specific population of services that exist in their community and encourage them to avail of such services.

Outreach work is a dedicated system of delivery in the community and is very successful with 'hard to reach' populations. We have learned that there is a significant amount of people, male and female, experimenting and using heroin in various communities in both Athlone and Portlaoise. Outreach work is typically understood to be non-threatening, speedy and facilitative.

The practice of outreach work has altered considerably over time. Outreach work has its longest tradition in the US, while Ireland has established an outreach tradition specifically tailored to drug users and people involved in prostitution (McElwee & Lalor, 1997).

Overall aims of outreach work are (1) identifying and contacting hidden populations; (2) referring these populations to existing services; (3) initiating activities aimed at prevention and demand reduction; and (4) promoting safer sex and safer drug use.

Three types of outreach workers can be distinguished: professionals; indigenous workers or peers; and volunteers (Korf et al, 1999).

We do feel that outreach could be very successful in both towns and could be used in an imaginary manner. For example, the outreach worker/team could operate an out-of-hours service, which is badly needed by some misusers and could also work directly in the community and with the community. Outreach workers tend to gain access to populations that are wary of more formalised modes of delivery.

Conclusion

"I have a problem. I'm trying to sort it out but I cannot do it on my own.

I can't do it on my own" (Mark).

This is a typical response from heroin misusers in this study. Services must be constructed around individual needs with more interceptive options available in the types and locations of treatments that they might avail of. Consideration needs to be expressed towards those who are addicted to heroin in terms of access to waiting lists. For some, methadone is useful and appropriate as a treatment, but for others it clearly is not.

This study indicates that heroin misuse is a real issue in Athlone and Portlaoise. Buying and selling heroin is not a rare activity. "*You know I mean get out of Portlaoise I mean Portlaoise is full of gear so it is, full of it, surrounded in gear. All my mates down there like they're all either smoking gear or doing crack or something but on some drug they are. So, hopefully I'm going to stay away from all the gear, that's if everything goes alright for me in here*."

Our research provides important information for policy and practice because the data suggests that individuals attending medical/treatment/intervention services are likely to comprise a particularly chaotic and vulnerable group, which manifests a wide range of complex problems, and support needs.

We have been deeply privileged to listen to the stories of heroin misusers in Athlone and Portlaoise. We have learned a great deal. At one point when we were in a project, we witnessed a young man who was trying to come off heroin in obvious physical and emotional pain desperate to locate a hostel bed for the night. He is facing into Christmas with little hope in his life and no view of a future. At least he was out of the rain and in a warm room for a time.

And yet we must recognise that some heroin misusers are just 'not in the right place yet in their heads' to access formal services, be they voluntary or statutory, and a more informal approach must be utilised to attract them into services. This is the most significant challenge in formulating a response to this crisis in the making.

We have many challenges ahead.

Recommendations

Recommendations — Short-term

- The main focus of this phase of the task is to re-establish a partnership environment for both clients/patients of services within the Midlands region and staff in their respective organisations/agencies.
- Appoint a full-time co-ordinator of the Regional Drugs Task Force with a clear mandate to lead the region out of its current difficulties and restore trust and confidence in the Task Force as an entity.
- Allocation of significantly greater resources for expansion of both voluntary and statutory services.
- This should be dedicated monies allocated at defined periods from defined sources so that they may be drawn down in a planned fashion.
- Inpatient detoxification and stabilisation facilities should be created in the Midlands (the provision of services to opiate drug users should not be contingent upon drug users' agreement to enter drug treatment programmes).
- Re-evaluate the existing strategic objectives of each organisation/agency involved in working with people with 'problem' drug misuse for 2005 and beyond and prioritise key tasks for implementation.
- A regional action plan involving each stakeholder will have to be agreed and signed off for the region.
- All services to buy into a needs-led and client-centred approach which is based on best practice and is empirically validated from a right's perspective.
- Recognition must be made by all providers that those coming forward for treatment are likely to represent only a particular subgroup of the opiate using population. Many more, whose characteristics remain unknown, wait on the margins. These populations must be identified earlier in their heroin

experimentation pathways.

- A multi-disciplinary team must be made available to all persons who participate in methadone programmes in Athlone and Portlaoise. These include primary health care, counselling, education, and support services. This should fully embrace an holistic orientation.
- The Opiate Clinics should introduce urine analysis testing on a more randomised basis to get over the problem of clients misusing the service.
- A harm reduction approach which includes, for example, needle exchange programmes should be more easily accessible to injection drug users throughout the midlands. Sites should be actively explored in Athlone and Portlaoise with this in mind.
- Appointment scheduling may need review. Frequency of missed appointments needs to be considered at the same time.
- A key worker from one of the multi-disciplinary backgrounds should be nominated to act as an advocate for each patient/client to ensure that no-one falls through any gaps in the intervention/treatment system.

Recommendations — Medium-term

- Using the Partnership Model:
  – Build/Re-establish the essential elements around service delivery
  – Multi-disciplinary perspectives
  – Policies, procedures and protocols for working with persons with problem drug use
  – Management accountability and transparency in each organisation/agency
- Plan and commence essential training and development for each provider/profession/discipline, which will underpin the establishment of these key elements.
- Review and evaluate the short and medium term recommendations and assess the future viability of the Task Force.
- Provision of services in the midlands region particular to women misusing opiates such as childcare facilities and transport to

clinical/medical and intervention services.

- Provision of a detox facility with twelve dedicated beds to be situated in the region.
- Present services need to review their current opening times which are not seen to be user friendly and more based around resourcing issues therein as opposed to clients of these services.
- The provision of shared training and protocols between all the service providers with mandatory attendance from agency personnel.
- The appointment of an outreach worker(s) with a background in addictions with a specific remit to work with problem drug using populations. This post should be allocated to several key areas such as courts, community, home visits and inter-agency work. A key role for the Outreach Worker(s) should be following through with patients/clients in terms of aftercare.
- Develop a dedicated addiction service response for those under the age of eighteen who are misusing drugs. The region should adopt the national protocol for under 18's.
- Additional Community Pharmacists should be actively encouraged to partake in dispensing methadone in the midlands.

Recommendations — Long-term

- Further research should be commissioned to investigate gaps in evidence-based practice – such as strategies to locate, engage and maintain people in treatment. Areas not included in this research should be investigated to uncover the escalating heroin problem.
- Depending on the outcome of the above, re-establish a five-year strategic plan for the Midlands region.
- Commission a study into the efficacy of provision of a needle exchange programme and/or 'safe house' in the Midlands for opiate misusers.
- Staffing of social work departments should be expanded in order to reduce: excessive caseloads; lengthy waiting lists; insufficient cover for holidays, training and absences; and occupational stress.
- Additional practice nurses could be involved in GP training to

share their experience of managing difficult cases such as poly-drug users and widen GPs perspective of the social benefits of drug misuse treatment.

- A five year follow up study should be undertaken which would aim to track and re-interview the participants of this study to map individuals' pathways through services; assess any significant events occurring in their lives; monitor their drug taking; measure their progress across a range of life areas; and ultimately provide some evaluation of the effectiveness of the drug treatments they receive.
- All persons working in the drugs area should be provided with appropriate on-going training, procedures and practices to allow them to carry out their work safely.
- The deprofitization of drugs sales should be further investigated so that children and youth are not offered 'party packs' or 'taster packs' to get them using drugs.
- Prevention will have a better chance of success if it starts with younger populations. The reallignment of educational material in the school curricula from primary levels onwards, and specific in-service training of teachers which adopts a health promotion perspective.
- The positive outcomes of initiatives such as diversion policies and alternative measures should be assessed.
- The prison system should ensure that all prisoners who were in a methadone maintenance programme prior to incarceration are able to continue methadone maintenance treatment while incarcerated and be put on this in a timely manner.
- Methadone programmes should be continually responsive to the needs of different populations (such as travellers, refugees, asylum seekers) as these populations come to attention.

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About the Authors

Dr Niall McElwee has been involved in child and youth care for over a decade and is the author of several books and national reports in the area of child and youth care including *Children at Risk* (1996), *Irish Society: A Reader in Applied Social Studies* (1996) and *Views from the Managers of Residential Child Care Units in Ireland* (2000). He is the co-author of *Prostitution in Waterford City* (1997), *Choosing Carers in Caring Occupations* (2000), *Risk and Resilience* (2003), *Where have all the Good Men Gone: Exploring Males in Social Care in Ireland* (2003), *Effective Interventions with Families: The EirCan Perspective* (2005) and *Social Care in Ireland: An Introductory Text* (2005). He is the founding editor of the *Irish Journal of Applied Social Studies*. Dr McElwee has presented over 100 conference papers and workshops in several countries including Ireland, Northern Ireland, Scotland, England, Sweden and Canada. He is Director of the Centre for Child & Youth Care Learning at Athlone Institute of Technology and presently works one shift a week in residential care. He is a regular visitor to Canada where he consults.

Gráinne Monaghan is an honours graduate of social care at the Athlone Institute of Technology, Ireland. She has worked in the areas of youth work, social care and substance misuse. Her undergraduate thesis explored heroin misuse in Athlone Town for which she received honours commendation. Her areas of specific interest are parenting, substance misuse and educational initiatives. Gráinne has worked in social care for seven years.

APPENDIX

Heroin Misuse Study Questionnaire

Midland Health Board Region
May/June 2004

Section 1: Personal Details

1. Are you:
1. Male [ ] 2. Female [ ]

2. Which of the following categories best describes your age?

15-20	[ ]	46-50	[ ]
21-25	[ ]	51-55	[ ]
26-30	[ ]	56-60	[ ]
31-35	[ ]	61-65	[ ]
36-40	[ ]	66 or over	[ ]
41-45	[ ]		

3. Please name the main town/village of your upbringing up to the age of 10

_____

4. In what area do you now normally live?

1. Athlone [ ] 2. Portlaoise [ ]
3. Other (specify) _____ [ ]

5a. What is/was the usual occupation of your father?

_____

5b. Was/is he usually employed?
1. Yes [ ] 2. No [ ]

6a. What is/was the usual occupation of your mother?

_____

6b. Was/is she usually employed?
1. Yes [ ] 2. No [ ]

7. What is your marital status?
1. Never married [ ] 2. Married [ ]
3. Widowed [ ] 4. Separated [ ]
5. Divorced [ ] 6. In a relationship [ ]
7. Other (specify) _____ [ ]

8. Which one of the boxes below best describes your current level of education?
Incomplete Primary Education [ ]
Completed Primary Education [ ]
Incomplete 2nd Level Education [ ]
Completed 2nd Level Education [ ]
Incomplete 3rd Level Education [ ]
Completed 3rd Level Education [ ]
Other (specify) _____ [ ]

9a. What type of school did you attend?

1. Convent [ ]
2. Priests/Brothers [ ]
3. Community School [ ]
4. Vocational [ ]
5. Other (Specify) _____ [ ]

9b. Was your school:

1. Mixed [ ] 2. All Girls [ ] 3. All Boys [ ]

10a. At what age did you finish in school?
_____ Years of age

10b. Recently after leaving school, did you:
1. Get a Job [ ]
2. Take up an Apprenticeship [ ]
3. Do a Fás Course [ ]
4. Do a Secretarial Course [ ]
5. Do a CERT Course [ ]
6. Join Youthreach [ ]
7. Go to College [ ]
8. Other (specify) _____ [ ]

11a. Are you currently in employment?
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to Question 12)

11b. Which of the following categories best describes your present employment status?

Full time permanent	[ ]
Full time temporary	[ ]
Part time permanent	[ ]
Part time temporary	[ ]
Self Employed	[ ]
Student	[ ]
Home Duties	[ ]
Disabled/Sick	[ ]
CE Scheme	[ ]
Other (specify) _____	[ ]

12. From the four options below, indicate how many years you spent in each, since the age of 15:

Education	___ years
Employment	___ years
Unemployment	___ years
Prison	___ years

13a. Which of the following options best describes your present type of accommodation?

1. Parents' home	[ ]
2. Your own house	[ ]
3. Privately rented	[ ]
4. Local authority rented	[ ]
5. Refuge	[ ]
6. Halting site	[ ]
7. Homeless	[ ]
8. Other (specify) _____	[ ]

13b. Is it:

1. Detached [ ]
2. Semi-detached [ ]
3. Terraced [ ]
4. Flat/Bed sit [ ]
5. Caravan [ ]
6. Sleeping Rough [ ]
7. Other (specify) _____ [ ]

14a. Do you have children?

1. Yes [ ] 2. No [ ]

(If "No", please go to Question 15)

14b. Please indicate how many of your children are in the following age group.

Age Cohort	No. of Children	Age Cohort	No. of Children	Age Cohort	No. of Children
		7 years old		14 years old	
0-1 year old		8 years old		15 years old	
2 years old		9 years old		16 years old	
3 years old		10 years old		17 years old	
4 years old		11 years old		18 years old	
5 years old		12 years old		18 & over	
6 years old		13 years old			

Section 2: Use of Tobacco & Alcohol

15a. Do you smoke?
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 16a)

15b. How often do you smoke?
1. Every Day [ ]
2. One to three times a week [ ]
3. One to three times a month [ ]
4. One to three times a year [ ]
5. Other _____ [ ]

16a. Do you drink alcohol?
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 20)

16b. How often do you drink alcohol?
1. Every Day [ ]
2. One to three times a week [ ]
3. One to three times a month [ ]
4. One to three times a year [ ]
5. Other _____ [ ]

17. The last time you had an alcoholic drink, whom did you drink it with? (Please tick one answer only)
On your own [ ]
With parents [ ]
With brother(s)/Sister(s) [ ]
With other relative [ ]
With friends [ ]
With my boyfriend/girlfriend [ ]
With my husband/wife [ ]
Other (please specify) _____ [ ]

18a. Have you drunk for TWO OR MORE SUCCESSIVE DAYS in the past year? (Please tick one answer)

1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 19a)

18b. How many times has this occurred in the last year?

1-2 times a year [ ]
3-5 times a year [ ]
6-10 times a year [ ]
Once a month [ ]
2-3 times a month [ ]
4 or more times a month [ ]
Other _____ [ ]

19a. How many occasions, if any, have you been drunk from drinking alcoholic beverages? (Please circle one number for each line)

Period in Question	None	1-5	6-10	11-15	16-20	21-25	26 or more
In Your lifetime	1	2	3	4	5	6	7
During the last 3 months	1	2	3	4	5	6	7
During the last 30 days	1	2	3	4	5	6	7

19b. How much would each of the following people disapprove if you were drunk? (Please tick one answer for each type of person)

Person	Strongly Disapprove	Disapprove	Would not disapprove	No such person	Don't Know
Mother/ Stepmother	1	2	3	4	5
Father/ Stepfather	1	2	3	4	5
Grand-parents(s)	1	2	3	4	5
Best friend	1	2	3	4	5
Other good friends	1	2	3	4	5
Other family members	1	2	3	4	5
Wife/ Husband	1	2	3	4	5

Section 3: Use of Illegal Drugs

20a. At what age did you see your first drug? (apart from cigarettes and alcohol)

_____ years of age

20b. Where did this occur? (Tick all the appropriate boxes below)

1. Home [ ] 2. School [ ]
3. Disco/Rave [ ] 4. Street [ ]
5. Youth Club/Group [ ] 6. Local area [ ]
7. Other (please specify) _____

21. Were drugs widely available in your area at that time?
1. Yes [ ] 2. No [ ] 3. Don't Know [ ]

22. Have you ever used drugs? (apart from cigarettes and alcohol)
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to Question 31a)

23a. Which of the following drugs have you used? (Please circle a number for each type of drug)

Name of Drug	Yes	No
Tranquillisers or sedatives	1	2
Marijuana, cannabis, hashish, pot, grass	1	2
LSD	1	2
Amphetamines	1	2
Crack	1	2
Cocaine	1	2
Relevin	1	2
Ecstasy	1	2
Methadone	1	2
Magic Mushrooms	1	2

23b Are you currently using any drugs (other than heroin)
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to Question 24a)

23c if yes please specify what drugs are you using :

_____

_____

_____

_____

24a. Have you ever used heroin?
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 31a)

24b. What age were you when you first used heroin?
_____ years of age.

24c. Do you still use heroin?
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 31a)

25. How often do you use heroin?
1. Every Day [ ]
2. One to three times a week [ ]
3. One to three times a month [ ]
4. One to three times a year [ ]
5. Other _____

26a. What method do you normally use to take heroin (Tick as many as are appropriate for you)
1. Snort [ ] 2. Smoke [ ] 3. Inject [ ] 4. Other [ ] _____

26b. What methods have you used in the past to take heroin (Tick as many as are appropriate for you)
1. Snort [ ] 2. Smoke [ ] 3. Inject [ ] 4. Other [ ] _____

27. Why do you use heroin?
1. Boost how you feel [ ] 2. To overcome family problems [ ]
3. Problems in life [ ] 4. The Buzz [ ]
5. To experiment [ ] 6. My friends use it [ ]
7. Nothing else to do [ ] 8. Other _____

28. Where did you take heroin the last time? (Please tick one answer only)

1. Your own house [ ]
2. Friend's house [ ]
3. Night-club/Disco [ ]
4. Pub [ ]
5. Concert [ ]
6. Street [ ]
7. Park, beach, other open space [ ]
8. Other place (please specify)_____

29. From whom did you obtain heroin the LAST TIME? (Please tick one answer only)

1. A Friend [ ]
2. A Partner [ ]
3. Brother/Sister [ ]
4. Dealer/Supplier [ ]
5. Other (please specify) _____

30. How do you think each of the following people would feel about you using heroin?

Person	Strongly Disapprove	Disapprove	Would approve	No such person	Don't know
1. Mother/Stepmother	1	2	3	4	5
2.Father/Stepfather	1	2	3	4	5
3.Grandparents(s)	1	2	3	4	5
4.Best friend	1	2	3	4	5
5.Other good friends	1	2	3	4	5
6.Other family members	1	2	3	4	5
7.Wife/Husband				4	5

31a. Would you say that "The use of Heroin is a problem in your area"?

1. Yes [ ] 2. No [ ] 3. Don't Know [ ]

(If you answered "No", Please go to question 32)

31b. If "Yes", how serious a problem is it?

1. Very Serious [ ] 2. Serious [ ]
3. Don't Know [ ] 4. Not Serious [ ]
5. Not Very Serious [ ]

32. Do any of your friends use illegal drugs?

1. Yes [ ] 2. No [ ] 3. Don't Know [ ]

(If you answered "No", Please go to question 34)

33. How many of your friends do you think use heroin?

A Few	Some	Most	All
[ ]	[ ]	[ ]	[ ]

34. How satisfied are you that you could discuss issues relating to alcohol and drugs, with the following people? (Please tick one box for each person)

Person	Very Satisfied	Satisfied	Don't Know	Not Satisfied	Not Satisfied at all
Your Mother	1	2	3	4	5
Your Father	1	2	3	4	5
Your Wife/Husband	1	2	3	4	5
Your Friends	1	2	3	4	5
Others (specify)	1	2	3	4	5

35. How satisfied are you with the level of support available in Athlone/Portlaoise for people who use Heroin?

1. Very Satisfied [ ] 2. Satisfied [ ]
3. Don't Know [ ] 4. Not Satisfied [ ]
5. Not Satisfied At All [ ]

36b. Have you ever received treatment for Drugs?

1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to Question 39)

36c. If so, please indicate how much you agree with the following statements. (Circle a number for each question)

Questions	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
The staff have not always understood the kind of help I want.	1	2	3	4	5
The staff and I have had different ideas about my treatment objectives.	1	2	3	4	5
There has always been a member of staff available when I have wanted to talk.	1	2	3	4	5
The staff have helped to motivate me to sort out my problems.	1	2	3	4	5
I think the staff have been good at their jobs.	1	2	3	4	5
I have been well informed about decisions made about my treatment.	1	2	3	4	5
I have received the help that I was looking for.	1	2	3	4	5
I have not liked all of the counselling sessions I have attended.	1	2	3	4	5
I have not had enough time to sort out my problems.	1	2	3	4	5
I have not liked some of the treatment rules or regulations.	1	2	3	4	5

37a1. Where did you receive this treatment

37a2. What type of treatment did you receive

37b. How long did your treatment last for?

1. One day [ ]
2. Up to a week [ ]
4. Up to a month [ ]
5. More than a month [ ]
6. Up to six months [ ]
7. Presently on Methadone [ ]
8. Other (Please go to question 37c)

37c What other drug treatments have you received:

Treatment Type	Where received (location)	Year/mths ago (approx)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

38a If you are on Methadone Maintenance please specify your current mls

_____

38b. Do you have any other addictions, for example - psychological addictions – gambling, sex. etc

1. Yes [ ] 2. No [ ]

38c. If Yes, please specify

_____

39. How much do you think people risk harming themselves (physically or in other ways), if they do the following. Please circle what you think.

Activity	No Risk	Slight Risk	Moderate Risk	Great Risk	Don't Know
Smoking 20 cigarettes or more per day	1	2	3	4	5
Taking 4-5 drinks nearly everyday	1	2	3	4	5
Smoking cannabis regularly	1	2	3	4	5
Taking cocaine regularly	1	2	3	4	5
Smoking heroin	1	2	3	4	5
Injecting heroin	1	2	3	4	5

40a. Do you have regular health checks

1. Yes [ ] 2. No [ ]

40b. Have you suffered other illness from drug related activities

1. Yes [ ] 2. No [ ]

If yes can you please specify the illness ?

_____

41. The following table presents a number of statements. Tick the ones you agree with - In the past 12 months I:

	Yes	No
… found that using [named drug: e.g. heroin] has led me to neglect things, or cause problems socially, or at home, or work?		
…. used heroin in a risky or dangerous situation? (e.g. driving a car when under the effects).		
… have had problems with the law resulting from my heroin use?		
. . . . continued to use heroin despite having problems with it in my social life or with my relationships?		
. . . . needed to use more (named substance, e.g. heroin) to get the desired effect, or has continued use of the same amount which had less of an effect than it used to?		
. . . . felt sick or unwell when the effects of heroin have worn off, or I have taken more heroin or a similar drug to relieve or avoid feeling unwell?		
. . . . used heroin in larger amounts, or for a longer period of time than I intended?		
. . . . had a persistent or strong desire to take heroin or have had problems cutting down or controlling my use?		
. . . . take a great deal of time either obtaining, or using, or recovering from the effects of heroin?		
. . . . gave up or reduced important work, recreational or social activities as a result of my heroin use?		
. . . . continued to use heroin despite having physical or psychological problems with it?		

Section 4: Contact with Law

42. Would you see the Gardai as a source of information?
1. Yes [ ] 2. No [ ]

43. Would you see the Gardai as a source of help?
1. Yes [ ] 2. No [ ]

44. Has your use of illegal drugs brought you in contact with the Gardai
1. Yes [ ] 2. No [ ]

(If you answered "No", Please go to question 49)

45. If yes
How many times in the last two years?
1 [ ]
2 [ ]
3 [ ]
4 [ ]
5+ [ ]

46. Have any of these contacts resulted in court appearances
1. Yes [ ] 2. No [ ]

47. Did any of this contact with Gardai result in you being directed to a support service?
1. Yes [ ] 2. No [ ]

48. Did this contact make you aware of the trouble/damage illegal drug use can bring to yourself?
1. Yes [ ] 2. No [ ]

Section 5: Contact with Services

49. How did you find out about the service you are currently using?

_____

50. How helpful do you think this service is?

Extremely Helpful	Very helpful	Not sure	Not very helpful	Not at all helpful
[ ]	[ ]	[ ]	[ ]	[ ]

51. What does this service provide for you? (specify)

_____
_____
_____
_____
_____

52. In your opinion what would be the best way to help people find out about the service.

_____

53. How did you locate initial information about help/assistance on drug abuse?

1. new paper [ ]
2. posters [ ]
3. friend [ ]
4. Other _____ [ ]

54. Are there other sources of information that could be useful?

1. news paper [ ]
2. posters [ ]
3. confidential telephone line [ ]
4. Other _____ [ ]

55. How often do you use the current service?

1. First visit in this week [ ]
2. Every Day [ ]
3. Every week [ ]
4. Every Month [ ]
5. Once in the last year [ ]

56. Have you advised anyone else of this service?

1. Yes [ ] 2. No [ ]

57. Who did you first talk to in relation to your illegal drug use

Doctor [ ]
Partner [ ]
Friend [ ]
Counsellor [ ]
Service agent [ ]
Other (specify) _____

58. Had you used any other related service before this

1. Yes [ ] 2. No [ ]

59. If so which ones (specify)

_____

60. Where should services be located (private/away from)

Large towns/cities [ ]
Private locations [ ]
Away from home [ ]
Hospitals [ ]
Local areas [ ]
Other specify _____

61. Why did you use the service initially?

1. Needed Support [ ]
2. Needed a substitute [ ]
3. Needed to withdraw [ ]
4. Needed to stop using [ ]
5. Other _____

62. What else would you like this service to provide? (specify)

_____

63. When would you prefer to use this service (specify)

_____

64. What other services are you aware of for drug use assistance (specify)

_____

65. Do you have a contact number for a support service on you

1. Yes [ ] 2. No [ ]

66. How do you normally contact the service?

1. Drop In /Arrive in anytime [ ]
2. Ring before hand [ ]
3. By appointment [ ]

67. If by appointment who referrers you to the service (specify)

_____

68. How long do you spend in the service building?

_____

69. What ways do you think these services could reach others?

1. getting someone to go out [ ]
2. re-ensure privacy [ ]
3. gets others who are past users to help [ ]
4. other (specify) _____

70. How do you travel to this service?

Walk [ ]
Cycle [ ]
Bus [ ]
Train [ ]
Taxi [ ]
Car [ ]
Other _____

Over a nine-month period from April to December 2004, Dr. Niall McElwee and Gráinne Monaghan undertook a study into heroin misuse in Athlone and Portlaoise on behalf of the Midlands Regional Drugs Task Force. They spent hundreds of hours out in these communities meeting with and interviewing service providers, service users and families connected to heroin. This study, which embraces a relational child & youth care model, uncovers and presents these stories.

Darkness on the Edge of Town: A heroin misuser

"But once I took the drug, it totally changed me you know. You go, like, ah f*** it. Everything goes out the window, like everything you ever learn goes out the window. The good qualities and morals and values and all these things, with me anyway, just went totally out the window, you know?"

Darkness on the Edge of Town: A service provider

"I don't think an individual can pull this together. I think there has to be a policy decision made within each of the organisations involved ... that's not tokenistic … actually the solemn policy, edited on the ground."

Darkness on the Edge of Town: A family member

"Our natural inclination was to have sympathy for him, he was the victim of all of these things and in effect we weren't getting the true story I'd say. But, I understand that's the way people are affected. They lose all normal sense of decency and they become different people and not the person that they really are — and thank God he's back to the person he really is".

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Athlone Institute of Technology

Midlands Regional Drugs Task Force