A DIZZYING ARRAY OF SUBSTANCES: AN ETHNOGRAPHIC STUDY OF DRUG USE IN THE CANAL COMMUNITIES AREA.

A. Jamie Saris, PhD
Senior Lecturer, Department of Anthropology,
National University of Ireland, Maynooth

Fiona O'Reilly
Postdoctoral Research Fellow, Department of Anthropology,
National University of Ireland, Maynooth

With the Assistance of William Cullen, Ciarán Delaney, Daniel Flynn and Doireann MacKenzie

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Cover Photograph: 'The Journey' Sculpture by Cathy Thorpe

EXECUTIVE SUMMARY

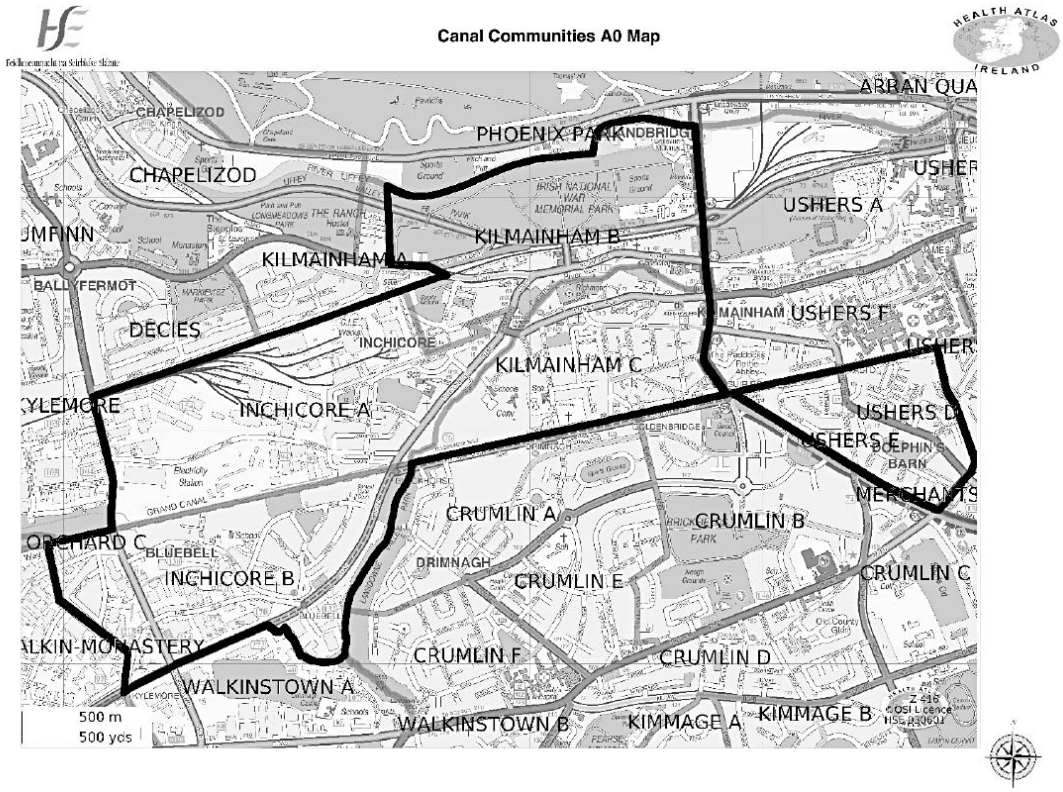
This is a study of changing patterns of drug use in Inchicore, Rialto, and Bluebell, the areas served by the Canal Communities Local Drugs Task Force (CCLDTF), using data collected from September 2007 until the end of 2008, with some follow-up work in 2009. This report grows out of a belief within the Task Force that the ideas and structures that emerged as a response to the 'drugs' crisis (almost exclusively defined in terms of opiates) in the 1990s might not be as relevant as they once were to drug use today, given the area's rapidly developing built environment, changing demographic make-up, and the sense that the younger generation has a different understanding of (and perhaps different appetites for) 'drugs'.

The analysis is conducted through an ethnographic examination of the lives of drug-users in the Canal Communities area, alongside quantitative data that we collected and some tabulation of secondary statistics. These data are analysed together to give a sense of the issues relating to drug use and treatment in this area, as well as a feel for the experience of drug use and drugs services.

While such data is, by its very nature, difficult to summarize, our most important findings are:

- Poly-drug use (almost always combining illegal drugs, legally-obtained pharmaceuticals and illegally-obtained, but otherwise legal pharmaceuticals) is the norm for the overwhelming majority of drug use in the Canal Communities area (and, we suspect, in most other places in Ireland).
- Nearly all of our qualitative and quantitative data demonstrates that the population 'in treatment' for opiate use has a range of unmet needs. It should be kept in mind, then, that people, not drugs, are the focus of any meaningful definition of treatment.
- While we lack a true baseline, we believe that crack use is increasing. In particular, its use seems to be increasing among those users already 'in treatment' for opiates.
- There are few clear, locally meaningful markers of problematic cocaine (either powder or crack) use, especially in comparison with problematic opiate use. Nonetheless, injecting cocaine ('banging') is widely considered to be very dangerous.
- Overall, drug-dealing is professionalizing at its entry level, and leaving drug use for 'treatment' does not necessarily mean that one leaves the business of drugs.
- In several of the stories below, we show how heroin use has been restigmatized amongst young people.
- The clear-cut categories of government policy, such as 'drug-user' and 'treatment' are difficult to discern at the local level. At the same time, ironically, the flexible understanding of 'treatment' by Local Drugs Task Forces is often difficult to justify to government funders. This divide needs to be bridged.

All of these findings have implications for how drug use is imagined as an issue and, consequently, what responses are appropriate to address the problem. They all require a more comprehensive understanding of the complexities of use and a more mature reflection on the meaning of such terms as 'treatment' and 'services' for drugs problems.



MAP 1: THE CANAL COMMUNITIES AREA TASK FORCE BOUNDARIES

(Electoral Divisions (EDs) covered in whole or part by the CCLDTF)

The Canal Communities Local Drugs Task Force (CCLDTF) was set up in 1997 to develop a response to the drugs issue in the Rialto, Bluebell, and Inchicore communities. It was one of fourteen Task Forces set up in 1997 in areas worst affected by the heroin problem. These organizations stemmed from the publication of the Ministerial Task Force on Measures to Reduce Demand for Drugs, which was published by the government in the previous year. The Task Force has attempted to bring a multi-agency approach to bear in developing appropriate responses to the drugs problem at a community level, involving key statutory, voluntary and community interests in the area. The EDs blocked out above describe a larger area than that covered by the CCLDTF (e.g., north Inchicore areas, such as Ring St and Nash St are not included, nor is Kilmainham and Islandbridge), but, overall, the map gives a good sense of the spatial milieu of this research.

OPENINGS

The rain came down in thin sheets, promising a wet day. The depressing grey and heavy dampness made the built environment of the flats feel even more grim than usual. I had just finished an interview with Sandra in the treatment centre she attends almost daily. As she was officially homeless and staying in a bed-and-breakfast, this centre was the closest thing to a stable place for her. We both left at the same time, so I offered her a lift. Though she was not going that far, she gladly accepted the offer to avoid the wet. We chatted easily, as we had a lot in common – family concerns, how the kids were coping in school, bullying, and so on. We parked at the stairwell. A thin, sickly-looking man with his hood up tapped at the car window. Sandra opened it a crack:

> 'Is he up there?' he said.
> 'With you in a minute' she replied.

We went on talking for a couple of minutes, but Sandra now had other priorities. The coke dealer had arrived. As I turned to leave, a police car passed.

Sandra was going to score cocaine, which was the big seller at that moment. Sandra was also 'in treatment' for drug abuse.

SCOPE OF THE WORK

In error, Sandra turned up three times in our survey having been interviewed by three different researchers across two different services. The various interviews were conducted over five months. While we eliminated the duplicates for the purposes of our statistical analysis, they nonetheless proved revealing. All of the questionnaires Sandra filled in painted a picture of exuberant poly-pharmacy with a variety of prescribed medication (Methadone, Diazepam, Dalmane, Cispin and Zimmovane) mixed with illicit substances: heroin (infrequently), hash, powder cocaine (both snorted and injected) and crack. Tellingly, at the time of the first interview (March 2008), Sandra considered intravenous cocaine her problem drug. At the time of the third interview (August 2008), though, she considered smoking crack to be her biggest issue.

Inadvertently, our over-sampling of Sandra tracked one of the major trends in both the qualitative and quantitative parts of this study: the emergence of crack as a sort of specialty drug for people on the Central Treatment List (CTL). This development is connected to several other issues: from the increasing professionalization of those selling drugs (especially cocaine) to the ubiquity of poly-drug use in the lives of drug-users. Sandra also illustrates several other findings of the main work that we detail below. While she appears in several services for drug-users, for example, significant aspects of her drug use do not appear in any of the professional assessments of her treatment needs. At the same time, many of her other problems, such as her homelessness, while certainly impacted in a negative way by her usage, go considerably beyond a drug problem as such.

Even this sparingly-detailed picture of Sandra's drug use and service profile gives us a chance to appreciate how several forces intersect in a negative way in her life, while allowing us to track the path she charts through a service environment, and to glimpse how some of these services match up to her actual needs. In this report, we knit together several of these ethnographic scenarios as a way of discussing changing patterns of drug use in the communities served by the CCLDTF. We are aware that this format does not conform to a standard report structure, which generally aims to cover a topic from a sort of bird's-eye view, in pursuit of a normalized depiction of the problem, occasionally mining down to the ethnographic layer (when it is even available) to retrieve an illustrative quote or description.

Instead, we aim to use the depth and richness of the thick description of individual lives and specific social practices, integrated with various background data, in order to unpack much broader social patterns that are applicable to drug use in the Canal Communities, and, we believe, in many other parts of Dublin (and indeed Ireland as a whole). Some of these patterns, such as exuberant poly-drug use, are ubiquitous, and they also have a long history in Dublin, but they seem to have been largely sidelined in discussions of the 'drug problem' at the levels of theory, policy and governance. Other patterns that emerge in this story, such as the remoralization of heroin amongst young people, are definitely more recent phenomena. This rejection of heroin use, we believe is a local community response to a significant social problem, although how long this respite will last is unclear. Finally, we discuss some issues around treatment: what constitutes it, whom can be understood to be in it, and, crucially, what comes after it.

THE ETHNOGRAPHIC REPORT: A USER'S GUIDE

This text is an example of a relatively unusual genre form, the Ethnographic Report. It tries both to present data and findings in ways that will be useful to policy-makers, service-providers, and other professionals interested in drug abuse, as well as to explore the complexities of the lives of those whose behaviour these experts are attempting to influence. We anticipate that the audience for such a report will be mixed, and we expect that not all parts of this audience will find all parts of this report of equal interest.

The job of a report is to provide lessons for specific purposes derived from distilled, real-world evidence. These take-away points are listed in the Executive Summary, with the specifics demonstrated by evidence in the body of the text. The task of an ethnography is to discover patterns in the social worlds of the people with whom researchers share their lives for a certain period of time, in order to glimpse how local meanings structure specific ways of being in the world, how that world looks from the inside out, and what motivates reasonable action in that environment. These patterns emerge in the descriptive integration of various sorts of data – narratives, descriptions of settings, interview transcripts, even background statistics. When the difference between these two viewpoints hinges on a recognized social problem, such as the use and abuse of dangerous substances, however, serious issues emerge. Many of the participants in our study, for example, regularly engage in activities that pose serious risks to their safety (and that of others in their environment) while subjecting themselves to the possibility of criminal sanctions. We do not mean to normalize these activities in a moral sense, but we try to structure the data and the argument of this work around the lives of our participants in such a way as to provide a bridge to understanding at least some of their motivations. Around this more narrative data, we have woven in quantitative data in text blocks throughout the work, with more analytical sections drawing on the expertise of the authors, as well as some comparative information from other sources.

Textual and Vocabulary Conventions

Direct citations from either transcripts or field notes (which have been minimally edited for clarity and readability) are indented and single-spaced. Longer scenarios that are directly informed by field notes and transcripts are also indented and single-spaced. These are standard conventions from ethnographic writing used to convey direct description of field settings. Direct quotes from interviews (again with minimal editing for readability) are in quotes in the indented sections (or indented again if they go beyond a few lines). Long transcript fragments or large chunks of reported speech are further separated by spaces in such scenarios in the interest of readability. We use the convention of a // to indicate cross-talk and interruptions during the back and forth of conversation. In direct quotes, paragraphing is used to indicate pauses and transitions within long fragments of speech, while long paragraphs indicate a continuous stream of talk on one topic.

Following another ethnographic convention, we often use meaningful local terms as first-order generalizations. Terms like 'junkie' and 'phoy'[1] for example, have a set of connotations that are very different from 'drug-user' (or even 'heroin-abuser')[2] and physeptone [a brand-name of methadone]. When used in the text, these terms convey the way that we came to understand local categories

1 The local term for Methadone, derived from the brand name Physeptone.

2 Generally, 'junkie' refers to a known heroin-user who shows the physical and social signs of use: thin body, risk-taking, and locally-known, low-level criminality to feed a habit. The term is beginning to extend its local semantic reach to encompass problematic cocaine users.

to be organized. When engaging in more experience-distant analysis, we use terms more familiar to policy reports, such as 'drug-user' and 'methadone'. Insofar as we are treating the individuals in this study as experts in their own lives, we have opted for the more prestigious term 'consultant' over the more inquisitorial term 'informant' when referring to those who shared their lives with us.

Finally, without assuming an internal homogeneity for populations in the area, we use the term 'Canal Communities' and 'the Canal Communities area' as a spatial marker for this study. Similarly, while there are slight differences between the formal area of responsibility of the CCLDTF and the Electoral Divisions (EDs) through which our secondary statistical sources are organized, they do not impinge on the usefulness of the maps included in 'Three Areas, Three Variations'.

DRUGS IN THE RECENT HISTORY OF THE CANAL COMMUNITIES

Fundamental to this work has been the CCLDTF's impression that the drug scene, and the service profile required by it, has altered, and, therefore, so must its mandate. This re-examination of the Task Force's mission is based on several different data streams.

1. The sense from government that the heroin problem in this area has levelled off.
2. The institutions dealing with drug use and abuse have specific histories, and they seem to be entering a new moment.
3. The observation that newer drugs, such as powder and crack cocaine, are becoming more widely popular.
4. The sense that there are new social problems, especially for youth.
5. The concern that these needs will increase at a time of significantly reduced budgets to the services trying to address them.

Clearly, these issues must contribute to our understanding of a 'drug service'. We have approached this question by addressing the history of the 'drug problem' in Ireland especially its inseperablility from the history of the main 'problem drug', that is, heroin and the services that it spawned.

In brief, the impact of heroin on certain communities in Dublin birthed various institutional responses that flowed into certain institutional channels already existing in these communities. These channels had been formed by the interaction between a lively Community Development movement and the Irish government's decision to spatialize its anti-poverty strategy in the 1990s, as well as the availablity of then-novel funding streams to encourage local responses to social problems, including heroin. The result of this confluence was a concentration of stakeholder-peopled, State-financed, relatively enduring collections of groups devoted to ameliorating the drugs problem in socially excluded neighbourhoods – mostly Drugs Task Forces and Community Drugs Teams, which were mandated with specific responisibilities towards discrete areas of Dublin.

The culmination of this process was an increase in government funding to address the 'heroin problem' in these specific areas of Dublin (built up from a very small base in the late 1980s). This money funded various 'drug services', which threw up a paradox. On the one hand, services for 'addiction' were increased, and the main means with which the Irish government has tried to address heroin treatment, that is Methadone Maintenance Therapy (MMT), became widely available thanks to the expansion of the Methadone Protocol (See Saris 2008). On the other hand, since addressing the needs of heroin addicts goes very much beyond any connection to a drug, many other activities were funded as well. While such developments were, for the most part, welcome at the local level, they were not without critics. In many neighbourhoods where drug-users were concentrated, for example, this proliferation of addiction services was experienced by some community members as an index of the community's distress, as much as it was seen by other community members as helping some of the community's most vulnerable members (see Saris *et al.* 2002a).

There are, it seems to us, two narrative frames into which drug abuse in the Canal Communities, and in Greater Dublin, is now being pushed, both of which need to be carefully examined. The first frame relates the story of heroin in Dublin as a great crisis that is just coming under control. In this frame heroin resembles a serious storm, a sort of pharmacological Hurricane Katrina, which, after some delay in getting government resources to specific areas and populations, certain Dublin communities have more or less weathered. These communities, while still affected, are now digging

themselves out of the rubble. The other story invokes a sense of constant, seemingly random flux in usage patterns, where drugs resemble certain mutateable diseases like Swine Flu – 'crack is coming', 'cocaine reaches across social class', 'soft drugs lead to hard drugs' – all point to a landscape of risks, containing only discrete individuals and particular chemicals, with little sense of the social context of (and even less of the social practices around) such usage. Under the first rubric, 'success' in dealing with the drugs issue remains disturbingly vague. Knowledgeable observers (Butler 1991, 2002, Keane 1995, O'Gorman 1998, Saris 2002b among many others), for example, have long understood that heroin's clustering in areas at the sharp end of structural violence is an index of marginality and widespread 'social exclusion'[3] as much as it is a 'social problem' in such areas, but such issues are clearly beyond the ability of any one intervention into drug abuse to solve. The second frame, though, takes a socially naive understanding of 'risk' as the basis for social policy. We have no idea if 'the party is over' for cocaine (although, the National Advisory Committee on Drugs (NACD) Report from 2008[4] suggests that it is not), but we are sure that both the risks for, and effects of, use will be crucially influenced by issues such as age, social class and gender. Any policy that takes as its object providing 'information' to a 'standard average cocaine-user', therefore, is simply doomed to failure.

This issue is difficult to broach at a time of moral panics concerning certain drugs and shrinking funds for social services. Consider cocaine. While different ways of using it can cause problems in the lives of users, in no meaningful sense is occasional use of powdered cocaine the same issue as chaotic injecting of the drug. Indeed, even for powder cocaine, it is quite possible that what gets sold as the 'same' drug in different parts in Dublin as well as at different times is not the same thing. As we detail in one of the stories below, early on in our work, several users complained that, unlike 'the Blacks' (Nigerians), their 'Irish' cocaine did not 'wash up' into 'rock' or 'crack', as whenever they tried, their samples only rarely produced the desired end-product. As the technical issues in 'rocking up' coke are not really that complex, we became convinced that much of what sold as 'cocaine', at least up until mid-2008, had very little of that drug in the sample. As the demand for crack grew, however, Irish-made crack became available locally, albeit at a very high price, in terms of the data that we have from other countries (see below, Footnotes 13 and 14).

Another issue that crops up in the stories below is how variable is any sense of progression in the lives of actual users. People begin and end drug-using careers with a dizzying array of compounds. In particular, it was very difficut to see in these stories, the folk distinction between 'hard' and 'soft' drugs, with the latter providing a slippery slope to the former. Specifically, we need to appreciate how poorly some of the most commonly abused drugs in Ireland, such as minor tranquillizers, fit

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3 'Social Exclusion' emerged in 1990s Irish policy circles as the main term in discussions of serious poverty. Its roots are in a variety of EU White Papers, heavily influenced by French thought on social policy, which considered the relationship between what was once called 'relative deprivation' and wealth creation. In other words, inequalities often widened when societies became richer. These documents suggest that 'exclusion' is a multi-axial concept, more broadly defined than (but generally related to) poverty, comprising dimensions including, but not limited to, civil rights, democratic participation in the economy and familial and community relationships (Room 1996). 'Social exclusion', then, has come to refer to populations who, by virtue of a range of structural conditions and other attributes, are 'cut off' from the mainstream economic, social and cultural resources of a nation. Other theorists influenced by Liberation Theology and various strands of Marxism however, deployed the term structural violence to indicate how oppression is actually experienced in social life (e.g., Farmer 2001). Other paired terms, such as 'inequality/equality', vie with 'exclusion/inclusion' in policy lexicons, but we have opted for 'exclusion' in the bulk of this report as most of the institutional responses to the heroin crisis in Ireland emerged under this rubric (see Saris 2002b).

4 See 'Drug use in Ireland and Northern Ireland: 2006/2007 drug prevalence survey: cocaine results: bulletin 4', http://www.drugsandalcohol.ie/11528/.

into this supposed continuum. Indeed, the relative invisibility of off-label prescription drug use and abuse in Irish drugs policy and the widespread tolerance of hash and cannabis at all levels of Irish society, tends to exoticize the image of an 'addict' or a 'junkie', producing a symbolic and policy gulf between different sorts of users who share similar blood chemistry at least some of the time. Even the idea of a drug for treatment, like methadone, can exist in a wide variety of ways in different social settings – from rigorously prescribed legal usage to illegally purchased pharmaceutical, albeit for therapeutic purposes, to being a street drug in its own right.

Thus, the stories below should be read from the perspective of making connections between drugs and the social practices that, on the one hand, make them more likely to be abused, and, on the other, those practices which drugs support. The narratives are broadly divided between people who see therapeutic possibilities in their lives: that is, those that can see some potential for change, as against those who claim to not have an issue with drugs or who feel that, while their drug problem is largely finished, they have not 'recovered' in any meaningful sense. After a decade and a half of declared crises, confident interventions and continuing problems, it is clear that whatever else 'the drugs problem' is, it extends much beyond certain chemicals and specfic users. It is bound up with lives that are often lived at the margins; it is central to much local economic activity (and indeed any one user represents but one endpoint, amongst thousands of others, of a lucrative black market that is international in scope, see *e.g.,* McCoy 2001). Drug use both connects and isolates individuals, networks and communities. We conclude with a discussion of what this complexity implies for the conception, provision, and understanding of the effectiveness of 'services'.

METHODOLOGY

The CCLDTF Research Advisory Group recognized that to deepen the knowledge and understanding of the changing nature of illicit drug use in their area more than quantitative methods were required. They defined much of the methodology when they chose an anthropologist to head up the research and agreed that they wanted data informed by ethnographic engagement. In other words, ethnography was both the research sensibility, as well as the primary method used in the study. Nonetheless, the study also had significant 'quantitative' components, which will also be briefly described in this section, but whose results will be discussed in a future work, whose findings, for the purposes of this report, are presented in some text boxes embedded in the main body of writing and some summary tables placed in the appendix.

Ethnography can be defined as a perspective as well as a means of data collection (Woolcott 1973). Like Brewer (2000), we see ethnography as not just one particular method of data collection, but as a style of research that is distinguished by its objectives, which are to understand social meanings and the activities of people in a given setting. Its approach involves a close association with, and often participation in these settings. In this way it was possible to employ different methods including 'the survey' within this broad theoretical framework.

The CCLDTF Research Advisory Group met regularly with the Principal Investigator and the Field Researcher to discuss progress, identify emerging findings, access appropriate information resources, and, importantly, decide upon shifting the focus of the research, given emerging findings. In broad terms, the following table maps the course of the research in terms of what issues were explored, in which places, at what times, and through which modalities.

Table 1. Research Schedule

Month	Fieldwork Site	Topic	Methods used
October-November 07	Services	Provider's perspective	Informal interviews
December 07-January 08	Drop-ins & community-based services	Users experience of past and current drug use	In-depth interviews Participant observation Field notes
February-March 08	Drop-ins Community-based Youth Services Dolphin House, St Michael's Estate, and the Bluebell area	as above, along with Crack Changing styles of use Changing environment What is treatment? Extent and type of illicit drug use	In-depth interviews Participant observation Field notes Reflexive notes Questionnaires
April-May 08	Drop-ins Community-based Youth services Dolphin House, St Michael's Estate, and the Bluebell area, homes, GPs, and Clinics	Young people's experience Focus on one community Extent and type of illicit drug use	In-depth interviews Focus groups Participant-observation Field notes Questionnaires Reflexive notes

June –July 08	Drop-ins Home visits Dolphin House, St Michael's (Estate) clinics	Young people's experience Behind closed doors Extent and type of illicit drug use	In-depth interviews Participant observation Field notes Reflexive notes Questionnaires Validating
August–December 08	Clinics and Individual call-backs	Extent and type of illicit drug use In-depth interviews	Re-visiting Cross-checking
November 08-end of study	NUIM	Coding and writing	Write-up

Ethnographic Methods

Participant observation (PO): In this study PO involved the acquisition of a 'new role' in largely familiar but sometimes unfamiliar settings. The 'familiar settings' are defined here as those familiar to services that comprise the CCLDTF. The 'new role' was that of the field researcher. The unfamiliar settings were those outside the services delivered by the CCLDTF agencies. Because the services represented by those involved in the CCLDTF included such a broad array from youth services to drop-ins to Health Services Executive (HSE) Clinics to community representation the so called 'familiar setting' could not be ruled out if understanding of drug use in the area was to be achieved. In the end and as a consequence of emerging findings, chosen 'base' sites were largely those that fell into the 'we know' category. These were St Andrew's Community Centre in Rialto, Kavanagh House in Inchicore, and the Youth Project and the Bluebell Addiction Advisory Group (BAAG) in Bluebell. Over the course of the fieldwork, these sites were visited regularly. From these sites the fieldworkers would identify other sites in which to observe and describe domains and practices. In Rialto, these included a Youth Project, Dolphin House, individual flats, as well as accompanying outreach workers. In Inchicore, they included St Michael's Estate, old sites for using, the Medical Centre, and the Health Centre. In Bluebell, they included the Youth Project, private houses and flats, as well as accompanying outreach workers.

The *descriptive observations* start when the researcher enters the social situation initially to get an overview and determine what is going on. Broad questions were asked: How is space organized? What is going on? Who are the actors? What are the activities? What objects are present and how are they used? For example, the following is taken from descriptive notes concerning the Community Drugs Team at Kavanagh House.

> Kavanagh House is a modern three-story building between a pub and a bookmakers. There is a crèche in the basement, offices and meeting room on the upper levels, where the project workers are situated. On the ground floor is the 'drop in'. This is one room with a divider to separate out an office-style and reception area at the front and a sitting area at the back. Next to the sitting area is a small kitchen, which opens to the yard, which has more seating and a shelter. The sitting area is small with six or seven armchairs and a coffee table. The age range of the clients seemed to be younger than in St Andrew's, mostly in the

late 20s. People drop in for a couple of hours, chat and have a cup of tea. Sometimes there is a massage therapist present in a room in the back but 'clients' don't necessarily come for a specific treatment or an appointment. There is no methadone prescription here, as it is available across the road in the Health Centre.

While at one of the sites we discovered that one of the clients was regularly using crack. We felt that a focused observation was required to look at the acquisition and use of this drug:

> Now, M and her friend J were 'getting some rock'.
> As we stood on the corner they kept looking down the road towards the cars to see if the guy was coming.
> 'Is that him' one would ask . 'Yes ... no.'
> The excitement was palpable.
> A car with 2 guys in it came in and parked.
> 'Go on see if that's them,' J told M.
> 'You'se walk on,' M told us and left to go to the dealers.
> We crossed over the road. Within two minutes she was back.
> 'Did you get it?' J asked.
> 'No, they've to wait for ____ to come,' M explained.

Such descriptions of day-to-day behaviour, along with notes on reported speech, transcripts from recorded interviews and our observations of those who shared aspects of their lives with us form the ethnographic data. This data and its handling is embedded in particular ethical-moral contexts.

Ethical Considerations

Clearly, this sort of research confronts the research team with various interpretive and ethical issues. In any situation involving potentially vulnerable populations, for example, research has an ethical burden to (a) not harm subjects involved and (b) have a reasonable expectation of benefiting such individuals. Consequently, Ethical Approval was sought from NUI Maynooth's Research Ethics Committee for this work. Based on this, permission to interview in HSE sites was also granted to the research team for the survey. Interview and survey consent forms were signed by participants, once a complete explanation about the research purpose and process was given. We have also consulted with each of the participants in this study, whose story has been developed at length, to get feedback on the accuracy, fairness, and level of identifying detail in these narratives. Finally, there were also safety issues for the primary Field Researcher that were reviewed on an ongoing basis.

Interviewing

Formal recorded interviews were conducted with fifty-one people, including twenty-four life histories and eight group discussions with twenty-nine young people. Return interviews were recorded with six of the initial interviewees. Interviews were both semi-structured and unstructured. Semi-structured interviews had a very flexible schedule in which a number of topical points would be covered. Unstructured interviews arose spontaneously, at which time the participant would be asked for permission to record the conversation. A further twenty-four formal and informal interviews were conducted with service providers. Six of these were recorded, and detailed notes were made and coded on the other eighteen. Dozens more people were more fleetingly interacted with, often multiple times, at specific research sites.

Recording Data

All recordings of interviews were transcribed. Field notes were kept or recorded during or after each 'field' visit. Rough field notes were also transcribed. Photographs were taken, when appropriate. The Field Researcher also kept reflexive notes. Reflexivity allows the researcher's experience of doing the study (Ellis and Bochner, 2000) to be included in the analysis and therefore can highlight areas of greater and lesser subjective connection between researcher and consultant. Also, while formal interview transcripts potentially provide rich fragments to evidence some aspect of ethnographic understanding, such understanding stretches beyond the transcript. The density of connections between the researchers and their consultants are themselves part of what is known ethnographically.

Quantitative Methods: The Survey

The survey: A questionnaire was adapted from one previously used by the Principal Investigator. This was then piloted and amended (see Appendix). The questionnaire was interviewer-administered by the field researcher or a trained assistant. It took approximately twenty to thirty minutes to conduct and collect demographic and employment data, current and past drug use as well as prescribed drug use, risk behaviour, morbidity, crime involvement and service usage data. Network data to estimate opiate prevalence and services coverage was also collected.

A target population of 100 current opiate users or people on methadone was included in the survey. This was deemed a significant proportion of the opiate users in the area, based on the fact that there was a point prevalence of 240 residents in the area on the CTL at the start of the study and coverage was thought to be high. Sites of recruitment for the survey were 'drop-ins' 'community services', clinics, a General Medical Practitioner (GP) surgery and referrals from initial contacts. For the most part the survey was built around the ethnographic research.

Validity

A number of processes were used to cross-check emerging findings with other sources as well as other data types. Indeed, the ethnographic approach requires a constant iterative process. This included going back to the same interviewees to check interpretations, presenting emerging findings to the Research Advisory Group of the Task Force, while developing meaningful categories through which data can be coded and interpreted.

Methods of Analysis

Analysis has been a continuous process: data reduction (selecting units of data from total universe of data), data display (assembling data) and conclusion-drawing (interpretation of the findings). The Principal Investigator and Field Researcher met at regular intervals, having reviewed the data in manageable units to conduct analysis. Themes and categories were identified and patterns (recurring themes, relationship between the data) were discovered. Negative cases (explaining exceptions and things that do not fit) would then be examined.

The quantitative data was analyzed using descriptive statistics on the statistical data management programme, SPSS (v.14), but we re-emphasize that we have not focussed on this aspect of the research in this report, much beyond providing broader illustrations of the conclusions emerging from the ethnographic work.

WHAT IS A DRUG-USER?

Any ethnography of 'drug abuse' is in danger of moving naively between patterns of behaviour and a reified identity, with little sense of the social history and institutional landscapes that help to produce the constellation of problems it seeks to understand. By reified identity, we mean the process whereby a label, in this case for a stigmatised behaviour, stands in for a complete description of a person. Thus, a focus on drug use makes possible a double-ended mistake that needs to be avoided. The first is that any of the lives we discuss, however arguably damaged by an attraction to certain pharmaceuticals, is only rarely defined solely by such behaviour. These individuals are also sons and daughters, fathers and mothers, partners and lovers, and employees and community members. Their narratives of 'use', therefore, were always connected to concrete social practices and specific social concerns – keeping or regaining custody of a child, connecting with friends, or servicing a debt. The second issue is more specific, but therefore easier to miss, i.e., that the stress that policy-makers and community activists place on 'crack' or 'heroin' as clear and present social dangers obscures the ubiquity of poly-pharmacy in the lives of our consultants. In this regard, we wish to emphasise the role of legal pharmaceuticals, such as benzodiazepines, as well as the off-label use of other drugs, especially by those on long-term Methadone Maintenance Therapy (MMT).

At the same time, the category 'drug-user' gains a certain social reality through specific institutional procedures – from arrest records to the Central Treatment List (CTL). Anthropologists and other social scientists often refer to such lists as 'normalizing technologies', insofar as they produce groupings of people who are easy to count and who seem to share obvious features with one another. On such a list, for example, one drug-user looks much like another, but closer to the ground, it is very difficult to see these bureaucratic categories as meaningful groupings. Such categories also principally obscure important local patterns of usage that are shared much more widely than the population labeled 'drug-user'. Legal drugs, like alcohol, and off-label use of legal pharmaceuticals, such as minor tranquillizers, for example, present enormous challenges to the lives of many of our consultants, just as they do for many people who would never consider using heroin or cocaine. Sometimes, these challenges occur when people are using one of the obvious 'problem' drugs, but not always. At the same time, other drugs – cannabis and its derivatives, for example – scarcely register in conversations of local drug use, even though some younger people with whom we interacted smoked hash almost continuously throughout the day. Still other compounds, say, some of the more exotic party drugs, such as ketamine, only appear as asides in conversations, generally about other activities, such as discussions of clubbing.

Our point is that there is no obvious way to define a priori 'drug', 'drug use', and 'drug abuse' in this study. Instead, we wish to present two broad patterns of lives intertwined with drug usage, each based on different relationships to 'treatment'. The first (larger) set is composed of scenarios built around Methadone Maintenance Therapy (MMT) as some kind of therapy. The individuals portrayed here, even if they resist aspects of the therapeutic regime, all believe that their lives can change for the better in part through being on prescribed methadone (and hence on the CTL). At the core of these cases are people who have experienced heroin use as a problem in their lives, although not one of them ever only used heroin. In these cases, we stress the complexities of being 'in treatment', or, perhaps better put, just how much problem drug use is in fact hiding in the most common ways that 'treatment' is defined. Yet, in each of these narratives, subjects hold on to the possibility that there is an 'after' moment to their drug-using lives.

The other (smaller) set of narratives are people who do not see methadone as therapy, or, indeed

who often reject any sense that they might need treatment at all. Many of these individuals (generally younger people), however experimental they might be, are very negatively disposed towards heroin, and, therefore, simply do not conceive its use as possible. Clearly, if they continue to avoid heroin, then they will never appear on the CTL. Others, whom we know, are using heroin, but do not see methadone as an option yet. Still others are on methadone, but stalled, if you will, not likely to change in either a positive or negative direction. Methadone has provided them with some distance from their riskier behaviours connected with heroin, but any chance of reintegration with the broader community looks remote.

Despite their differences, however, all of these users can be discussed in terms of their style of use at different times in their narratives, which can be roughly labelled, chaotic, disorganized or stable. We arrive at such a categorization because, in so many words, users themselves employ such concepts. Problematic users, that is, those who come to the attention of the authorities, for example, take in all of the first and much of the second category. While there is scope to quibble about the boundaries between these patterns, we are actually drawing out some fairly basic observations that most users recognize in both themselves and others, and ones with which we feel many coalface workers would be in agreement. In other words, the idea of styles gets to the sense that an individual career of use intersects with the category of 'social problem' in different ways.

Thirteen of our ninety-two survey respondents felt that they did not have a drug problem. Nine of these were on prescribed minor tranquillizers. Six occasionally used street benzos, cocaine, crack or heroin.

By 'stable' we mean that both the amount of drugs consumed and the various networks of friends, families and associates are perceived as not changing much on a day-to-day, week-to-week, even month-to-month basis. Users find periods of stability (sometimes quite lengthy ones) on heroin and methadone, cocaine and benzos, indeed nearly any combination of drugs.

> Martin is 33 years old. He works for a computer company and lives with his mother. He is on methadone with the local GP and is very stable. He smokes heroin alone about once a month and takes no other drugs. He drinks moderately once a week.

> Catherine is 32 years old. She lives with her two children. She smoked heroin in the past and until very recently snorted coke once a week as a 'treat'. She credits her stability to the fact she is working. She is on methadone in the local community. She times her cocaine usage so that her urine sample will be clean for the following week. She never injected.

Of eighty-three people who were on methadone every day of the past ninety days, 59% had also used heroin and 47% had bought minor tranquillizers on the black market.30 % had smoked crack, 22% had used powdered cocaine and 14% had bought methadone on the black market.

When stable, use is a factor in an individual's life but is not perceived as the dominant one. By 'disorganized' use, we mean a pattern of use, where amounts needed are felt to be in flux (generally increasing) and the user experiences stresses within the various networks in which they are embedded because of this change. Also, users more frequently come into contact with the Gardaí and/or a hospital during periods when use is increasing, as they tend to take more risks in both procuring drugs and/or raising resources to support this activity. As treatment is often offered as an alternative to criminal sanctions for early or minor offences connected with heroin in particular, many of these users appear 'in treatment' (that is get on the CTL) for the first time at this point. At the same time, other

heroin-users outside of treatment will sometimes look to procure methadone illegally as a means of slowing their increasing consumption of heroin. It is this group of disorganized users, in our opinion, who make up a large proportion of people consuming both heroin and methadone simultaneously. One can also go into this pattern of use with cocaine.

Of the sixteen people who used heroin every day for the past three months all bar one were being prescribed methadone (three had only started within the last month). Nine were buying street tranquillizers and six were smoking crack. Five had used cocaine powder in the past three months and five had bought street methadone.

Brendan is 34, and he is both a heroin-user and an occasional dealer. He has never been on a methadone programme because, 'it's a life sentence.' His probation officer and partner have talked him into coming for treatment. Tellingly, he looks back on his dealing career as having been very successful until he started using cocaine. He started to use more and more, while taking risks he wouldn't have dreamt of when he was only using heroin.

Louise is 34 years old. She finished her Community Employment (CE) scheme recently. She lives with her sister. Louise is on methadone and prescribed sleeping tablets and an antidepressant. She smokes a couple of bags of heroin every few days. Recently, she has been smoking crack every day. This is her main problem drug at the moment. Her weight loss is noticeable.

Fifteen of our survey respondents spent over €250 (average of €422) on drugs in a typical week. Eleven said they were currently involved in criminal activity to make ends meet. Seven of these who reported earnings from crime made between €400 and €6000 in the past month.

Finally, 'chaotic' users both experience use as the main feature of their lives and experience their networks and social personhood fraying as a result of their abuse. Increasingly large risks are taken in procuring resources for, in looking to buy, and in modes of use of heroin and cocaine. Increasing amounts of one or both drugs are also used. One aspect in this chaotic stage that still is not generally appreciated is that it is often self-limiting: at some point, arrest or serious injury occurs, or injecting either cocaine or heroin simply becomes impossible due to vascular damage or other health issues. People committed to treatment, then, will often look back to such chaotic periods of their lives, where everything was falling apart for them, as the moment when they realized that they had a desperate problem that they needed help in overcoming (see also Saris et al. 1999b).

Niall has been on a crack binge for the past two weeks. He was robbing to get more daily, and he had crossed boundaries he was very ashamed of. He has been sleeping in car parks and chasing 'more rock' daily. He is on methadone and only very occasionally uses heroin. He regularly takes large quantities of minor tranquillizers (300mg Diazepam on a typical day). He is on prescribed benzodiazepines as well as an antidepressant.

Andrew is twenty-three years old. He had been living with his grandmother, but was homeless when we met him. His drug use had spiraled out of control. He was looking for a place on the local community-based methadone programme, which could not take him on because of his homeless status. He had also been barred from his local GP. He was smoking heroin and buying minor tranquillizers illegally. He was finding it more difficult to fund his habit and was robbing shops to do so. He was thinking of self-harming, if he didn't get things under control soon.

We call these patterns of use, 'styles', because the term conveys some of the fluidity of their boundaries, as well as a sense of how they can merge into one another over time. These styles represent, at any one moment, populations that overlap certain institutional categories (disorganized heroin-users, for example, can be found both in and out of treatment, often using both methadone and heroin simultaneously), while presenting different challenges to various intervention strategies. The life cycle of the user, as well as the stage in their using career, clearly influences their relationship to these styles. Older users, in our experience at least, become more risk-averse, especially with respect to contact with the Gardaí, and in terms of their own harm-reduction strategies (see also Fleisher 1995).

Of the seventy-nine people surveyed who had past drug treatment, thirty-nine (53%) had experienced a structured/supervised detox at least once.

Of the seventy-eight people in our survey who believed they had a drug problem, only thirty-four (44%) said their main problem drug was heroin. Twelve felt their main problem was cocaine or crack. Fifteen said it was methadone. Eight said it was benzos and three saw alcohol as their main drug problem.

The logic of Methadone Maintenance Therapy fits into users lives in a particular way. It is meant to provide a mechanism for opiate stability, but this stability is rarely as neat as many outsiders assume (that is either methadone or heroin), nor is it often clear what comes after this stabilization. Many 'former' users on methadone, for example, lack marketable skills while dealing with many other health problems and psychosocial burdens. This is not a trivial issue: according to the logic under which it was developed (see Dole and Nyswander 1967, Agar and Reisinger 2002a and 2002b, and Saris 2008), a user could stay on methadone for decades. In practice, most long-term users have experienced different moments of attempted (sometimes successful) detox and others where only avoidance of heroin was the goal. Such stability comes packaged with other things that might not be so apparent – from the way that methadone allows bodies to be managed in the built environment, to how time is periodized through the dosing schedule, even to how such bodies can be identified visually within the community (Saris 2008). Yet the stability of methadone, like the stabilization of the number of drug-users in the Greater Dublin Area at around 14,000 (Kelley et al. 2004), highly concentrated in specific areas, comes at a price. In the latter instance, it showed that opiates had become institutionalized at levels far beyond what was imaginable only a decade before. Methadone's institutionalization, on the other hand, has stabilized users in place, sometimes for more than a decade, yet many of these individuals still lack an obvious 'after' moment to this treatment.

Not surprisingly, most users are ambivalent about both this drug and the treatment regime. The majority of users with whom we spoke, for example, do not consider methadone 'treatment' as such. Some talk about replacing 'one addiction with another' or even more severely, being 'a government junkie'. Methadone, like heroin, seems to freeze time for many users (see Marlowe 2003, see also Negroponte 2003), the cyclical routine of 'maintenance' overwhelming the linear narrative of a life trajectory. Nonetheless, methadone is at the heart of the Irish opiate-centric treatment/service infrastructure, one that has matured over the course of the last decade and a half. This structure developed in response to a still older fearful imaginary that had heroin at its centre, as a novel terror in the process of ripping apart communities. However accurate or understandable was this fear at one point, the situation is now different.

PLEASURES AND PERILS

The co-use of methadone and heroin is quite common in our experience. For example, 59% of our survey participants, who had been taking methadone daily for the previous three months had also used heroin over the same period.[5] Nonetheless, while this issue has been recognized by researchers in Dublin for some time (e.g., Cullen et al. 2000), it has yet to make much impact on drug policy. Why continue to use heroin, though, if methadone is doing its job? Methadone, an opiate agonist, operates basically by getting to the mu opiate receptor ahead of heroin and, consequently, blocking the euphoric qualities associated with this drug. It also binds to this receptor for longer periods, thereby significantly reducing withdrawal symptoms, that is, getting 'dope sick' (Dole and Nyswander 1967, 1976). Without either the carrot of a 'high' or the stick of withdrawal symptoms needing to be countered, what possible reason exists to continue heroin ingestion?

One possible explanation is to be found in the variability within the population that reported co-use. The frequency of use in the past ninety days varied significantly: (minimum one day, maximum of ninety days, with an average of thirty-four days). Yet, one third (33%) used heroin regularly (more than sixty days out of ninety). Forty-three percent infrequently (less than thirteen days of ninety) and the remainder (24%) used between thirteen and sixty of the previous ninety days. Clearly, users find a wide variety of uses for methadone in many different settings, and in turn, the use of heroin can satisfy other needs than the search for ecstasy or the avoidance of withdrawal symptoms. Sometimes, like Ken, users find that, on MMT, they become more professional dealers, able to sell heroin without risking the profits to fund an opiate habit. Ironically, Ken now spends his money on crack, to which he acknowledges he is now 'addicted'. At the same time, while he finds he can be among people smoking heroin without temptation to use, he still finds pleasure in the setting.

> You know the way it is, I'd be able to sit there now and if there was ten people sitting there at the moment, the others would say 'yeah'. I'll roll the gear for them and it wouldn't bother me, some people wouldn't be able to do that.

Of course, this sort of 'high', when achieved through the ritual of drug-using as such, is obviously not affected by methadone. In particular, when some 'addicts' develop a fascination for the route of ingestion, rather than for the drug itself, methadone does not even curtail 'risky' behaviour. Darragh, for example, tried to articulate the attraction of injecting, and how the experience can be largely divorced from the drug that is being injected:

> Darragh: I don't really know, it's just eh ... it's just the sensation of getting it all together and all, like.
>
> Researcher: And how long does it take to get together?
>
> Darragh: It depends on where you are really, like if you're in your own place you'll do it slow, do you know what I mean, but if you're in a block somewhere you'll do it as fast as you can, [be]cause you don't want to be caught by the neighbours or whatever. But I don't know... it's like, say I stuck a needle in me arm now, by accident, like, that would hurt me. But if I'm having a turn-on, I won't even feel that going in. But if I do it by accident it will actually hurt.

5 In the context of this report 'use' refers to any method of consumption. Among most of our long-term heroin-using sample, however, 'use' generally means 'inject'.

> Like it's like, you get so used to the needle going in sort of thing. It's sort of hard to explain. But like, some people say – now I don't know if this is true or not but some people say it – when you're strung out like that, you can actually get water, and inject the water and your cravings will go away. Now I never tried it now [be]cause I wouldn't bother looking for veins to inject water in, but a few people have said that now, that the cravings actually go away if you're injecting the water.
>
> Researcher: So there's a separate need you have to actually inject?
>
> Darragh: Yeah, when you're injecting it's like you have two habits. You have a habit of injecting, and then you have a habit of the gear. Where smoking it, to be honest with you smoking it, I think it's all in their head. I can't even understand how they get sickness when they're smoking. Don't get me wrong, I understand that it is a sickness because the gear is going into them but I mean, there wouldn't be much of a sickness. I smoked the gear when I first started on drugs, and it's like I was never sick from it until I started using. But in saying that, I think I'm more addicted to the needle.

Darragh describes the central place injecting occupies in his daily life: he wakes up in the morning and the first thing he thinks about is using (injecting) that night. He always uses at night. He plans ahead. All day, he thinks about using that night, when and where, and what he needs to do to get to that point. He visualizes the process. He is slightly anxious all day waiting for the evening to come. He would happily use all day but he is trying to cut down so he just does two bags at night. Darragh, when he can, also uses alone. His preferred use is personal, private, and intimate. Getting needles is a bit more inconvenient at the moment because the health centre stopped dispensing them, so he has to go to Merchants Quay. The odd time he is caught short and has to borrow. He does not like doing this, as these 'works' (needles and syringe) may have been previously used. When the night comes, if he has the place to himself, he takes his time, prepares everything and injects his heroin. He reports that he feels fine and that the anxiety is gone.

> Darragh: It's, it's like a relief coming over you, do you know what I mean? Like eh...now, I don't even get stoned on the two bags I don't, no, but if I didn't do them, I'd be awake all night, sort of thinking of it. The sensation is there in me head. If I haven't got them I'll tell meself that I'm going to be sick and all. Even though I'm not sick, do you know what I mean? Like I know ... I know
>
> Researcher: You're looking out for the sickness?
>
> Darragh: Yeah, yeah. I know now that I won't be sick, but if I don't get it it's like ... I'll convince meself that I'm going to be sick, do you know what I mean? It's a curse. Curse.

The next morning he wakes with injecting on his mind again.

There are number of ramifications arising from Darragh's story. It may be, for example, that some people on Methadone Maintenance Therapy might do better on higher doses – some therapists in the US, for example, seem to prescribe much higher daily doses than their Irish counterparts (up to 200mls, whereas in Ireland a Level 1 GP is not allowed prescribe more than 120mls). The average dose of methadone prescribed to the persistent heroin-users in our sample was 80mls per day (min 28mls, max 170mls, depending on the Category Level of the prescribing GP). Darragh's interest in

needles, though, is clearly not dose-dependent, and it seems largely indifferent even to the quality of the heroin. Insofar as one of the main pillars of the harm-reduction logic of MMT is that injection is less likely to occur, it is clear that Darragh poses a risk to both himself and others, as he continues to inject, while trying to source a supply of needles outside of the exchange. Anyone who uses in this fashion, then, is potentially a danger to a person with whom he is sexually intimate, and, if he decides at some point to inject with others, he becomes a significant public health problem as well. Even in the most clear-cut cases, when heroin is the main problem drug and methadone is largely successful in keeping people away from craving the drug as such, the social context of use, or the patterns of social interactions of a 'former user' need to be understood before someone can be declared 'clean' or indeed, that they are curbing 'risky' behaviour.

THE HISTORY OF THE DRUG PROBLEM IN DUBLIN: AGES AND EPOCHS

It is impossible to discuss the 'drugs problem' anywhere in Ireland without providing a recent history of heroin in the country, both because of the devastation this drug wreaked in many places, and the profound effect it had in shaping not just 'treatment' but the governance of many poorer communities. Especially (but not exclusively) in Dublin, Task Forces and Drug Teams became increasingly important, not just as conduits of treatment, but as local institutions in their own right. We construct this history, below, through the reminiscences of several individuals who lived through critical moments of this problem. We also use individual reflections (Cases 1-4 below) to underscore a point to which we often return in this work concerning the importance of life-cycle for understanding crucial aspects of how individuals use or seek treatment, and how different types of users measure their understanding of a 'drug problem' and a 'problem drug'.

In Ireland, heroin emerged as a social problem in the 1980s in the midst of a sustained economic crisis, partly connected to Irish emigrants who picked up the habit in 1970's London, but quickly settling into specific communities – largely young men from so-called 'excluded' communities (as that phrase became increasingly central to Irish Social Policy discourse in the 1980s and into the 1990s), who injected. By the end of the decade a basic detox programme had been organized by the Irish government, at a time when use seemed to have stabilized.

CASE 1: Forty-eight year-old man with a history of intravenous heroin use

Paul started drinking at eleven years and smoking hash at fourteen years. He came from a big family. He says he did poorly in school due to behavioural problems and poor concentration. At sixteen he was locked away in St Patrick's for 'robbin money for drink and clothes'. He served nine months and within a year was back in prison. Then he started taking painkillers (palphine, diphenol). He took heroin first in 1978, when it was 'beginning to creep in'. People he hung around with offered him some, a well-known Dublin criminal family were bringing it in from London. He would have tried anything at the time. He didn't even know what it was, and didn't get much out of it either, at first. He started injecting almost immediately. He knew he had a problem before he went to prison again. When he got out in the early 1980s, he dabbled a bit, but managed to keep things more or less together for a couple of years, using heroin on weekends with a core group of friends. He did everything else: LSD, speed, coke and magic mushrooms. He was also drinking and swallowing vast quantities of prescribed and non prescribed benzos.

Heroin was starting to destroy people he knew. He said:

> People couldn't understand what it was doing to them, to their friends or to their daughters or to their sons, or brothers or even their mothers, they just couldn't understand it, couldn't comprehend the effect it was having on people so, hence, the vigilantes was born then.

He got strung out, tried detoxes and relapsed. He went on MMT, however he didn't like the terms, that is, to have his kids taken away from him if he gave dirty urines. Eventually he got 'sick and tired [of] being sick and tired' and he went to the Community Drugs Team for help. Eventually he took the drug free option. He is now ten years drug-free.

In the 1990s, a new wave of heroin emerges. Again, excluded communities, especially in Dublin, are to the fore but several important differences are there as well. First, heroin is getting cheaper at that point and stays pretty cheap for the next several years. The destabilisation of Afghanistan, the often-unpleasant nature of Great Power politics whose representatives often collude in this trade (see McCoy 2001), and the flows of guns and drugs push this very cheap heroin wave towards Europe by the early 1990s. Locally, a little more money is circulating in Ireland (with the benefit of hindsight, the first mewling of the Celtic Tiger is audible) and a new scene for young people, raves, becomes increasingly popular throughout the 1990s. These kids knew uncles and older brothers who were 'junkies', and they decided that they weren't going to be like them. Second, during this same period, a new risk is becoming widely appreciated – HIV/AIDS. This sense of risk focuses on the danger of injecting, with the result that heroin and syringes become partly uncoupled from one another in local moral worlds. At the same time, the relative quality of the 'gear' makes smoking an easy possibility (see Saris *et al.* 1999a and 2002b). The ready availability of cheap heroin, and the pairing of smoking heroin with Ecstasy opens up new populations to heroin, laying the groundwork for a much grimmer boom.

CASE 2: Thirty-seven year-old woman with a history of heroin use (smoking then injecting)

Mary avoided heroin through her teens, as it had a stigma. In her twenties, however, she started going to raves and using Ecstasy. It wasn't long before she started to take heroin to 'come down' off the Ecstasy.

> You'd see people smoking heroin and that in the raves, upstairs and that's how it started.

Eventually she went to a clinic for methadone but was 'put off' because she was giving 'dirty urines'. She found it very hard to get back onto a clinic list.

Mary started injecting in order to get onto a clinic and had to show the track marks to prove it. After a couple of years she stopped the heroin and was stable on methadone.

> But I was drinking fairly heavily, you know, sort of [a] substitute, but you're not getting really stoned on the methadone, you know, you sort of substitute one thing for another, so I started drinking and smoking hash.

She was also put on antidepressants and sleeping tablets by the doctor. She didn't want to be on methadone so asked to detox, but found it hard to get the support of the doctors. One day she quit everything, including the clinic, and is now seven years drug-free.

By the middle part of the 1990s, people working on the ground are declaring a crisis in certain neighbourhoods in Dublin, but government response takes some time to organize and new forms of indifference make themselves felt. Ironically, increasing wealth in Irish society starts to make pockets of severe deprivation look like individual and local failures rather than collective responsibilities. The so-called 'spatial turn' of Irish government policy to 'social exclusion' further exacerbates this trend (e.g. Hasse 1999, amongst other contributors to Pringle *et al.* 1999). The sense that Ireland was a materially poor society, which happened to have poorer members to whom the society had an obligation, begins to be replaced by the sense that Ireland was a collection of sometimes weakly interacting communities, some of whom had serious problems to address.

CASE 3: Twenty-five year-old woman with a history of smoking heroin

Carol is a 25 year-old woman who smokes heroin twice daily. She has a decade-long history of taking tablets and smoking hash and heroin. She has never injected. She grew up in an environment in which all her peers were smoking heroin. At fourteen she started drinking and smoking hash, she was thrown out of school at her Junior Cert year and started smoking 'gear' at fifteen.

> It was everywhere: people were selling it as right outside your door.

Carol started selling it too and then smoking it. For a time more recently she snorted cocaine but not anymore.

> You wouldn't know what it's been mixed with.

Currently she smokes heroin, takes benzodiazepines, and smokes hash. She is now on a methadone programme.

This is the historical context in the mid to late 1990s in which most of the Local Drugs Task Forces then later Community Drugs Teams organize, often alongside other, extra-legal community responses to the problem, such as direct action groups (for an early look at some of these groups, see Bennett 1988). Local Drugs Task Forces rapidly become some of the more stable institutional presences in certain Dublin neighbourhoods, effectively lobbying for funds and scoring several successes in setting up local treatment options. However, while such groups are often imaginative and experimental in defining treatment, the Irish government stays wedded to Methadone Maintenance Therapy as its official way of treating the problem. In areas that have the longest-standing heroin problems, we can see the numbers on the CTL gradually rising during this period, eventually settling on something like a saturation point in the late 2000s. In other words, nearly everyone who can benefit from methadone in many places in Dublin is now on the CTL, and we would expect that newer recruits will start to come increasingly from those areas outside of Dublin that are newer to mass heroin use. Despite MMT's benefits for many former users, in our experience, many people on a methadone programme do not consider the drug 'treatment'. At the same time, the policy choice of making a pharmacological workaround for only one drug the prototypical definition of 'treatment' at the national level, makes other drugs which are also being taken by heroin-users (and more broadly by many others in the community) harder to imagine as an object of services. The fact that some of these drugs, such as powder cocaine, are widely used (and frankly enjoyed) by wide swathes of Irish society makes the definition of problem usage and effective intervention even more difficult to conceptualize.

We asked our survey participants to list five opiate users in their immediate network and then asked how many were on a methadone programme. We found that 72% of those named were on methadone. With 262 people living in the Canals area in receipt of methadone this provides a prevalence estimate, of 363 opiate users in 9618 adults or a rate for the area of 38 per 1000.

CASE 4: Twenty year-old non-opiate drug-user

Kim, aged twenty, is currently drinking, and smoking hash daily and snorting coke on weekends.

She is aware that she has not been drug-free since age twelve. She occasionally worries that she may have a drink and/or a hash problem but does not see herself as addicted to coke. She no longer takes E because it makes her depressed.

She explained that she does not believe she is addicted to cocaine. Though she consumed it regularly every weekend she was not dependent on it Monday to Friday.

Kim's uncle was a heroin 'addict', and she insists she would never touch it. She works part-time and socializes on the weekend with her friends who are working. She is not attending any drug service.

During the last couple of years, though, things change again. Heroin is still around, but young people have increasingly stigmatized it. They have seen older brothers, uncles, aunts and other relations devastated by gear, and want no part of it. Indeed, even some low-level dealers seem surprisingly fastidious when discussing selling heroin at all.

Researcher: But like, would you, em, sell heroin as well?
Dealer: No.
Researcher: No, but if you were asked for it by your customers, could you get it?
Dealer: I wouldn't do anything like that.
Researcher: Why?
Dealer: I wouldn't associate, it's too dangerous of a drug. Like that's murder like if you're
caught with something like that, like attempted murder giving that to someone.

Using these four cases, then, we see an initially small population of heroin-users, which increases dramatically in the 1990s, with many new users being recruited to the drug amongst a population that is also using a lot of other drugs as well. By the late-1990s, a treatment regime for opiates is beginning to mature, while high levels of opiate use have become a fact of life in certain 'socially excluded' neighbourhoods in Dublin. The current situation seems to show a saturation in opiate consumption. Far fewer new users are being recruited and even some dealers now express distaste with respect to handling 'gear'.

THREE AREAS, THREE VARIATIONS

As an administrative unit, the 'Canal Communities area' is very much a child of the history outlined above, especially the intersections between Irish government policy to deal with the problem of severe poverty and social exclusion from the late 1980s and the various local responses to this marginalization. The so-called spatial turn that Irish Poverty Policy adopted (see Fahy 1999) identified the places and populations that showed the greatest concentration of markers for social exclusion and attempted to focus resources on them, often through semi-government channels, such as Community Development Groups and Local Drugs Task Forces (for a summary and a critical look at this process, see Saris and Bartley 2002). As part of this process the CCLDTF was one of the Local Drugs Task Forces set up in 1996-1997, comprising groups that were dealing with the drugs issue in three slightly different communities.

As we can see from Table 2, which displays measures of deprivation for the Canal Communities Partnership area (Haase and Pratschke 2008), the population has been relatively stable since 1991 ranging between 12.4 thousand to 13.3 thousand. The Absolute Index Score measures the actual affluence/deprivation of each area on a single fixed scale.[6] This score increases significantly between 1991 and 2002 reflecting the exceptional economic growth nationally, however in 2002 it begins to decline. The Relative Index Score[7] which is more important for targeting resources towards disadvantaged areas show the position of any given ED (or aggregation of EDs) in terms of affluence / deprivation to all other EDs at one point in time. The Canal Partnership area in 2006 ranked among the bottom three of eight Dublin Partnership areas on this indicator. While the age-dependency ratio has reduced since 1991, the proportion of lone parents (as a proportion of all households with dependent children) has risen to 49% compared to 21% nationally in 2006. The proportion of professionals has increased to 26% in 2006 compared to 33% nationally, while the proportion of semi-skilled and unskilled workers has reduced. Also, similar to the rest of the country the unemployment rate has halved since 1991 to 14% for males and 12% for females in 2006 (compared to 9% and 8% respectively nationally).This situation will have deteriorated in recent months. Overall the proportion renting from the Local Authority has decreased by 10 percentage points to 20% in 2006 compared to a 2 percentage point decline to 7.5% nationally. This is matched by a 10 percentage point increase in the proportion renting privately. The proportion of owner-occupied increased until 2002 and then decreased in 2006 to the 1991 level (59%).

At the level of the Canal Communities area then, improvements on many socio-demographic indicators can be seen, at least until 2002, when such improvement slowed down, stopped, or even reversed. However, problems persist. These trends mask a pattern of inequalities at a much more local level, where resistant 'black spots' persist at the level of the Electoral District areas and within EDs at the level of the Enumerator Area (EA). This can be seen below in the analysis of the three areas Rialto, Inchicore and Bluebell. Not coincidentally, these areas of persistent social exclusion overlap with the known areas for problematic opiate use.

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6 The Absolute Index Score (AIS) for 1991 has a mean of zero and standard deviation of ten. Because affluence/deprivation is measured on a fixed scale, it is possible to use the Absolute Index Scores to evaluate this progress across successive waves of data (Haase and Pratschke 2008)

7 The Relative Index Score (RIS) has been rescaled so as to have a mean of zero and standard deviation of ten at each census wave. It shows the position of any given ED relative to all other EDs in that year. Relevant to the Canal Partnership RIS,0 to -10 indicates marginally below average in terms of affluence / deprivation, -10 to -20 is disadvantaged (Haase and Pratschke 2008)

Table 2. Change in deprivation indicators in the Canal Communities, 1991-2006[8]

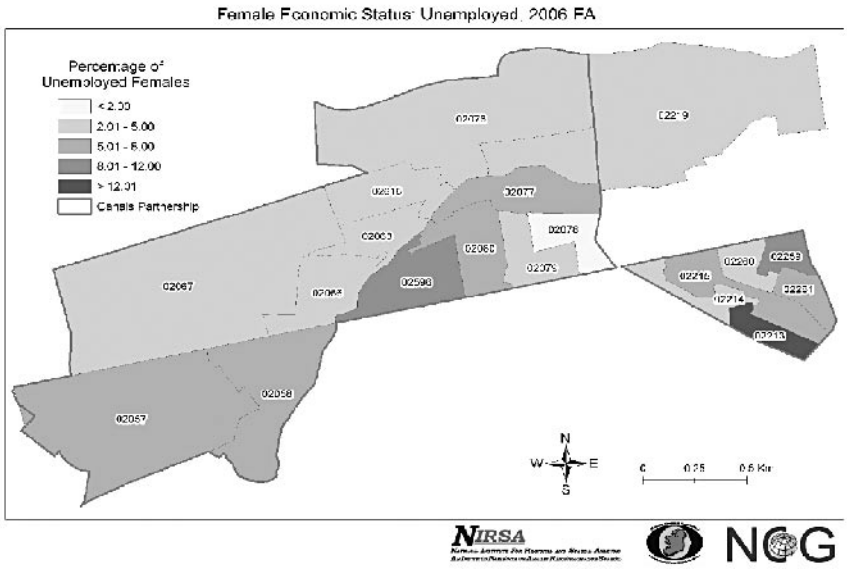
Indicator	1991	1996	2002	2006
Absolute index score	-14.6	-12.3	2.0	1.8
Relative index score	-14.6	-15.2	-7.7	-9.8
Ranked Relative Index Score (of eight Partnership areas)	7	7	6	6
Total population	13079	12442	12580	13332
Age dependency ratio [9]	37.3	36.4	30.1	27.9
Lone parents ratio	37.1	43.0	42.6	49.0
Proportion with primary education only	52.6	43.4	30.3	26.2
Proportion of higher and lower professionals	13.2	15.2	23.3	25.9
Proportion of semi and unskilled manual workers	37.7	34.8	25.8	25.6
Unemployment rate-male	31.1	31.3	16.1	14.4
Proportion of Local Authority rented	30.3	24.4	18.7	20.5
Proportion of private rented	9.4	13.2	17.0	19.7
Proportion of owner occupied	59.1	61.1	63.0	58.8
Average persons per room	.61	.58	.55	.56
Permanent private households	4937	5057	5121	5421

This recent history, though, has thrown up further complexities. The redistribution of the tenants at St Michael's Estate, then Fatima Mansions, was part of a broader change in the social and demographic picture, which includes new populations coming into the area, but these processes have more intensively affected some sections more than others (for a critical analysis of this process for St Michael's Estate see Bissett 2008). Basically, we find a picture of relative deprivation pretty evenly spread across the area, when compared to Dublin (and the rest of the country) in the 1990s, changing to one of a less wealthy reflection or microcosm of the sort of uneven development, which has characterised the growth (and most likely will presage the contraction) of the Celtic Tiger, by the end of the first decade of the new century. The striking connection between the five maps shown below, however, is the consistently disadvantaged status of the Enumerator Area 02213, which captures about two-thirds of Dolphin House. In the relative employment rate, as well as the social class of those employed, it presents a picture of serious inequalities. It is also one of the most ethnically pure 'white Irish' areas and populations, as demonstrated by the final map in the series.

8 This table is compiled from New Measures of Deprivation which is made publicly available on http://www.pobal.ie/WhatWeDo/Deprivation/Pages/DeprivationIndex.aspx. The data includes the absolute and relative deprivation scores for each Electoral Division (ED) and the key socio-economic indicators which are used in the construction of the index. The data is provided in a consistent manner for four successive Censuses, 1991, 1996, 2002 and 2006 (Haase and Pratschke 2008).

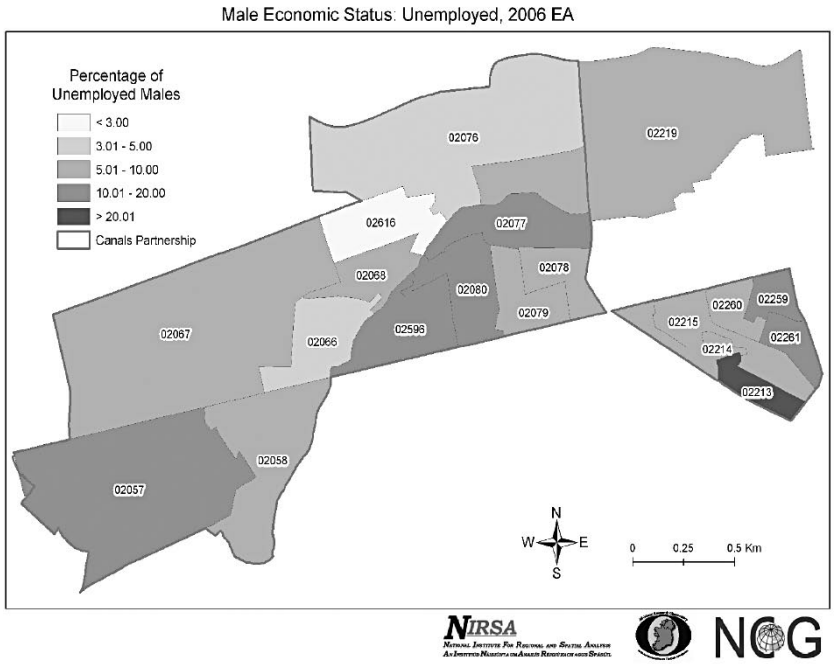
9 The ratio of the number of people in the workforce to the number of people who are either too young to work (usually fifteen years or younger) or beyond working age (typically sixty-five years or older).

MAP 2



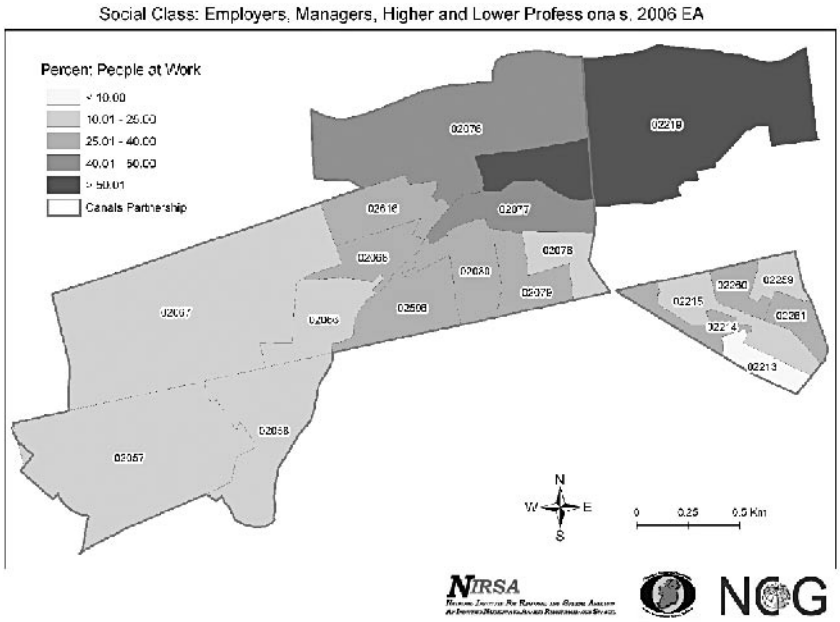
In 2006 female unemployment in the Canal Communities Partnership area was 12%. In Ushers E it was 12% for EA 02213 (most of Dolphin House) it was also 12%.

MAP 3



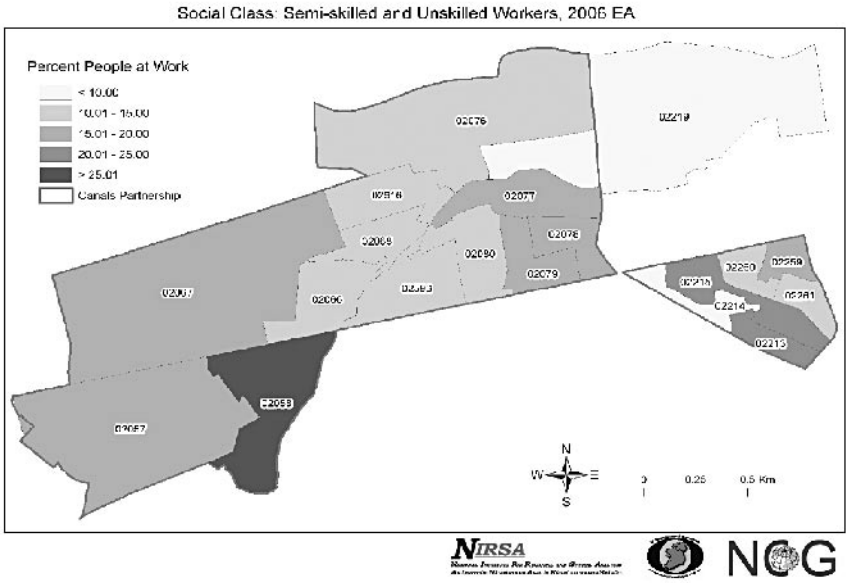
In 2006 male unemployment was 14% in the Canal Communities Partnership area. For ED Ushers E it was 18% and for EA 02213(most of Dolphin House) it was 20%.

MAP 4



In 2006 the proportion of professionals in the Canal Communities Partnership was 26%. For Ushers E it was 22% and for EA 02213(most of Dolphin House) it was 6%

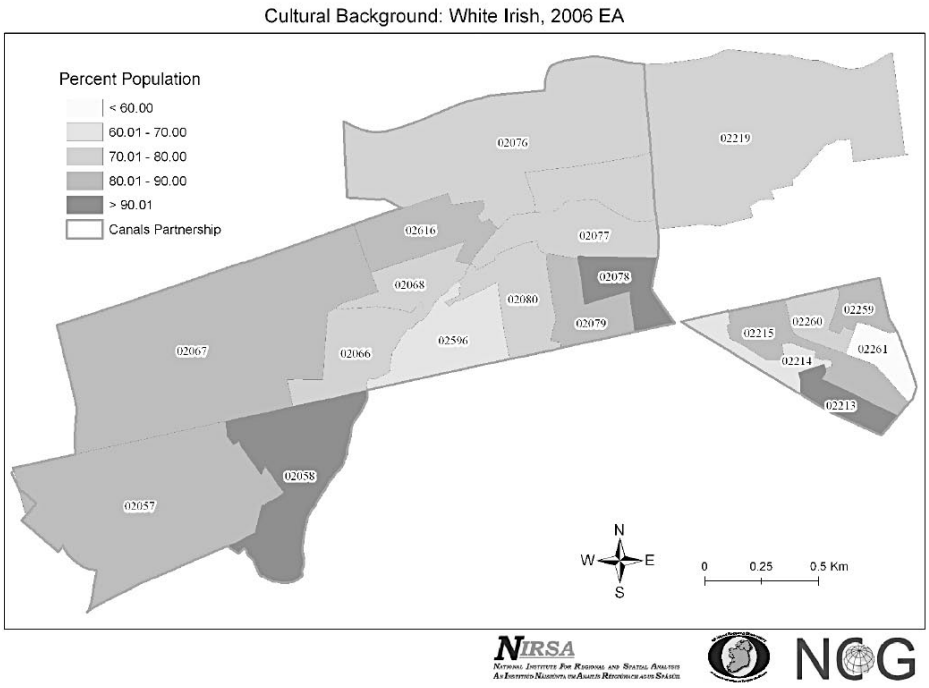
MAP 5



In 2006 the proportion of semi and unskilled workers in the the Canal Communities Partnership was 26%. For Inchicore B it was 34% for EA 02058(Bluebell) it was 40%.

In these maps, then, we see a sort of microcosm of modern Ireland with pockets of relative affluence and serious social exclusion cheek by jowl. Overlying this picture of class variability are the large numbers of foreign nationals attracted to the Canal Communities area because of its proximity to the city centre and the relative reasonableness of the rents in this part of Dublin.

MAP 6



Again, we see how certain enumerator areas stand out, this time not on a class, but an ethnic, basis. Our basic point below is that there is a lot of variability within even the modestly-sized area and population covered by the term 'Canal Communities', and, further, this variability appears at levels below the three 'constituents' of the Canal Communities: Rialto, Inchicore, and Bluebell. In the following sections, we try to deal with this variability by weaving some background statistics with reminiscences of different moments of drug-use in each area.

Inchicore

Inchicore has changed physically and demographically over the past decade. The three Inchicore EDs (Kilmainham B and C, and Inchicore A) account for over half the population (7,909) in the Canal Communities area. This has risen dramatically by over 50%, in the past ten years. The 2006 Census shows a significant foreign national presence with 16% born outside Ireland or England (Poland 5%, EU 25 3% and Rest of World 8%) (NIRSA 2008). Like the area as a whole, Inchicore is a mix of advantage and disadvantage, as defined on indicators such as early school leaving, lone parent households, and social class. The influx of foreign nationals may have influenced the level of advantage as described by these indicators.

The observed demographic change, however, has not changed the profile of those presenting to drug services in the area. The local GP has observed fewer new patients presenting for methadone treatment and very few from the so-called new communities (*i.e.*, non-Irish immigrants), nor does he see much cocaine-related morbidity presenting for treatment. In other words, 'drugs services' remains highly opiate-centric.

Historically, when one imagined drug use in Inchicore, one thought largely of St Michael's Estate. St Michael's Estate, previously Keogh Square, was identified as the most 'deprived' spot in Inchicore. Thus, it was a target of several interventions, finally culminating in significant demolition a few years ago. Drugs, in particular, heroin, are usually cited locally as one of the main reasons that residents opted for the destruction of these flats. These changes, while widely welcomed, are still not without their local critics.[10] According to some local community workers, the stripping of community leaders from St Michael's Estate was facilitated by a social policy that granted a sum of money enabling home ownership elsewhere. The 1990's St Michael's Estate, then, became a site of negative selection as vulnerable families replaced the families that could get out. Now, St Michaels is a shadow of its former self. There is a strange haunted feel as one stands on the site where fourteen blocks once stood. The empty blocks resemble a monument to an earlier time. One of our consultants, acting as a guide described how the block with only a few occupied flats would be used as a site for using drugs while another block was where everyone bought and sold drugs.

Even in the midst of often-harrowing stories, however, it was easy to hear a certain nostalgia for the old St Michael's Estate. As we visited old sites for using (disused house on the canal, the butcher's and disused slaughter house, and the graveyard), it became clear just how much building

10 The regeneration of St Michael's began with high hopes and ended in bitter disappointment. The worst excesses of property development in Celtic Tiger Ireland and a public/private partnership model conducted with little oversight left hundreds of families in residential limbo between the destruction of one home and the building of another. Most of these families left the area (see Bissett 2008 for a detailed and critical look at this process).

development had occurred. Bar the graveyard, all of these sites are now new apartments, generally housing people who recently moved into the area. This destruction of these old flats, however, pushed public dealing and consumption elsewhere.

Rialto

The population of the two Rialto EDs (Ushers D and E) has decreased by 6% over the past ten years. Twelve per cent of this population (3687 total) were born outside Ireland or the UK (Poland 3%, EU25 3% and Rest of World 6%)(NIRSA, 2008). The EA containing St Anthony's Road, Reuben Avenue and Haroldville Avenue has the highest proportion of non-Irish in the Task Force area (41%). As in Inchicore, the area is a mix of advantage and disadvantage in close proximity.

Dolphin House is the last remaining 'epicentre' of the drugs problem, which looks physically much as it did during the heroin epidemic of the 1990s. The old Fatima Mansions complex was recently completely demolished, and the estate has been completely rebuilt with new homes and state of the art community facilities. On the other hand, Dolphin House, built in the 1950s on eighteen acres, is one of the largest local authority flat complexes in the city. It houses approximately 1000 people in 436 units. The flat complex ranks high on most indicators of deprivation. The EA containing most of the flat complex (EA 02213) has the highest proportion of lone parents (69%) and the lowest proportion of professionals in the Canal Communities area.

In this small, almost face-to-face community, the sense of the proximity of extremes is immediately apparent when one talks about drugs. There are those that use, those that buy, those that sell, and those who are fiercely opposed to what they consider to be 'the drugs menace'. Everyone has been touched by some aspect of drug use. Nonetheless, all are living as neighbours in one community. The different parts of the community all possess an intimate knowledge of one another's dispositions and activities. In other words, they know a lot about one another's lives.

In this sense, Dolphin House is very recognizable to a research eye familiar with the history of Dublin's heroin waves. It still possesses obvious sites for drugs in a way that is now less apparent in the other areas of this study. In Dolphin House, for example, both children and adults can point out the young men known to sell drugs because of this intimate spatial concentration. There are fences erected at the back of every block, which serve as barriers to people fleeing the police.

Even the dealers and those whom they call 'the vigos' (vigilantes) nod as they pass one another on the street. People agree that only a handful of dealers live in the flats but they hang around with many people who come from outside. They stay socially visible to those who do not want them, staking their claim to public space, as well as reinforcing a fear-laced social climate, where 'ratting' is shunned and intimidation is rife. At the same time, there is also a sense by some that these men are

entitled to make 'their' money in this way, as one of the relatively rare local business opportunities available to them. The young people know who they are, and at least tolerate their activities. We heard statements like, 'They are alright' and, 'They walk away from us when they're doing it.' Many other residents, however, including some who buy from these young men, have little regard for them, remembering them as 'cheeky kids' who have managed to leapfrog into a powerful position in their lives. This local social memory, alongside the contempt that these young men often display for opiate-dependence, is experienced as demeaning for the local buyer.

This social intimacy is one of the aspects of life that gives Rialto a sense of being an old community whose consciousness of itself was in some ways strengthened through its response to the opiate crisis of the 1990s. There is a pre-Celtic Tiger feel as one walks from the roundabout. The church still physically dominates the area, even though the Boulangerie on the corner indicates the presence of a newer Ireland. The local shop, where a tab may still be run, coexists next to a large chain newsagent. Indeed, few of the buildings match on this street: the red church clashes with the crassly coloured DIY store, which, in turn, looks out of place next to the Tudor-style house fronts. Passing the church bus stop, on most days, the same homeless alcoholic man could be seen, a reminder of a more socially-accepted drug problem. Halfway between the roundabout and Dolphin's Barn, nestled off to the right, is Dolphin House, surprisingly discrete for such a big flat complex. The old pool hall (mentioned in Sandra's narrative below) is now a motor trade but the four-storey local authority flat complex has not changed much since its construction. The block walls now display posters of residents to depict different periods and the challenge: 'Dare to Dream'. St Andrew's, an old red bricked building (formerly a Methodist Church) houses the Community Drugs Team and Youth Project as well as numerous other community groups and activities. St Andrew's Community Centre lies between Dolphin House and Fatima Mansions.

Overall, these attributes give a strong community feel to Rialto. This main part of the fieldwork for this study, for example, was sandwiched between two annual celebrations of an important community ritual at St Andrew's Community Centre, titled 'Friends Remembering Friends'. This event has its roots in the worst days of the heroin crisis. For the past seventeen years, the community has remembered those individuals who died untimely because of drug-related issues. It has become an inclusive event, with old and young, regardless of blood chemistry, or political stance on the problem, sharing the loss of friends and family members.

Bluebell

The Bluebell ED (Inchicore B) has a population that has reduced by 8% in the previous ten years to 1830 in 2006. Eighteen percent of this population were born outside Ireland and the UK (3% Poland, 3% EU 25 and 12% Rest of World) (NIRSA, 2008). Bluebell scores high on indicators of deprivation. There is a high proportion of semi and unskilled workers and a high proportion of white-Irish (see Maps). A high proportion of lone parents (57%) and low education (39% of the adult population with primary education only) are also evident (Haase and Pratschke 2008).

Overall, Bluebell is largely an industrial area. Housing in this area is a mix of blocks of flats, terraced housing and maisonettes. The whole area has a 1950s feel with a sense of isolation and separateness (Costello and Corr 2003). The area has a peaceful and pretty veneer with well-kept uniform houses with front and back gardens. The flat complex is small, discrete and well maintained.

> In front and to the right are well-kept terraced houses with porches, extensions, replaced windows, paved drives and well-kept gardens. The park is situated in the centre with mature trees and a new-looking playground and colourful basketball court. The maisonettes and five blocks of flats look newly painted. Behind, lies the industrial area, separated by a green field and a walkway. Electricity pylons stretch into the distance. At the end of the green area are high metal gates leading to the industrial area in front of five terraced houses. The gates are decorated with dozens of flowers in honour of the young man from the area who was shot dead last Monday. The reminder of the extremely violent act contrasts with the peaceful atmosphere in Bluebell, giving a sense that another world lies beneath the still face.

At night, going from house to house delivering leaflets with a local outreach worker, the place feels quiet and seemingly safe. However, behind the door of a normal home, things can be very different:

> The drugs worker knocks on doors during an outreach visit. No one is home, or if they are they are not answering. Eventually the front door is opened to reveal a mother in chaos with her addiction to alcohol and pills. Having 'relapsed' in her struggle with addiction she has locked herself away, missing appointments with the drugs services. The house is in good order and a 42-inch TV screen hangs above the fireplace, on full volume. The woman is upset. She knows she is out of control, but cannot seem to get herself together. She has missed her methadone, but refused the heroin she was offered. The scene is distressing particularly because of the young child present. The worker takes control and gives the woman some tasks to do tomorrow to get back on track, and the offer of full support. We leave, struck by the contrast between the stillness on the outside and the chaos within.

Bluebell may connect to a newer pattern of serious drug use where private spaces supplant public ones for the sale and ingestion of illegal substances. In this sense, it might be considered a harbinger of things to come, as users who may be based in more dispersed, private accommodation become more common.

The context of this exuberant consumption, though, needs to be appreciated. These private and semi-private spaces are much more socially variable than the semi-public spaces of the old flats of the 1990s, whose grim physical condition, lack of security, and general social danger was immediately recognized by both the residents of the complexes and the broader society. While some of these newer spaces are appalling in their absolute poverty, many of them show more similarities than differences to the broader consumer society. An expensive flat screen TV and other indices of consumerism can now be found in conjunction with problematic patterns of drug use. This picture of affluence becomes easy grist for many critical mills – from the conservative condemnation of the fecklessness of the underclass to the therapeutic impulse to train people to make better choices. This opulence, however, is often more apparent than actual. High-end consumer durables sometimes exist as a resource to be sold in distress (like the gold chains of dealers from an earlier era, see Saris *et al*. 1999), but most of the time they simply exist as a reservoir of fixed capital, a material memory of some good times when cash was easy. These spaces of use and despair are also much more private than the semi-public spaces associated with the flats. They have, therefore, the potential to remain relatively invisible. As more and more housing in this area moves towards lower density and single-family accommodation, we can surmise that some of the issues in Bluebell will provide insights into some of the future problems in the Canal Communities Local Drugs Task Force area.

VOICES OF DRUG USE

SET 1: THERAPEAUTIC POSSIBILITIES

In the following pages we explore several life histories, recollections of spaces, and current social practices around drug use in the Canal Communities area. Through two main narratives, interspersed with ethnographically-informed discussions of a number of key issues, such as 'space' and 'dealing', we review about twelve years of local changes in drug use, more or less at the stage of life and the point in the history illustrated by Examples 2 and 3 in the 'Ages and Epochs' section above. All of these people formally appear 'in treatment', but they also show the immense amount of usage that goes on under this label. Crucially, though, they are 'in treatment' in a more meaningful social sense in that they expect their lives (at least potentially) to change for the better. In other words, these stories are about individuals who acknowledge that at some point they had a significant issue with heroin, and they understand their treatment largely through this lens.

Being Sandra: A Normal Life

Sandra entered the drop-in centre, close to where she lived in accommodation provided by the Homeless Persons Unit on a temporary basis. She lived there with her nine year-old daughter. Sandra's daily routine included getting her daughter to school, scoring coke if she had money, going to her clinic for her methadone and 'dropping in' to the community services for a couple of hours, killing time until her daughter met her there after school. When she was 'strung-out' she would live from day to day, focused on scraping and scrounging money or selling her Dalmane or Ensures[11] to get a bag of cocaine.[12]

Sandra grew up in 'the flats'. By thirteen, she was addicted to Dalmane, and by fifteen she had become a regular heroin-user, joining the large number of her peers in the explosion of heroin popularity in 1990s Dublin. At sixteen, she was admitted to a methadone programme, taking her dose before going to school. She actually managed to get off heroin *and* methadone in her late teens, but after moving to London she became strung out on heroin again. She was also introduced to crack there. That was almost ten years ago. When she came home a few years ago, she enrolled again in a local methadone programme.

For a while, Sandra had made a decent living out of dealing heroin when sites for using and dealing were more concentrated in the built environment. The local Snooker Hall was one such spot:

> I used to sell heroin and I used to make thousands, jaysus make like hundreds a day, I'd be [in clothes shops buying tracksuits and Nike runners every day] and the young wan'd be saying fuckin' hell, where did you get the money? Like she'd be saying you must be rich and me Ma'd be saying where are you getting this money, are you selling drugs over in the snooker hall and I'd be saying I didn't, I sold a bottle of phoy: it's a hundred pounds. I used to get meself loads of tracksuits and runners and me [daughter would] be dressed the best and the babysitter, I'd have mindin' [her], she'd get Nike runners and whatever. I'd have money saved at home for,

Fifty-three of our ninety-two survey respondents reported selling drugs in the past. Seventeen of these currently sold drugs. Of these seventeen all were using illicit substances. Fifteen used heroin, fifteen street benzos and eleven crack or cocaine powder.

11 Dalmane, a minor tranquillizer, yields about €1 per tablet. Ensure is a high calorie food supplement, twenty packets of which sell for €15.

12 A bag of cocaine for intravenous use costs about €20.

> just in case it came on top, like it did, and it all had to stop, I had a thousand pound there at home to back me up do you know what I mean.

Eventually, the snooker hall was raided and closed, and it became harder for Sandra to make money selling drugs.

> I tried to sell it, and it wasn't the same. It wasn't as easy as sitting in a snooker hall, playing pool or playing the games, and people just coming over. It got harder so, and then I was up on two charges, so it had to stop.

Today, heroin is still being sold locally, but its sale is no longer located in one place. At the same time, cocaine and more recently crack have dominated the more site-specific local market. Dealing at street level is now more difficult to get into than it used to be because you have to have the money to buy your supplies in some quantity. Unlike the easy informality of dealing in Sandra's recollections, local dealing is now dominated by young men who are primarily interested in making a profit, rather than the older style of low-level dealer who got involved in selling in order to fund a habit, and who, like Sandra, saw dealing as much as an extension of leisure activity as it was 'work'.

Of our survey, of ninety-two respondents, eighty said they had been involved in crime, and fifty had served a custodial sentence.

This trend is part of a more general change from how drugs were dealt at street level earlier in Sandra's life. Many users we spoke to, for example, now insist that the young men dealing to them are not much interested in using their own products. This professionalization is expressed in a variety of ways. These young men tend not to be in debt to bigger dealers (and therefore have the potential to make a reasonable living from their profits, e.g. being able to afford nice cars and holidays). There was also the impression that they were organized into a 'gang' structure and, thus, would be able to provide at least some of their own security, while being able to count on their associates to intimidate potential competitors or intelligence threats. Finally, many of the older heroin-users, in particular, expressed the sentiment that, as opiate consumers, they were largely held in contempt by these young men.

Sandra was still on the methadone programme when she started injecting cocaine five years ago. Failing to source crack locally, she considered injecting, as her partner at the time said it was like smoking a pipe of crack. Thus, she started 'banging coke', and this form of cocaine became her major addiction over the next five years. At that point, heroin became less of a problem for her. Indeed, she considered herself off it when she started on coke:

Sixty-four of our sample had injected at some time in the past. Twenty-five had injected in the past three months.

> I'd have the odd time, on the heroin before I got on the coke, but mainly I'd just take me phoy, and then I got on the coke. Heroin doesn't even appeal to me now ... I wouldn't even bother with it now, even if I was sick I wouldn't bother with heroin. If I was getting it for nothing I'd probably take a skin pop to take the sickness away, but, ah, I wouldn't buy it.

Ironically, from an opiate-centric service perspective, Sandra could be considered a success story, as methadone has largely been keeping her off 'gear'.

Unfortunately, cocaine had taken a heavy toll on Sandra by the time she entered this study. She had contracted HIV through injecting with her partner (who had then overdosed and died) and her arm and leg veins were effectively destroyed, so she was injecting into her groin. Her weight loss was also clearly visible.

Twenty of our sample had taken cocaine powder in the past three months, five of whom reported using it intravenously.

We asked what prompted her regular cocaine use:

> Researcher: Is it a social thing to feel good, or do you get withdrawals?
>
> Sandra: No, well the past few days now when I haven't had it in me system, I've been feeling a little bit angry**.** Do you know what I mean, and when I got it and get it into me, I'm alright, but then you get a bit annoyed after it, it puts you in a bit of a bad humour.... But then, when you come down off it you're alright, but it wouldn't give me withdrawals or anything like that, no, it's just kind of in the head, you want more, you want more. Coke is like, it makes you feel you want more. Some people need either heroin to come down off it, or tablets.
>
> Researcher: Do you, do you use anything to come down?
>
> Sandra: Sometimes I do have me tablets to come down, today I had nothing to come down, I just went down the clinic and got me phoy, ... but it's horrible to come down off it ... just sit there paranoid, don't talk to nobody.

We asked our survey respondents to list those in their immediate network with a cocaine addiction. 185 people were listed. Of these, only six were reported as receiving treatment for this addiction.

Of the forty-six people in our sample who were prescribed minor tranquillizers, twenty were also buying them on the street.

In nearly all of her reminiscences on her drug use, Sandra mentions her most enduring pharmacological fascination – her tablets: 'D5, D10 Zimmervane, Dalmane, anything I can get me hands on', in addition to those she is being legally prescribed. Her addiction to tablets goes undetected, indeed, for the most part, it appears as part of her 'treatment'. She is prescribed benzodiazepines and antidepressants, which means her urine is expected to legitimately test positive for these drugs. In order to detect her benzo problem, absolute levels of the drug would need to be tested for, and Sandra does not believe that this is likely because of the expense the clinic would incur.

Of the twenty-five who had injected in the past three months, fifteen reported past use of needles or syringes, which may have been used by somebody else. No one had done this in the past month. Twelve reported they have passed on a used needle or syringe to someone else. One had done this in the past month. Twenty-four reported they had reused their own needles or syringes in the past with fourteen doing so in the past month. Fourteen had also shared a filter, spoon or flush water.

Sandra also echoes a common complaint up until about the mid-point of our fieldwork among users throughout the Canal Communities area that the coke available in Dublin was of poor quality and 'mixed with stuff', so there were risks of 'fitting' (going into convulsions) when injecting. At the same time, this poor quality was one of the commonly mentioned reasons behind injecting or 'banging' for more experienced users, as the effects of what cocaine there is in the sample will be maximized

through this route. Injecting, however, presents enormous risks, as impurities and quality vary greatly.[13] For this reason Sandra, while using a complete bag for one 'turn on', claimed to exercise extreme caution in injecting it all at once to prevent harming herself:

> Sandra: I kinda just put 5mls in, stand there and let it kinda come up on me to see how strong it's gonna come up on me. I always have me drink and me fan there, and I'm always beside the seat, so if I feel like I want a drink to take me heart down from beating so fast or fan meself to give me a bit of air, or if I know that I'm goin' into a thing that I need to whip it out and get the toilet roll on me and sit down, I'm always beside something.
>
> Researcher: So you'd take it in little by little.
>
> Sandra: Yeah, I always put, like say five mls in and let her come up then two mls to see which way it's coming up. You'd think you only take, you'd have it on ten minutes and you'd be there about an hour. Yeah, like the hour'd be gone. Like I've often got it at two o'clock and I'd say ah, I'll be ready for me clinic at three, and I'd look at me watch quarter past three and I'd be still only pushing it into me, do you know what I mean, the time just flies, when you're doing it.

Sandra would only snort coke if she 'had to go to a nightclub', for example. She explains the difference:

> I'd snort it if I was going to a nightclub. I wouldn't ah take the turn, '[be]cause you're just left sitting in the corner on your own, just thinking he knows this or she knows that … paranoid. Snorting is more sociable, like you can get up and dance and chat away, and you're not paranoid, do you know what I mean. It just hits your brain different, I suppose.

A couple of weeks after this interaction Sandra had to be hospitalized. She had a clot in her lung, which required a chest drain to be inserted. The doctors told her if she injected coke again she would die. When she came out of hospital she was determined to stop. The drugs worker in the community centre had told her to take it hour by hour. She did. It wasn't easy. The local dealers helped by refusing to sell coke to her. The benzos also helped her to forget how badly she wanted the coke.

As the months went by, Sandra looked more and more like a poster girl for quitting drugs. She put on weight. Dressed and made-up, she genuinely looked like a changed person. The drugs environment had altered slightly however over the months she had been recovering. In particular, crack was now locally available. When we spoke to Sandra first in January 2008, though she had said many of her friends had been smoking crack, it had been hard to get:

> It is hard to get if you don't know who to get it off. Like I wouldn't be able to get it unless I went to one of me friends and they brought me to a black fella, but I wouldn't be introduced to the black fella because she'd be making off me, do you know what I mean, or if I bought two, you get

Of the twenty-eight people in the sample who used crack in the past three months sixteen smoked it on fewer than twelve days, three on thirteen to thirty days, six on thirty-one to sixty days and three on more than sixty days. Twenty-two had also used heroin. All were being prescribed methadone.

13 There is also the inevitable vascular damage that tends to limit the amount of time a user can stay with this method.

> one free, so she'd make on the one. But if you go into Moore Street or at ____ or anything like that, and you see a black fella, [you would say] 'Have you any crack?' [Then], you'd get it, especially on Moore Street.

This assertion of African expertise in crack production was very easy to elicit in early 2008 and could still be found intermittently to near the end of this study. Like many others, Sandra was insisting at that time that it was wasteful to try to 'rock up' your own buy of coke, as you risked losing it all if the process did not work.[14] As the process of 'rocking' is straightforward, what end-users were probably experiencing was how little cocaine their street-level buys in fact contained. Disturbingly, though, Sandra predicted that crack would be quite popular, if it was more locally available. While Sandra was prescient in her prediction that the young men who had been selling cocaine powder locally would soon diversify into selling 'rock', she did not anticipate that they would keep the same price structure between the two varieties. Thus, at a cost of €50 per rock, price still remains a significant barrier to crack use.[15] As she ruefully exclaimed at another interview, 'It's hard enough to get €20 for a bag of coke to inject.'

Nonetheless, Sandra was smoking crack regularly throughout 2008. She kept her promise to herself that she would never inject coke again. As she saw it, the needles were doing the damage:

> I got a pipe off someone and I says, ah that's not doing me any harm, [be]cause it was really the needles that was doing the harm, the blood poisoning, septicaemia, so I says ah I'll have a pipe and then I went to have another one, ...going half with someone, and when I was going well, I would get one for meself. 'Just one', I'd say, 'and I'll go down and have a nice smoke at the end of the night,' to meself. And then I met up with people that were getting weights for a night [buying in bulk, see Footnote 16], and I was smokin' every morning and all.

While Sandra's addiction to crack consumed her over the next few months it did not have the same control over her as injecting cocaine. Her daily routine of getting her daughter to school, getting to the clinic and to the Community Drop-In Centre was maintained. Though Sandra said that she knew girls who would 'go on the game' to get 'rock', she insisted that she never had to go beyond what she had, or what she could borrow, for crack. Overall, it appeared that Sandra consumed marginally above her means. On a day-to-day basis this meant that she would not be able 'to do a shop' for the week, but would, instead, live from day to day, e.g. getting dinner in the chipper.

In August, under increasing pressure to stop smoking crack, she managed to reduce it to one or two pipes on a Thursday, the day she collected her welfare payment. In this way, Thursdays became different from other days. This was the day she would get her money and score. This was the day she could 'get away from it all', punctuating a weekly cycle that possessed few other climaxes. Even though she knew it would only be for minutes, this experience was eagerly anticipated.

Recently, however, Sandra smoked heroin to come down off crack. This was the first time she had touched 'gear' in the past five years. She had asked a girl staying at her accommodation for ash for the crack pipe because she did not smoke cigarettes herself. The girl then asked for some of her 'rock'. Sandra gave some and in return the girl repaid her with crack and heroin:

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14 *Crack* is produced by dissolving powdered cocaine in a mixture of water and ammonia or sodium bicarbonate (baking soda). The mixture is then heated until a precipitate is left over. The solid is then dried and broken into the chunks (rocks) that are subsequently sold as crack cocaine.

15 By international standards, these prices are exorbitant. The same amount of 'rock' on the North American market can retail for less than $20 (about €14).

> So I went back up [having got the cigarette] to do a pipe and a knock came to the door and it was her and she says, so you're only using that smoke for ash? And I says, 'Yeah.' So you have a rock there? And I says, 'Yeah, I have a bit of a rock, I'm after giving somebody a pipe already.' She says, 'I know, I was just going to ask you for a pipe.' And I says, 'Here, there's a rock.' So she says, 'That's the best thing you could have ever done. I'll come back up tonight and I'll fix you up.' [Now], she's out on the game. So she didn't come up that night, [but] the next night at half twelve she came up and brought me down and we were smoking it [crack] all night, and then to come down off it, they took out the foil, and I literally just started smoking it.

Sandra is now struggling to get off crack. At the moment she has got it down to one or two rocks per week because she is under pressure from social workers to give clean urines. She is on methadone and prescribed benzos, as well as antidepressants (SSRIs). Occasionally, she takes non-prescribed benzos and smokes hash. She does not smoke or drink alcohol.

Sandra looks and feels much healthier than she did at the beginning of the year, when she was injecting cocaine a number of times on most days. With the services she attends, her days have routine and structure, while her weeks are punctuated by the high-point of Thursdays when she is likely to score.

Our last interaction with Sandra was towards the end of 2008, on a Thursday. She didn't need to score that Thursday, as she had had a pipe last night. She has a 'fella' she met some months ago. He calls up to her most evenings and they go for a two-hour walk. Later in the night as a token of their deepening relationship, he gave her a 'rock' of crack.

Remembering St Michael's in the 1990s

Carol was twenty-five years old, when we first met her. She was very thin and unhealthy looking, but still pretty. Indeed, she looked almost like a child. One of her peers commented separately that he had heard that, 'Methadone stops you aging!' While it was not the youthful look that would provide a separate market for methadone, he had a point; some of those on methadone in the centre did look as if stalled somewhere between childhood and adulthood, as if some crucial formative moment had been interrupted. Carol, like many of her peers – Derek, Ali and Ken – had started smoking heroin in the flats at fifteen years of age. Everyone was already smoking hash and, for Carol, 'the tablets came out' at fourteen. 'Roche 5, D10, Dalmane 15, Dalmane 30, Zimmervane and Stilnock, but ah, I was just takin' anything I could,' she recalled.

She relates that she had no interest in school and spent her time there ' just lookin' around and not doin' nothin'. She kept getting into trouble so when she was caught with drugs while in her school uniform in her Junior Cert year, she was expelled. 'From then I just went AWOL,' she said.

Carol used to escape from getting caught in the middle of her parents' quarrels by going out to her

mates sitting on the landings in the blocks of St Michael's Estate. She would walk out of the flat and all her mates were on the landing, smoking hash or heroin and taking tablets.

> That's how bad it was, that's how I started sellin' then, heroin like, then I got caught up with it and I used to smoke it in joints, you know, like, just smoke it in me hash, with me hash like and take a few tablets. Then I learned how to do it on the foil, you know, like smoke it on the foil.

Seventy-eight of our sample left school before attending 'upper secondary'. The mean age at which our respondents left school was fifteen years. Twenty-five had not completed any schooling beyond primary level. Only one had third-level education.

Carol did heroin for the buzz, but also to fit in. Ken described how ubiquitous heroin was when he was a teenager:

> Like all the young fellas were doing it that we were hanging around with, even the young ones that we were hanging around with. There wasn't one young one that wasn't doing it. Like every one was doing it. Sure we used to go up on to the landing to have yer smoke and there'd be about forty people sittin' there doin' theirs. Like if the police wanted us they could come in and catch us there.

Friendship and fun was undoubtedly part of this scene, at least to begin with. Though Derek (another of our consultants who remembers these days) lived outside St Michael's Estate, he kept coming back to hang out with his friends. After a residential detox in his teenage years, he lasted eight months off heroin. However, once back in this environment, he began to use again.

> I ended up coming back to Michael's Estate. Basically, one of the main reasons I kept coming over to Michael's Estate was because I had no friends in _____, all me friends were over in Michael's Estate, like even before, like I know a lot of people say, if you're on drugs then they're not friends, they're acquaintances**,** *but these were friends* [his emphasis] I had before drugs ever came into the equation.

In retrospect, it could appear as though these landings were designed for hanging out and using illicit substances (see Fahy 1999). They were public spaces, in the sense that anyone from the street potentially had access to them, but they were also well sheltered from the elements (and the eyes of the Gardaí). Most of the high-rise blocks are now gone, but they took a while to go. Derek described how particular blocks were designated by their abandonment as sites for using:

> Where we're standing now was my old block. It was Block eight, and it used to be called the 'H Block'. It was called the 'H Block' because three or four people hung themselves, including my uncle. This was the block that even though everyone sold their drugs over in Block three. Everybody used their drugs in Block eight because nobody really lived in it. When I lived here I think there were only eight were occupied. All the landings were basically empty. People who were homeless would sleep on the landings. We'd sit on the landings smoking heroin.

Twenty-eight (30%) of our sample had thoughts of ending their lives in the past three months. Twenty-seven said they had attempted suicide at some stage in the past.

There were many sites for smoking heroin and part of the excitement and fun was finding new hiding spots.

> There was a catch on the other side of the door of the lift and you'd put a plastic bag around it and if we were on the second floor, we'd send the lift down to our feet level, we'd pull the catch and open the door and we'd basically step on top of the lift and while we were holdin' the door open we'd put the bulb in. We'd sit there while people would be getting in an out and we'd be smoking gear and people would be none the wiser that there'd be four or five [of us] sittin' on top of the lift smoking gear.
>
> And if there were people we didn't like, we'd give them the bumps (that's what we used to call it, there was a switch on the top – on and off). So we'd go on-off-on-off and it would go shake-shake-shake and people would be goin' what the fuck is goin' on [laughs].

Of the thirty-three people in our sample who saw heroin as their main drug problem, eight injected and twenty-five smoked. Seven were less than twenty-five years old, seven were between twenty-six and thirty-two, and nineteen were over thirty-three years.

This cohort of users would not use in places where people were injecting heroin. They saw themselves as different in that they did not want to end up like 'the junkies'. If they saw others, usually older users injecting, then they would move to another spot.

Selling for these teenagers was fun to start with, but things became more serious, as people began to get strung-out and competition for buyers began to creep in. Older people would supply the teenagers with their batches. Derek explained:

> Some people would do bigger deals than others, like eh, for instance one person would offer a batch of gear of twenty-two bags. Sell fifteen, keep seven. Whereas another person would offer a batch of eight bags, sell five [and] keep three. It's obvious you're going to take the one with seven in it because it's more for you.

Another man, Ken, remembered how fun turned to competition and squabbling.

> Only young fellas getting sent out and there used to be about twenty of us standing at one block and you used to think you were real brave. Then, it would be, ah it's my turn, it's my turn.

It is important to note, however, that for this group, benzos were almost as common as heroin: indeed some users even sold their heroin for access to benzos.

> [O]ther drug addicts would come into the flats looking for gear and sometimes they'd have benzos on them and they wouldn't have money so they'd do a swap, you'd do a swap with them.

Ali, another young woman who hung out with this group at the time, saw her opportunity, and got into selling tablets. She was advised by the guy she sold them for to, 'Just make your money out of it, don't get strung out, it's a horrible thing to get strung out on.' However, like most of her peers she eventually slipped into dependency on her own heroin product.

At different times during the late 1990s, the Gardaí came down hard on drug-dealing in St Michael's, and a handful of key individuals were removed. The teenagers smoking heroin, on the other hand, were targeted by the local Community Drugs Team as it tried to establish a base in the area, the need having been identified by the Community Development Project.

Eventually, most of these young people, by their own admission, came to the realization that they had a problem, and they tried several detoxes. Nearly all of them are now on a methadone programme. This progress was made possible by their engagement with the local Community Drugs Team. These drugs workers persisted in engaging with the young people and eventually gained their trust:

> *[Names drug worker]* and *[names drug worker]* would be comin' up and they'd say like they'd be telling us that they wanted to open up a drug team, and they'd be telling us that they had no premises and everything and they want to get help for the drug addicts in the area and stuff like that. And the first couple of times they came up we sort of treated them with a bit of discontent like we didn't believe them because we'd heard it before. But *[names drug worker]*, she persisted with it and she kept coming up onto the landings while we're smoking gear and she'd be sittin' there trying to counsel us. While we'd be smoking gear!

By the end of the 1990s, there was now a methadone protocol in place. There was also a health centre in Inchicore, as well as local doctors, who prescribed the drug.

Carol had been on a methadone programme in the past and like many of her peers had tried and failed detox. When we met her, she had only just lasted a week in a residential detox before self-discharging and going back on the gear. As a result she was not allowed back home and was separated from her baby. She was facing Christmas in a Bed-and-Breakfast serving homeless people, without knowing if she would be able to see her child.

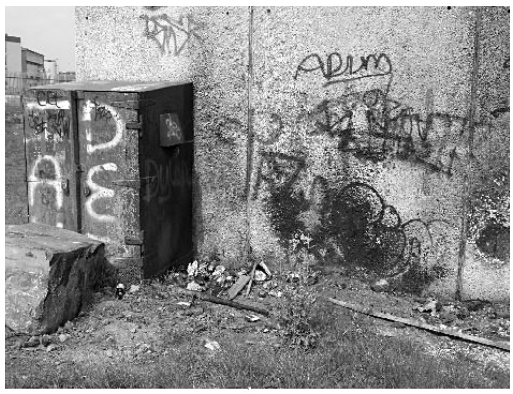
After Christmas, she began the methadone programme in the local health centre and hoped to rent a flat in order to have her child back. Gradually, she reduced her heroin use and gained access to her child. However, finding stable accommodation proved more difficult. Hopes were raised at the end of the summer when, with the help of the Community Drugs Team, she was accepted by a private landlord for an apartment to be paid for with rent allowance from her Welfare Officer. Hopes were dashed again, however, when a week later the landlord changed his mind.

Seventy of our survey respondents had children. Of these, twenty-nine did not have children living with them.

Today, the environment in which Carol grew up has changed dramatically. Much of the population has dispersed; the buildings have been knocked down; and the sites for using collectively, such as the old stairwells are now simply far more limited. While dealing does go on around the remaining blocks of St Michael's, today, many sites are more ephemeral, quickly destroyed or boarded up when discovered. Proportionately, more using goes on behind closed doors, or under the cloak of off-label usage of prescription medication.

Generally speaking, though, while this cohort saw and sold to the older 'junkies', they did not think they would ever end up like them. In some respects, many of them did not. They continued to smoke 'gear' and did not turn to the needle (the defining attribute of 'junkie' in the 1990s). Others,

however, did begin to inject, finding it harder to get high from smoking, after they began to tolerate the euphoric effects of heroin. To these individuals, smoking gear ultimately represented a waste of money. Nearly all of them also used minor tranquillizers, both prescribed and non-prescribed.



Methadone clearly changes the effect of, and need for, heroin, despite the fact that many users use heroin and methadone simultaneously. The buzz of 'gear', as Derek describes it, is not how it makes him feel, but how it makes him 'not feel'. 'It makes you numb for a while.' Perhaps this numbness is more cheaply (certainly more legally), and perhaps more pleasurably, experienced through certain benzodiazepines.

Sixty-eight of our survey respondents (74%) took either prescribed or non-prescribed minor tranquilizers, and twenty used both.

Discussion

We unpack the scenarios above in several ways below. We will begin with the complex challenges that the lives of Sandra and Carol and others discussed in the two scenarios present to a simple definition of such central terms in the management of their lives, as 'drug', 'treatment', and 'service'. Drug use is certainly a problem in all these lives, but there is a dizzying array of substances under the term 'drug', crucially, only some of which are illegal. We come to this issue again and again in these and other scenarios. Prescription drugs, such as minor tranquillizers, obtained both legally and extra-legally are nearly always amongst the first psychoactive compounds consumed in the using careers of our consultants, and they are amongst the longest-serving as well. Generally, they change function during the course of an opiate-using career. They are sought out for their euphoric effect early on, but, by the time heroin use is becoming a problem, they serve a more obviously therapeutic purpose of taking the edge off some of the physical symptoms of withdrawal and to allay the anxiety associated with this state. After methadone maintenance becomes routine, they serve once again as a sort of narcotic, with some users insisting that particular combinations are enhanced under the influence of the heroin substitute.

There is at least anecdotal evidence to support the idea that some users gravitate towards certain pharmacological combinations with methadone. Xanax, for example, is mentioned as a particularly pleasurable companion to methadone (see also Negroponte 2005). In any case, older users at this point will often maintain an impressive collection of legally and illegally obtained tranquilizers, often with other tablets, such as antidepressants, from prescriptions that were not completely consumed. These tablets underlie several common social practices. Their sharing, for example, indexes a concern for another's well-being. Based on personal experience and remembered advice from professionals, certain tablets are exchanged between friends as being good for 'nerves' or to alleviate 'stress'.

Twenty-five of ninety-two survey respondents were prescribed antidepressants. Fifty-four were prescribed antidepressants and minor tranquilizers or both as well as their prescribed methadone .Only nine out of the ninety two took methadone alone without other prescribed or non prescribed drugs (hash alcohol and tobacco excluded from this analysis).

In short, drugs are social facts, as well as being physical compounds that influence body chemistry. To be sure, they affect the bodies of users, but they are also a key component

of the social relations between these bodies. The specifics of using drugs, moreover, is also a densely historical phenomenon. In other words, types of drug use track broader social changes. Both of the narratives above, for example, clearly connect certain drugs, specific social practices, and particular spots in the built environment. Sandra's initial success selling 'gear' in the snooker hall, and the peculiarities of public building design in Ireland (as elsewhere) which provided a veritable ecology of places (stairwells, tops of lifts) that various social groups exploited for drug use, underscores this connection. Nonetheless, the built environment of the visible drug (mainly opiate) problem in the Canal Communities area has changed dramatically in the last several years. As stated above, St Michael's Estate on fourteen acres close to Inchicore village, for example, has diminished to a mere four blocks, housing a small number of families, a Family Resource Centre, and a crèche. While St Michael's is still an important dealing site, the well-sheltered 'landings', which previously accommodated scores of local young people and outsiders both scoring and using drugs, are now empty. Physical sites for drug use have moved away from these residential areas, while the residential areas themselves have been dismantled.

Dealing

Transformations in the built environments also shaped changes in the structure of dealing drugs at the 'retail' level, a situation especially apparent in Sandra's story. Both of the researchers on this project have observed the heroin situation in different parts of Dublin over the last decade. The social distance between dealers and users has been growing wider, and, crucially, dealers seem less likely to have developed from users than was the case only a few years ago. Cocaine, in particular, resembles a classic commodity, with little social connection between the seller and buyer, even when both are users.

Tina scores drugs regularly in the flats. She does not live in the area but comes to get heroin and coke and recently to get crack. The last time, it was heroin she came to score:

> She had the number of a guy, Joe, who sold 'weight'.[16] She phoned the number:
> 'Hi this is Tina.'
> It was not Joe who answered but she recognized the guy who did, Mark.
> 'Don't call me Mark', he said.
> She wanted an 'eight' (of an ounce of heroin), €100 worth, in a couple of hours. 'Yes,' he promised, 'He would have it at 3 PM.'
> That suited Tina. Before she left the city centre she called to make sure he had it.
> 'I haven't got it yet but he's on his way down to me.'
>
> She got on the Luas and headed for the flats. She tried getting him on the phone on the way but his phone rang out. He called her back and said he still hadn't got it but he [meaning his supplier] was on his way. She walked into the flats. Tried to call him but his phone was off. It was a nice sunny day so she and her friend sat on the grass. She saw him then in one of the blocks of flats, alone. She went over to him. As she approached him an old woman was coming down the stairwell.
>
> 'How's it going Mark?' Tina asked.

16 Dealers sell 'weight' to certain clients, based on their ability to buy in relative bulk with an eighth of an ounce being a typical bulk buy. 'Eighth' is pronounced 'eight' which allows the term to rhyme with 'weight' and 'garden gate' making it possible to discuss such buys in thinly disguised code. From the perspective of the dealer, 'weight' is less profitable, but moves relatively larger amounts more safely to fewer users. From the perspective of the user, weight is very economical, but requires larger sums up front to make the purchase. Those users who can stay stable, and who have access to enough cash, can effectively fund their own use through this buying strategy, by selling on the excess.

She was about to continue to ask him if he had 'it', when the old woman launched herself at the two of them.
'Get away from this stairwell, yis drug pushers, get away from here. Yis are destroying these flats.'

Tina kept walking. Mark walked over to the other stairwell facing where they had been. Tina walked off around the blocks of flats and came back within ten minutes and went over to Mark again.

'What's the story?' she asked.

'Yer after getting me into trouble.'

Tina was getting annoyed at this point. She doesn't like Mark, and describes him as having a huge ego because he's selling drugs. She had more dealings with his predecessor, Joe, who had passed his phone and business on to Mark, as he had been caught by the police. Mark is about twenty-five, lives close to the flats and doesn't use heroin himself. Joe didn't use heroin either and was younger than Mark.

Mark was joined by three other friends, all of them young men in their early twenties. All were similarly dressed in jeans or tracksuits and trainers with hoodies, some with their hoods pulled up.

Again Tina approached him and was told, 'Not now, not now.' Eventually, he sent one of the men with him over to Tina with her heroin. He handed it to her and she handed him €90. He told her it was €100 but she said she had only €90. He called Mark on his mobile 'She's only after giving me 90'. Tina kept walking.

For her €90, Tina received 'an eight' (of an ounce) of heroin, which would make up about ten €20-bags, proving the principle that bulk buying is indeed more economical. The incentive to buy 'weight' is obvious to a user, as it makes it possible to sell on smaller quantities, and, therefore, to more easily fund one's own use. At the same time, those most in need will find it harder to raise the funds for buying 'weight'. These individuals provide a market for those more able to sell on bags from buying in this fashion.

More rarely, some users are given the 'weight' up front and then pay their supplier once the consignment is sold. Paul, a heroin-user, explained that he got €200 worth of heroin to sell up front, but then got caught with it, so was in debt to his supplier. The chain of debt stopped there as his supplier had paid for it and so owed no one. There are obvious disadvantages to selling a drug you are using, as Ken pointed out. He had between ten and twenty regular customers for heroin, but his main drug of choice was crack. He insisted, however, that he wouldn't consider dealing crack, not for moral reasons, but economic ones:

> Yeah, I wouldn't deal crack now, [be]cause if I was dealin' that I'd end up goin' through all of it, and I'd be bollixed out of it.

As a general rule, though, the people selling 'weight' are less likely to use, or less likely to use in a

disorganised or chaotic way. They buy larger amounts from bigger dealers paying up front and then accruing profit. From her transaction, if she was interested, Tina could have kept half of what she had bought and sold on the remainder, making her money back and, effectively, getting her drugs for free. While the margin of profit is greater in more retail transactions, the advantages in selling 'weight' is also apparent for professional dealers, as a business with customers buying weight attracts less attention because there are fewer people hanging about the landings looking to buy.

For cocaine powder or crack, drug-users go to the same location, but generally to a different set of dealers. At the moment, it appears easier to get cocaine than heroin. The sense that the dealers are non-drug-users, though, is modified in the case of cocaine, as most of the customers that we know concede that some of the dealers would snort from time to time, or occasionally indulge in Ecstasy. One or two would snort coke at the weekend and 'go through their money.' One young dealer said he developed a cocaine habit after selling it for six months. He was now trying to deal with his own addiction problem. We were struck by the heroic sense of agency in his account of his transition between dealing and use. He was adamant that this was based on his (poor) decision-making.

> They don't force you like, it's up to yourself what you want to do, [be]cause nobody forces you over there like. Only in other places people do it different, do it different like … Once you pay them like, the person, like, if it's a friend, you get off, like, it's alright, if not, [then] it's a different story.

The profile of the men who sell the cocaine powder and crack in the flats was similar: they were early to mid-20s and largely non-drug using. They appear connected to each other in the business but exactly how (in the sense of their 'gang' structure) was beyond the scope of this study. There is a 'main man' identifiable, yet individuals or pairs also bought what they sold up front, seeming to work independently. They sold with the agreement of the others on the territory, however, and they all 'looked out for one another'.

Tina, having scored regularly in the flats, occasionally witnessed objections from residents, mainly women,

> Move off them stairs! We're not fuckin' eejits round here. Do you think yer foolin' people?! Yer foolin' no one.

In other interactions, Tina told us how she observed the dealers differentiating between residents, indicating that they immediately knew who would have a problem with their activities and who would not:

> I have been on the stairwell as they were taking it out of a big packet into, say, a fifty-bag or a hundred-bag for me so they'd be dishing it out and they hear someone coming out of a flat and they'd watch to see who it is. So some of the people were cool and some of the residents they'd hide it from.

There would only be a problem if there were police around and you could do nothing. The young dealer agreed:

> I don't get much hassle like, off the people in the place like, but they know, like they know what goes on and all like, the most hassle like, you get is from the police, is the most thing that hassles us.

The opinion of many of the residents about the men supplying drugs in the flats is interesting. Some users who buy from them remember them as cheeky young kids. Others see them as doing what they must do to make their money. Some young people see them as 'all right' and others as 'stupid' to be doing what they are doing. Still others would not cross them, as they are afraid of the consequences. What is clear, though, is that everyone knows what everyone else is doing. One resident described to us a very similar scene, referring to the same block where Tina regularly bought her heroin.

> As we speak, he looks over his shoulder from time to time, through his window pane... There are four or five young men across the green standing outside of one of the flats. Periodically, one of them goes up to the first level and into one of the flats. He explains how they indicate across balconies when it is safe to get the drugs (from wherever in the hall they have them stashed). It amazes me that he knows in detail the people involved and what they are doing.

This resident acknowledges that he would be seen as a 'vigo' (vigilante) by the dealers, though he insists that he is not. He says that vigilantism was recognized as not working, though he claims there is a core group of about eight residents who, if pushed far enough, could turn again to 'direct action'. The killing of Josie Dwyer, a local drug-user, at the height of the 'Pushers Out' campaign is still a watershed in the fight against drugs in the community, however. This death was met with much local revulsion, and subsequently, the 'Pushers Out' signs were taken down, and legitimate means were pursued to stop local dealing. While the Garda Drugs Unit still see it as possible to 'clean up' this locality, through sustained effort over a longer period of time, they claim that the resources are not there to do it.[17]

Many of the residents, of course, despise the dealers and what they are doing, but they also feel intimidated. The business end of drugs is simply too big and risky for the Residents Association to deal with. Residents have been threatened, homes attacked, and people forced to resign. One mother of a nineteen year-old man explains that, if she was seen to do anything, she's sure her son would be punished. The papers are carrying stories daily about gang warfare and shootings and, 'It just seems to be coming closer and closer'.

Overall, the professionalization of dealing we see here echoes some themes from North America (see Venkatesh 2008). Many research questions remain, however, about the organization of drug-dealing in Dublin, particularly about the social organization of these groups of young men and how they actually interact within and between what are labelled 'criminal gangs' by the Gardaí and the press. Such questions, regrettably, were beyond the scope of this study. With respect to our discussion of the changes that have occurred around drug use and abuse in the Canal Communities, we can assert that this kind of dealing, which is located in known sites and which draws customers from outside, seems to have become less routine after the demolition of most of the local flat complexes. The main new characteristic of this trade is the centrality of non-using young men at a relatively low level. The attraction of this activity, then, is to be found in the access to fast cash, camaraderie and peer respect that it clearly provides, rather than as a means of funding a personal drug habit.

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17 Personal Communications with garda from Drug Unit. See also, Cooke 2007 http://archives.tcm.ie/businesspost/2007/02/04/story20801.asp

Stigma

The discussion of space, above, highlights the importance of the visibility of drug (especially heroin) use. The public nature of heroin use in the 1990s in the large flat complexes was a significant part of the moral panic surrounding it. Similarly, the visible markers of all opiate use are often highlighted in a negative fashion. In this way the body of the opiate user can stand for a series of broader social problems: the sense that the broader society is neglecting these areas, or the threatening aspect with which public spaces are imbued because of the drugs trade, or the serious social and economic inequalities that allow problems to grow and fester in certain places, can all be marked by the body of the addict.

Indeed, the negative sense of heroin (in particular) at all levels of this study was much more profound than in our other drugs research experience. All the young people we spoke with (teens to under twenty-four) strongly rejected heroin use, insofar as they almost all knew a parent or an older sibling, or an uncle or aunt, who was a 'junkie' (a category pitied and despised in almost equal measure). Some went further, attacking not just the drug as dangerous, but the user as weak, spontaneously offering statements like, 'Brownheads [heroin-users] are stupid.' Nearly everyone (with critical exceptions detailed below), insisted that, 'injecting, it's disgusting.' We were probably most taken aback by the spasms of morality displayed even by dealers towards the universe of potential products. The coke dealer we cite above, for example, who insisted, with some heat, that, 'Sellin' heroin' is 'like murder' simply stated more forcefully, what many other younger people also maintained: heroin was itself an evil.

Nearly all of our sample had, of course, seen the effects of heroin on the older generation in the area. There was something else going on as well. Heroin's stigma (and by implication methadone), however, was also mitigated by a local appreciation of relative marginalization of certain settings and families. Two young teens, 'John' and 'Pat', in a community with very high rate of opiate addiction, for example, tried to articulate how they felt about heroin-users. In a small group discussion, they moved between condemning the poor choices such users made, while showing some understanding of (if not actual sympathy for) the context in which certain people 'chose' to use. On the other hand, they found it difficult to say that agency was entirely absent:

Pat: I feel sorry for the users, it's their way of life.

Researcher: Mmm.

John: Some people can't help it, if you think of it.

Pat: You can really, say if you see like, a person on gear or whatever walking through flats like … Like you see them right, they have kids and all, but like if I was a kid at the age of three or four and I saw my Ma walk out the flats looking for drugs and all … some people like, they don't have, not that they don't have a choice but that's what their life is.

John: They look at it like that's the way it is.

Pat: Look at it: that's their way of life, if you know what I mean.

Researcher: They don't know any different?

Pat: They don't know, yeah, exactly so, it starts when, so it's not like, like, a lot of people do grow up, they'd have wives and children and then go on drugs and all but some people grow into it. Like, for some people I feel sorry for and then the others I wouldn't give a fuck about//

Researcher: You mean//

Pat: You don't know, like, ah, it's hard to explain.

Researcher: So, I think I've got you, the people who have made a choice//

Pat: Yeah, I wouldn't care//

Researcher: Yeah, but the people who have grown into it?

Pat: Yeah, yeah, yeah.

Researcher: And grown up with it.

Pat: Like say I knew their Ma and Da were on it, and like, that's what, like I have a bit of sympathy for them alright.

Other young people tended to divide up drug and methods of use along a continuum. Snorting cocaine was 'clean' in comparison to injecting 'dirty' heroin, for example. A group of women who recreationally snorted cocaine and dabbled in hash, Ecstasy and drank a lot, provide another example of this negative view of heroin use.

Kim: You know what I mean when you hear about new drugs coming out and all these mad trips and you'd say oh I have to try this, it's an experience, but we never turn round and say, 'I have to try heroin and see what that's like', d'ya know what I mean?

Jade: Yeah, but it's probably the stigma that it has.

Paula: It's a real dirty drug.

Jade: Filthy.

Paula: The way ye see them going around and who wants to be like that?.... like, but some people might look at us locked and out of it and think what do you want to be like that.

Kim: But we snap out of it the next day and it won't happen again, [pause]... till the following week!

[all talk together and laughter]

Jade: I think it's because people can see it, like whereas someone like that is

probably after like, I could be after doing a bag of fuckin' coke like tonight and no one'll know any different.

Paula: You can hide it so easily, like.

Kim: Yeah, whereas if like, someone was in after smoking a bag of gear, you're gonna know he's gonna sit there goofin', d'ya know what I mean.

Visibility was clearly an important characteristic associated with heroin's stigma. Taking heroin was visually more evident to others, in the short-term because the user would 'sit there goofin'', and long-term usage produced the emaciated body of the 'junkie'. 'Coke', on the other hand, easily blended into normative social scenes for younger people. It could be discretely taken, and its effects were not obviously different from other drugs consumed in recreational settings (pubs and clubs).

Of ninety-two respondents, seventy-one had snorted coke in the past. Forty-nine had shared snorting paraphernalia.

This spoiled identity is a central part of the experience of heroin use. Concealing the fact that he smoked crack and heroin to his 'friend', with whom he snorted coke, for example, was extremely important for Ron (aged late thirties). His friend, a middle-class man who 'goes on holidays twice a year', supplied the cocaine. Ron supplied the companionship, in 'coke' use only. This friend, whom he had known since childhood, had pointedly ignored him on more than one occasion in the past, when he was a known active heroin-user. Ron described a scenario that highlights the sort of stigma that, he feels, exists for his heroin use.

> Ron and his recreational coke-sniffer buddy had left the pub with a couple of fizzy spirit drinks and were rolling a joint. Ron doesn't smoke as it makes him paranoid. But his mate did. There was a shout from a group across the canal, 'Hey got any brown?' 'No,' Ron answered. But as he passed he heard one of them say to the other that if they had answered 'Yes' he would have gotten 'a bottle in the neck'.

In another instance, a dealer described to us how he sold cocaine according to whether the customer was a 'sniffer' (recreational user) or a 'junkie'.

Researcher: And how much would it be for, like, a bag? Do you get 25, 30 (euro)?

Paul: Depends what you're gettin', there's different kind of bags. Like the lower bag like 25 bags like they'd be for junkies comin' in//

Researcher: Oh really?

Paul: Like, for them, and for sniffers, ye get one-er bags, 50 [euro] bags...

Researcher: Really? Why is the lower bags for the junkies comin' in?

Paul: It's the moneywise.

Researcher: They don't have the money?

Paul: Yeah. That's how much they come in with.

Researcher: And, and when they're comin' in for the lower bags, are they sniffin', are they snortin' it or injecting it?

Paul: Ah, they'd be injecting it.

Researcher: Would they be heroin-users?

Paul: They'd be the likes that take gear an all, crack whatever.

Negative attitudes about heroin use were not confined to the current young population or current cocaine-using population. Current heroin smokers and even those who have moved to injecting also spoke of how in the past they had said they would never end up like the 'junkies'. In fact, the stigma associated with the needle may still have a protective, harm-reduction effect. Some heroin smokers have not turned to injecting even over a decade of use.

At the same time, some heroin-users sometimes resist this sense of spoiled identity projected on them by 'recreational' cocaine users, in particular, by trying to place everyone within a shared discourse of 'addiction', as in the following example of a heroin-user:

> There's people then that only, say, party at the weekends and all, and they wouldn't class themselves the way other people would class them: [as] junkies you know. 'We only do it once a week' and all but, no matter, it doesn't matter if you do it like, once a month, you're still a drug addict, there's still drugs going into your system, do you know what I mean, so different people look at it differently, you know. I still, I know there's some people that'd like, say snort coke twice a week and '[be]cause I'm on phoy eleven years, and I was strung out on heroin and everything going like, they'd say, 'Oh no, you're a junkie', and I'd say, 'So are you.' [They would say,] 'No I'm not, no, I only do it twice a week.' And you know and they're probably selling it and all, no they still put you down, and put themselves on a pedestal, like it's gas, you know, '[be]cause you really know what's ahead, like, some day it's going to take them over you know. Like we can, even at the start, I could control heroin, everyone can control it at the start, and they'll say, 'No that's not controlling me, I'm controlling it.' But [it's] never [like that]. It'll just take a few weeks or, some people it might take a few months, but it will it'll control you in the end, you know, so.

As we have explained, the direct experience of an older sibling or cousin and aunt has resulted in a very negative impression of heroin and heroin-users, with even small-time dealers claiming to have moral reservations about moving the drug. The stabilized population of ex-users on methadone may also play a role in such stigma. In places like Dolphin House, for example, everyone really does know everyone else's history so such use is socially visible. Their continuing connection to opiates becomes another part of the knowledge of older 'junkies' and feeds into the desire to not be like them.

SET II: OUTSIDE THE THERAPEUTIC DISCOURSE

In the (shorter) set of stories below, we investigate several narratives of drug use and abuse outside of either a sense of a problem susceptible to therapeutic intervention, on the one hand, or, on the other, where it is very unclear what happens after a user is stabilized on MMT. Clearly, it is impossible to answer the question: 'Are these users outside services?' in the absence of an *a priori* definition of 'service'. One person discussed below is indeed on the CTL, but due to several complicating factors, his post-therapy horizons seem truncated, and the boredom of the halfway house of MMT itself represents a risk of his falling off the wagon. Most of these narratives are stories from young people or people very much older, representing contemporaries of Cases 1 and 4, respectively, in our initial framing of the problem ('The History of the Drug Problem in Dublin: Ages and Epochs' section above**)**. Some are so young that any therapeutization of their use seems difficult to imagine, despite the chemical saturation in their lives. Also, at least at an ideological level, they express such distaste for heroin that they are unlikely to appear as clients in what is still an opiate-centric treatment infrastructure. Other older users are simply structuring their lives around the notion of maintenance. Parked on methadone, at most, they merely seek to punctuate their stasis with something to look forward to during the week.

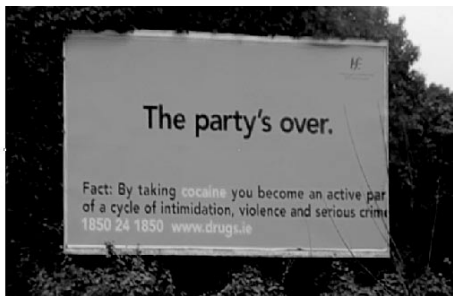
Party Girls

It was a good birthday party. Kim had promised her mum she would be on her best behaviour and she was, at least until after the official party was over. Her cousin had given her a bag of cocaine for her birthday, however, so she and her mate 'did a little bit' during the party. Contrary to the HSE's warnings, though, this party was only just beginning: it was destined to consume the weekend. Kim and her friend had between them, €400 worth of cocaine, which they begun using at 11pm on Friday night. Once the official party was over, everyone went back to Kim's friend's house. The party continued all night in the form of a rave in a shed at the back of the house. Kim was drinking alcohol, and she also had a couple of joints. She stayed up all of Saturday night, going through another 'one-er bag' (€100). Eventually, when it wore off, she went to bed and slept. It was a good weekend.

The following weekend, when Kim and her mates went to a rave on Friday, most of her friends had switched to E. The media coverage of coke-related deaths around that time had given them a scare (especially the death of the model, Katy French), which lasted 'a good few weeks'. But Kim did not like E. She claimed to become depressed after taking it. She did, however, envy her friends because of the efficiency of what could be described as their harm reduction strategy:

> But like, when you think of it, they do save themselves a fortune. Their not payin' out, and they're payin' for the E on the night, [so] they're not getting' into debt like. And, then, if they do E, they're not really drinking [be]cause they're up bleedin' boppin' away, do you know what I mean?

Because of her past E-associated depression, Kim and one of her friends got a bag between them, which did her for the night, as she was sharing cocaine with her "fella", "so it was grand". The next day having been up all night she didn't feel so good:



> I got, you know, depression, it was like...[pause], then on Saturday me head was just melting, and

it was just like ah, real bad.

The sheer quantity of cocaine in this young woman's life belies the popular image of a heavy coke-user as a successful professional with a good wage. At the same time, despite her modest socio-demographic profile, Kim manages to financially survive this heavy use, at least for the moment. She lives with her mother and brother in a two-bedroom flat in a very poor area. She was an early school-leaver and is unemployed except for a bit of casual work. Nevertheless, cocaine, at €50 or €100 a bag seemed to be literally everywhere, as Kim herself discovered, while cleaning her room:

> I picked up my jeans, you know, to put in the washing, I put me hand in me jeans and there was a bag of coke and I couldn't remember, I still can't remember, who owned that or where I got it. And I was like, 'Oh I'm not even gonna do it,' but I did. I had me little brother and I wasn't going to do it in front of him. Once I took one or two coins out of it, that was it, and I left it like [be]cause I was bollixed. I had still got that coke, a €100-bag, and I started doing that at about 4 o'clock and then yeah, still had a bit of that when I was in the pub, and then me friend came along and we had a big whopper bag.

Kim and her friends did coke most weekends. They tried to recall one recently on which they had not snorted cocaine.

> Jade: I've never, ever gone out with youse and like not one of you're saying like, ah I'd love a bag of coke now, d'ya know what I mean or something like that.
>
> Kim: But we didn't do it the night we went to [names club].
>
> Jade: Yes, we did.
>
> [Laughter]
>
> Researcher: So at the moment does it stick to weekends?
>
> Sam: Yeah.
>
> Kim: Sometimes it might slip into a Monday.
>
> Sam: Or Thursday.

Kim did not need to steal or do anything illegal to get her drugs. To be sure, she would constantly be in debt to family and friends and sometimes to those who supplied the drugs, but she generally managed to pull together what she needed to orchestrate a good night out. She recalled with one of her friends how they had managed to gather together a significant amount of money for a coke buy.

> Me and her, a few months ago, her nana died, and we were after being like out on a big mad session like from Friday night right through 'till Saturday and we owed like fuckin' €500 each, we gave about €900 euro … over. And like, we were saying like, if we wanted to put our money together for town, to go in and shop, we wouldn't have done it, the fact it was coke like we did it. Paid it all in cash.

These sorts of expenditures are possible for Kim and her friends because of the sort of Zen-like affluence, their structural situation affords them. Most of these women have relatively low-paying service industry jobs, but their expenses are minimal. They will give a little money over to their mothers to help out with the running expenses of the flat, and they do not aspire to home ownership or other longer-term projects where saving money is required. Consequently, nearly all their income can be considered disposable. In this way, Kim and her mates can party as if they had incomes and socio-economic status considerably in excess of what they do in fact possess.

The collective chemical experience of these young women, then, is impressive. From hash through Ecstasy, magic mushrooms, acid, alcohol, ketamine, speed, and cocaine Kim and her friends, despite their tender years, seem to have tried it all. Nonetheless, they insisted that they would not even consider heroin. They were all in agreement that heroin was taboo. It was off the cards: 'Thank God, not in anyone our age,' as one of them said.

Some were beginning to be concerned about some of the drugs that they used. However this was a personal perspective and did tally with a particular public health view. Sam, a sales assistant, claimed to 'love her vodka' and lived for it after a week of hard work. She was beginning to be concerned that she loved it too much.

> The thing I worry about is, would be alcohol, me liver to be honest. You see Friday morning, I do wake up and I ah, what I'd love, right next to my bed on Friday morning is a double vodka and Red Bull, every Friday ah, everyone in my job … I'd be out having a smoke, [and I'd say] 'I'd love a glass of vodka now'; they actually think I'm an alcoholic. Every Friday, that's all I talk about.

Nevertheless, they were beginning to recognize and point out to each other the grip that coke was beginning to have. Sam vowed to herself, for example, that she would not pay for it again. Six months later she still had not. She had used it less frequently and replaced it by a range of other drugs including MDMA (Ecstasy) and ketamine, but she had not paid for cocaine. She was hanging out in the dance scene and rarely had to pay for drugs. She still struggled not to drink during the week, however.

Indeed, Kim was more concerned about her hash and alcohol than her weekend cocaine intake. Though she recognized that she could not say 'no to coke', she didn't consider herself as being addicted as such.

Kim: But it's just like, when someone says it, if you're not thinking of it, if you are, you're waiting for someone to say it. You don't want to be the one to say it, you're sittin' there and you're like 'aahh' you want to say no, like you *really* want to, I do in any way, personally I do be like 'Aahh', and I struggle to like actually say, 'No!' and I don't think I've ever said, 'No'.

Researcher: Really?

Kim: Yeah and I don't know like why it is and I'd love to know why it is, there's obviously like something in the drug that's making me attracted to it that I keep like, that's forcing me to.

Researcher: Then why do you think it is that you don't feel addicted if you have never said no?

Kim: [Be]cause I'm not dependent on it Monday to Friday or anything, it would be like, if someone said it, and I was having a few drinks. Or if I got it for nothing, I'd do it for nothing, I'd do it Monday to Friday. Or if something was happening - it could be a funeral or it could be I don't know, things like that. But I don't see myself [as] addicted to drink and hash now.

Researcher: Would you, do you smoke every day?

Kim: Yeah, constantly.

Researcher: And ye drink everyday?

Kim: Well, I haven't last week I didn't drink last Monday to Friday. I didn't drink any day and I haven't done that in about 2 years. But I don't see it the same as coke like. I wouldn't see meself as an addict, like.

Our initial interpretation was that Kim was 'in denial', that coke had a major grip over her, and that she was, in fact, 'addicted' as this term is understood both medically and locally. However, at our last meeting with Kim, some months later, she seemed to be thinking less about cocaine. She had more important things on her mind: she was focusing on her alcohol issues, which she *was* experiencing as something that was interfering with her life. She saw these as potentially problematic for her future ambitions.

Only as we spoke about cocaine did she begin to recognize that, in fact, she had been saying 'no' to coke more recently. The previous weekend, for example, a couple of her friends were going to one of their houses with a few cans and a bag of coke and invited Kim to come along:

> They were sayin', like, are you coming down to do a few sniffs? And I said, 'No. I'm goin' in, and I was glad because I knew if I had went down I would have felt poxy, I would have went in on the bag with them. I says, 'They're going to be sick in the morning, a waste like.' I was right as well.

She was hesitant to see this as saying 'no' to cocaine, however. She had said 'no' to socializing, but in the knowledge that if she had been in the immediate environment, then she may well not have refused the cocaine. Perhaps Kim's lack of explicit attachment to the label of 'addiction' for her cocaine use allowed it slip out of her life more easily, when she found her choices were taking her in a different direction.

Overall, it is difficult to characterize these young women in the standard terms around which a discourse of 'drug abuse' is constructed. They use a dizzying variety of drugs with different intensities and at different times, depending on taste, resources, and availability. They are also psychologically sophisticated, familiar with the concepts of dependence and addiction, while monitoring themselves for signs of trouble with their usage and engaging in corrective self-care accordingly. Yet, through it all, they remain invisible to drug services (although they have experience of some youth services). For the most part, they do not they even see themselves as logical targets of drugs advice. An opiate-centric service infrastructure, combined with a local fixation on 'gear' as the primary problem drug, largely insulates them from both local and government understandings of 'treatment'.

Parked on Methadone

The relationships between problem drug use and various physical and mental illnesses is a theoretically fraught one and largely beyond the scope of this work. On the one hand, many of the primary addiction theorists see some basic flaw in brain chemistry as underlying 'addiction' and see the theoretical connections between this model and current thinking on major mental illnesses (such as the schizophrenias) as intriguing. It is assumed that there are probably a limited number of these basic flaws in brain chemistry that lead to variable pathologies and that, at some point, a more unified understanding of the brain will lead to more powerful models and, indeed, cures. On the other hand, there are researchers who approach the aetiology of some major mental illnesses through a model of drug use that somehow tips a badly wired brain into recognizable pathology. In this way, cannabis has recently acquired a renewed aura of danger in some psychiatric theorizing: both as a 'gateway' drug to more serious use, as well as a risk factor for major mental illness. At the same time, many of our consultants are at serious risk for various types of physical illnesses that require long-term pharmacological interventions, such as infection with HIV. Nonetheless, there is relatively little evidence of how methadone acts with the various drugs that constitute Anti-Retroviral Therapy (ARVs), to take but one example (see Leavitt *et al.* 2005). In short, we wish to point out that the clinical mirror-image of what we have called 'exuberant poly-pharmacy' in some of the examples above is found in how the body of the 'compliant' methadone patient, who is often the site of several overlapping prescription regimes generally handled by different Consultant Physicians.

We include the case below, then, as it demonstrates some of the complexities of co-morbidity in the social life of one user. While the individual involved relates to methadone as a means of stability because of hard experience of a truly chaotic life, there is little sense that there will be an 'after methadone' moment for him, either in terms of a true detox, or even in terms of what his methadone-achieved stability allows him to accomplish. The question we wish to highlight in this section is: 'What next?' for individuals who are stable on the CTL for a relatively long period of time.

Mark, age forty-eight

Mark now lives in long-term hostel accommodation for homeless people. Prior to this he was accommodated by the Homeless Persons Unit in a Bed-and-Breakfast. He was one of three men staying there and describes a struggling existence recalling the 'beans and mash' they ate for Christmas dinner last year. 'We'd one tin of beans between us,' he recalled. He is very happy to be in this hostel. 'Everyone is very nice here', he relates, and residents get their breakfast and evening meal free of charge.

Indeed, the accommodation is clean and warm with single rooms for residents. As we sit in the alcove of one of the corridors, Mark speaks easily of his life and history. His voice drops, however, when he mentions drug use and heroin as if he is ashamed, or, indeed, that the words themselves are dangerous to utter. His memory is also intermittent, and he explains that the doctors have told him it may take years to regain this capacity, and that it may be that crucial parts of his memory may not come back at all.

Mark was living in a bedsit when he had a breakdown. His daughter encouraged him to move in with her and her children, which he did. When his daughter's boyfriend, 'a bogie' (criminal), moved in things did not work out (he was using drugs, as was Mark's daughter). Mark did not want to be a burden, and he did not like his daughter's boyfriend, so left and presented to the Homeless Persons Unit.

In his past life, Mark had lived with his wife and children in a council flat. A well-known local dealer introduced him to 'the money that could be made selling 'gear', which, at that time, the dealer was bringing in from England. This was the start of Mark's involvement with drugs. At twenty-six, he became addicted to the heroin he was selling. Mark does not talk too much about that time or, interestingly, what he charts as his progression *from* heroin *to* other drugs, but admits that he eventually took 'everything'. He also talks of family and friends who got 'strung-out', and the desperate consequences that followed in the wake of these troubles. One of his family who was also addicted to heroin, died a drug related death. Another who had never used drugs contracted 'the virus' from a spouse.[18] Another was caught with heroin and spent five years in prison. As she was pregnant at the time of her incarceration, she gave birth to her daughter in prison, which was given to another family member to bring up.

Eventually, Mark, his wife and children were evicted from their flat, and accommodated in Bed-and-Breakfasts for the homeless. Mark then left the country to work in the UK. While labouring on a building site (while going through 'cold turkey' detox), he collapsed and was taken to hospital. There, he detoxed from heroin under medical supervision, with the help of tablets which his doctor had told him were 'very strong'. On discharge, the doctor revealed this potent drug to be simple Anadin. Mark had been detoxing with the help of a placebo. Such was Mark's lack of confidence in his own ability to detox, though, he immediately felt physically unwell on discovering the deception. He returned to Dublin and then relapsed.

Mark hit rock bottom and was living in the Phoenix Park for about a year in a tent with some girl whose name he cannot remember.

> I kept getting moved on ... I was in a bad way, lost lots of weight taking everything ... pills ... really in a bad way.

One day he was brutally attacked:

> I was walking through the park stoned [on tablets and gear] when, well I'm told this is what happened. My niece was there, she saw it. Two guys came up behind me and whacked me with something on the back of the head.

A number of others had jumped in and started kicking him, while he lay on the ground. Someone called an ambulance. Mark was taken to Hospital, where, months later, he woke up. He suffered a stroke after the beating, and was told he would never walk again. That was seven years ago.

Mark recovered gradually. He said he would rather be dead than not able to walk. He made steady progress from wheelchair to Zimmer frame to crutches. It was only during that stint in hospital when Mark realized how frequently he had been in and out of hospital. He had heard the nurse tell a colleague that he had also been admitted recently after being knocked down by a car. Though Mark does not explicitly link drugs to the events in his life, until pressed, the impression is that they were so a part of everything it was difficult or pointless to single them out or talk of them separately: they had pushed out even his memories.

Surprisingly, Mark bears no ill will towards his attackers and proved this when he spoke up for one of them at his trial. 'Look,' he explained to the judge, 'It's not really his fault, ... things happen.'

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18 The 'virus' refers, of course, to HIV.

Indeed, a lot seemed 'to happen' to Mark and many of his contemporaries, much of it included trauma and tragedy. He recounts how the person who had phoned the ambulance for him when he lay dying in the Phoenix Park, had himself been shot in the back about four years ago.

> He was knocking out a bit of hash, [and] thought he was invincible [and] went around threatening people who owed him money. One of his client's fathers came at him with a gun. The guy ran and got shot in the back.

Mark no longer uses heroin. He has the odd drink and smokes about seven cigarettes per day and occasionally some cannabis. He blames himself and his 'greed' for his starting to use. He says he was trying to take the fast, easy route to wealth. He sees drugs as evil and believes that, instead of pumping children with the 'do's and don'ts' of catechism from the time they go to school, they should instead be brainwashed away from drugs. He says, 'Drugs are hell [and] staying off them is heaven.'

Nonetheless, when Mark came out of his coma in hospital, chunks of his life were missing. He thought he was still living with his wife and kids. Bit by bit, pieces came back, at times more than he would have liked. 'I couldn't believe some of the things I remembered I had done. I wouldn't do that I thought.' But he had. He had done it all.

Today Mark lives a simple life. He gets up at 6.30 in the morning and takes his 20mls of methadone, which he says is part of him now. 'It's in my bones,' he insists. He believes that he has been on it so long that he can never come off.

Mark's days have a certain routine. After breakfast, for example, he exercises by going up and down the stairs several times. He also does some weights. After lunch, he goes out and walks around the city. Mark expresses some hope for the future. He highlights a number of positive indicators he has recently experienced. He tested himself on the Driving Theory Exam, for example, and achieved top score. Last night, for the first time ever, he sang at the karaoke. He has good contact with his children and is proud of them.

Despite having completed all the training programmes the treatment services could offer, Mark's health problems still render him unfit for work. He desperately wants to get some work or 'do something'. He insists that, 'The boredom would make you think of starting drugs.' Some people he knows dabble because of the boredom: 'Eventually it will creep up [on you].'

THE EMERGENCE OF CRACK

In this section we discuss another kind of stability: regular drug use while stabilized on methadone. These are mostly older users who, to some extent, answer to the Scottish categorization of Opiate and Stimulant Co-users**.**

> This group are primarily opiate-users who also use psycho-stimulants. Data clearly show that the Scottish drug using population are poly-drug-users. These individuals may well be in contact with services but their psychostimulant use may not be addressed. (Scottish Executive 2002*)*

Some of our consultants had moved from injecting cocaine to smoking crack because of the health risks associated with the former. All of them were stable a lot of the time, but they had little sense of what comes next in their lives. If they can be said to be 'in treatment', then it must also be conceded that they have a lot of unmet needs. Sandra (introduced in the beginning of this work) is one such example.

More often however crack was smoked because it provided a 'buzz' for people on methadone, who found they still missed the high that they remembered from heroin. For some, crack is experienced as more pleasurable that heroin.

> Barry is forty-two. He does not do heroin any more, gets nothing out of it. He smokes crack every one to two weeks when he bumps into a certain person. He does not go looking for it, and does not answer calls from people who he knows are going to smoke. When he bumps into this person who says, 'Here I have a bit of stuff,' he just can't refuse. He goes along and pays €50 for a rock. Then, he regrets it later. He describes a session as four to five of them get together in someone's house or flat. He has said there has been 'near killings' in sessions like these, fighting over who got the most. Crack is not available in his local area. The person he bumps into gets it from outside and brings it in. It's mainly ex-heroin-users or current users that smoke with him. They are 'on methadone [and] need the buzz from something'.

Crack use, then, is increasing within the Canal Communities from a fairly small base, and one of the most important populations in which this problem is emerging are those who are currently being 'successfully' treated for opiate addiction. While the stability of MMT is valued by those users who remember very bad times from their lives 'on gear', those on methadone miss aspects of this earlier life. The success of methadone in blocking opiate-induced highs, and (arguably) the lack of other options in these individuals' lives, makes some kind of 'high' attractive. Within the context of unvarying daily and weekly cycles, this experience can be imbued with an almost ritual importance, literally the high point of a week, satisfying embodied needs for pleasure and for sociality. The effects of crack and the mechanisms employed to source it are both also clearly valued. In this respect the narratives around crack recall earlier work on heroin use in Dublin in the 1990s, as users spend as much time discussing the adventures involved in procuring the drug, and the sharing of experiences during group use, as they devote to discussing its physiological effects (Saris *et al*. 1999).

Having scored the crack we go back to Louise's flat.

'Excuse the mess,' Louise said and disappeared into one of the bedrooms. Frank went into the kitchenette to find a bottle. He came into the living room with a bottle and began turning it into a pipe. Foil on top with a rubber band. Ash on top as the base, and a pen casing stuck in side of bottle. Louise came back into the sitting room and opened the small piece of plastic which was holding the 'rock'. Frank broke it up and placed smaller pieces on the ash. They commented on the decent size of the rock (not much bigger than a pea). Frank held the flame of a lighter to the fragments on the ash base as he sucked through the pen. He held his breath for a few seconds before letting it out. He lit it again and followed the same process before passing it on to Louise to do the same. As they smoked they described the effects.

Fifty-five of ninety-two respondents had smoked crack in the past with twenty-eight of them smoking it in the past three months. Those who currently smoked crack spent an average of €205 per week on drugs.

In this study, crack is connected more to the pharmacological connoisseur, rather than a cheap option for the relative neophyte. This has probably contributed to crack's relatively high price. It remains largely a specialty drug. Its use is probably also influenced by the widely bemoaned woeful purity of powdered cocaine in the Irish context. Given the 'styles' of use alluded to above, however, it is likely that crack will become a problem for at least some of those who are currently using it with methadone. As in most other combinations of pharmaceuticals, the long-term effects of opiates and cocaine used in this way are not well-researched, but they are likely to cause increased morbidity.

Crack use was associated with current heroin use with 79% of those using crack in the past 3 months also using heroin compared to 56% not using crack ($p<0.05$).

CHANGING PATTERNS, ENDURING PROBLEMS

We began this analysis with the idea that different perspectives yield different views of a problem. In other words, the impression that opiate use was levelling off could coexist with a sense on the ground that drugs were still a major issue in the community. For the Canal Communities area, for example, Kelly *et al.* (2001) estimated a prevalence of opiate users in 2001 of 42.4/1000 or 367 in 8,648 adults. This estimate was based on a two-source method, using garda records and the CTL. Our estimate for 2007 is 363 or 38/1000, confirming the sense that the number of heroin-users has probably levelled off in this area. Furthermore, our estimates show good coverage of the MMT in our area, with 72% of those potentially requiring a place on the CTL, having one. The relatively high rate of registration for methadone is seen in the next table.

Table 3. Persons registered on the Central Treatment List, 2007 (CTL)

Area	Male %	Female %	Total	Population [19] (2006)	Per 1000 population
Canal Communities[20] **LDTF**	**61**	**39**	**262**	**13,332**	**20**
Clondalkin LDTF [21]	**71**	**27**	**363**	**75,389**	**5**
Ireland [20]	**70**	**30**	**9656**	**4,239,848**	**2**

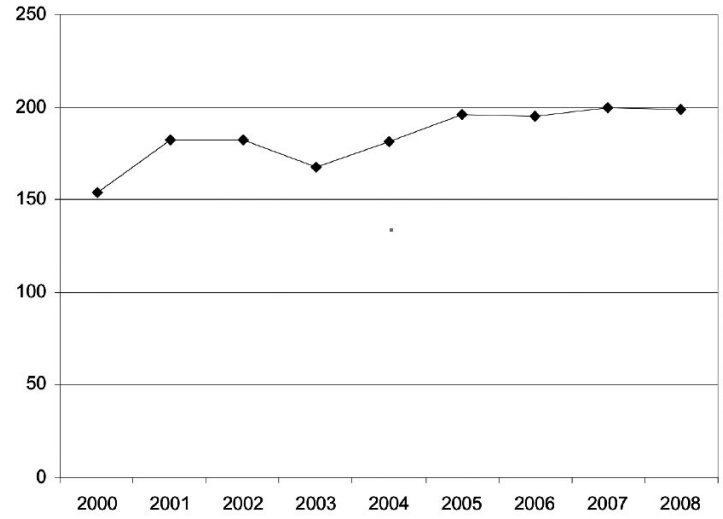
There has been a considerable drop in the number of people under eighteen in treatment over the last five years (eighty in 2001 down to eighteen in 2006) (CTL, Jan 2008). The numbers in the Canal Communities Local Task Force area registered as receiving methadone on one day in the year has increased from 1998 to 2001 but levelled off in 2005, from which point it has remained relatively stable.

19 Population for the Canal Communities Partnership area from Haase and Pratschke (2008). Population for the Clondalkin Partnership area from Clondalkin Partnership (2006). Population from CSO (2006). http://www.cso.ie/statistics/Population.htm

20 Total clients on CTL during period 1/1/07 to 30/11/07. Methadone numbers in treatment. Report from The Drug Treatment Centre Board. January 2008

21 Total number of clients on CTL in 2006. in Breen M., 2007

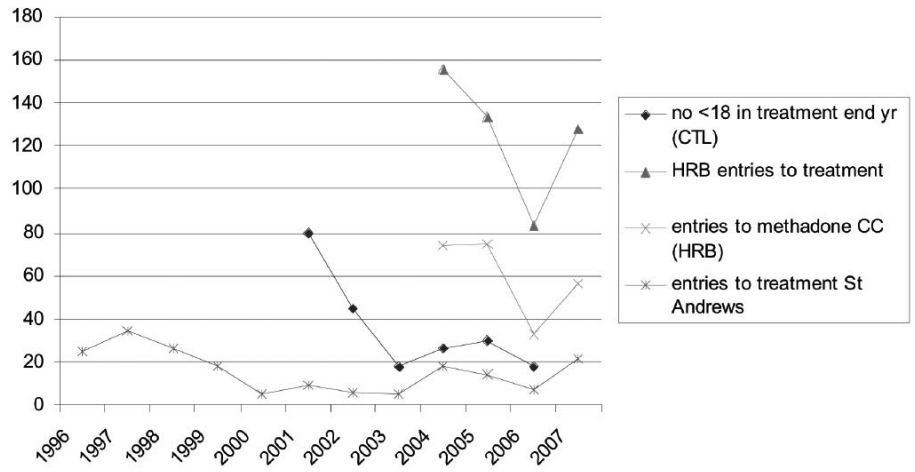
Figure 1. Persons registered on the CTL resident in the Canal Communities area at one point in each year



† Data provided by the Central Treatment List to the NDTRS 2009

Entries to treatment (see 'treatment' definition below) in the Canal Communities area decreased from 2004 to 2006 and rose again in 2007 according to the Health Research Board's National Drug Treatment Reporting System (NDTRS, 2009) (Figure 2 and Table 5). However some of the flux may be due to increased data collection coverage from this source in recent years. A downward trend in admissions to the local methadone programme in Rialto from 1997 to 2003 is seen with an increase in 2004 and 2007 (Rialto Community Drug Team, April 2008) (Figure 2). Again, this may be explained by an increase in the catchments for this service, which extended to include Inchicore and more recently Bluebell, as well as Rialto.

Figure 2. Trends according to various categories of treatment



The age profile of those in treatment has also changed, with the highest proportions in an older age group (thirty to thirty-four) and only 8% in those under twenty-five years of age. The rates per 1000

population of people on the CTL, divided by age band is seen in Table 4. The rates increase with age, with the highest rate 54/1000 in the thirty-five to thirty-nine age range. In short, the population of those in receipt of methadone is getting older and young people are not going onto the CTL fast enough to replace those exiting the list.

Table 4. Age specific rates on the CTL in the Canal Communities area

CTL Age group	Clients on CTL	Pop. Group	No. in Age Band	Rate per 1000
		0-14	2166	
18-24	24	15-24	1996	12i
25-29	70	25-29	1757	40
30-34	76	30-34	1686	45
35-39	58	35-39	1074	54
40-44	20	40-44	919	22
45+	14	45-64	2631	5ii
		65+	1658	
Total	262	Total	13887	19

Based on Figures Compiled from the CTL, 1 January 2007 to 30 November 2007

[i] *rate derived from population group 15-24 while numbers on CTL give only from 18-24. The rate is likely to increase slightly if numbers on CTL age 15 to 17 are included*

[ii] *rate derived from population 45 -64 and numbers on CTL over 45. The assumption is no one over 65 is on the CTL and living in the Canal Communities area.*

Table 5. Cases resident in the Canal Communities area entering treatment

HRB NDTRS	2004	2005	2006	2007
New to treatment	29	26	22	24
Returns to treatment	127	108	61	92
Entered methadone treatment (included within new and returns)	74	75	33	59

Source: HRB-NDTRS

From the viewpoint of an opiate-centric treatment infrastructure, the sense that most of the people who need methadone are probably on MMT is reasonably well supported. As we have seen, however, a lot of serious non-opiate drug use takes place on MMT *and* the mere fact that one is in receipt of methadone does not mean that heroin is given up completely. In other words, a treatment infrastructure that developed to address a serious opiate problem is struggling to come to terms with other drugs, *and* the reality that those 'in treatment' still have a lot of unmet needs (not the least of which is heavy non-heroin drug use). In our final section, then, we try to marry some of the statistics that we outline above (as well as those that we gathered from this project) into more complete understanding of the challenges ahead.

CONCLUSION

The preceding section indicates that the number of people newly registering on the CTL in the Canal Communities area has stabilized, with a rough balance being maintained between people dropping off each year and the number entering/re-entering services. This stability appears likely for the foreseeable future (see Figure 2). For the moment, then, the coverage of the MMT has probably reached its saturation point in this area. At the same time, it is clear from the other parts of this report (as well as from the sense of many local elements, from outreach workers through community members) that there is still a lot of 'drug use' within the population currently availing of services. Furthermore, there seem to be many new using trends emerging in populations who are largely outside of services, as they are currently defined. This sense is also well supported by our data.

The Methadone Protocol, however, exists as one service in an area that is ostensibly already highly 'serviced' by the State – youth projects, outreach programmes, integration and rehabilitation projects, and the like. Do these services also count as 'treatment'? On the one hand, the HRB (2006) defines treatment as:

> Any activity targeted at people who have problems with substance use, and which aims to improve the psychological, medical and social state of individuals who seek help for their problem drug use, including one or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training.

In 2006, according to this definition, eighty-three cases with addresses in the Canal Communities, who went for treatment for either an alcohol or a drug problem, accessed a wide range of services inside and outside the area. On the other hand, most of Irish policy-making discourse conflates 'drugs' with 'opiates', so much of the discussion focuses on the CTL. Thus, we have a situation where, according to some measures many people are 'in treatment', while at the same time, they are using a lot of drugs. Not surprisingly, many people providing a wide variety of well-subscribed services legitimately feel that drug problems are developing (such as a youth cocaine interest) on which their services are having little or no impact.

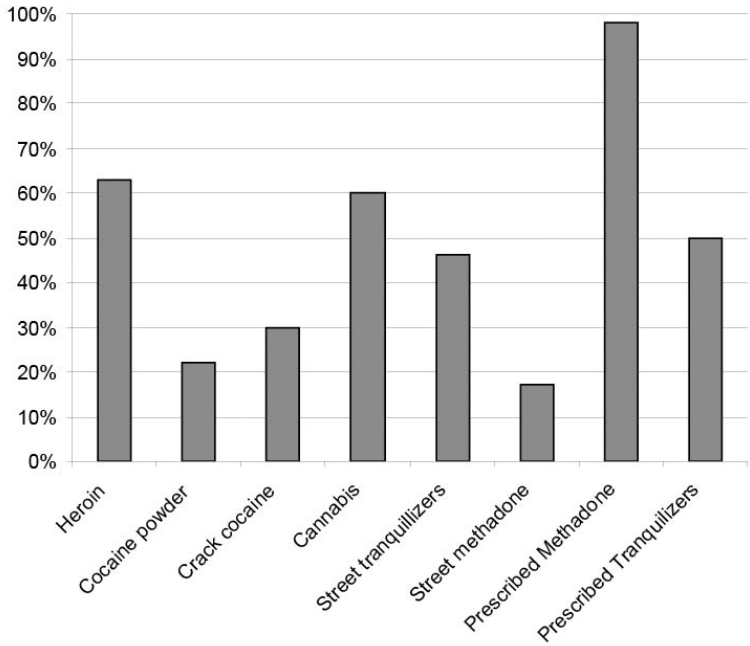
Poly-drug Use, Social Problems and the Definition of 'Services'

This confusion, however, is not simply a matter of definition. As we have seen, the same person can present multiple facets and several different challenges to the service structure. Our statistics echo the ethnographic data in underscoring how actual drug use in Ireland differs dramatically from the way that the drug-user appears in the vision of government and public understandings of the problem or, indeed, in most official understandings of 'treatment'. With the exception of heroin, nearly all the drug-users in this study potentially use nearly everything, and practically no heroin-user *only* uses heroin. Indeed, one of the primary markets for the emergence of crack is former 'gear-users' who have been stabilized on methadone. At the risk of belabouring the point, then, in any instance with which we are acquainted, no one uses merely one drug, and nearly everyone who is using avails of a dizzying array of legal and illegal pharmaceuticals, in combinations that generally change (sometimes dramatically) over time. For this reason, the understanding of people being 'outside of services' is related to, and as difficult to pin down, as the question of 'what is a drug'? Is a person on methadone, who uses benzos and hash regularly and cocaine when it is available, 'in treatment' for opiates, or outside of it for his or her other pharmacological interests? What if he

or she is still using heroin occasionally? Is a person buying methadone on the street to control a spiralling 'gear' problem attempting to self-treat or merely adding another problem drug to his or her use pattern? Is a young person, involved in one of the many services for youth available in the area, who is increasing her use of cocaine (while also using 'hash' and alcohol), in any meaningful sense available to the formal drug services? Is her friend outside of the service infrastructure entirely, who is withdrawing from cocaine into regular weekend Ecstasy use, a logical target for services or engaged in her own harm-reduction programme?

There are no simple answers to the questions above. An analysis of the completed questionnaires from the survey makes it clear that being on a methadone programme *per se* does not mean that one no longer uses illicit drugs, never mind abusing legal pharmaceuticals. The vast majority of those we surveyed who were on methadone treatment, for example, had taken an illicit drug in the last three months. The majority of respondents continued to use heroin and smoked cannabis regularly. Almost half had either used cocaine or crack and a significant proportion bought minor tranquilizers on the street, regardless of whether they were also prescribed them. A smaller number had bought 'street methadone' on top of their MMT prescription.

Figure 3. Current drug use (previous 90 days) among survey respondents (n=92)



Looking to the Future

As we have seen in these narratives, people make choices around drugs, but not just as they please and certainly not in a time or at a place of their own choosing. Drugs appear in these stories, at least initially, as both social products *and* as productive of certain social practices, central to specific scenes. They are almost always initially a source of pleasure within a social setting, central to young people's understanding of their emerging identity, as well as a way of avoiding (generally individual) pain or boredom. Indeed, they are even productive of a certain kind of community. All these stories of use, for example, start out as collective enterprises, and even the economy of drugs, as when Sandra was living well on her snooker hall franchise, in part develops from, and strengthens,

certain pre-existing networks. Such networks are very enduring: complex networks of kinship and debt, for example, are fundamental to understanding much of the social life in the area. Drugs and cash circulate in these networks, but so do many other things, such as intimacy and affection, and sometimes pain and abuse. One of the significant local markers of the professionalization of dealing, on the other hand, is the increasing removal of dealers from such networks, with cocaine emerging as a genuine commodity: buyer and seller are connected predominantly through a cash nexus, with debt collection becoming an increasingly ruthless enterprise, and violent competition between rival franchises now commonplace.

At the same time, of course, the compounds graphed above also present themselves as severe personal and social risks. Bodies can be literally unmade – infectious disease, vascular destruction, and potential brain damage, amongst other problems – impose high mortality and morbidity burdens on this population. In these situations, the social fabric is shredded faster than it can be knit anew – from ripping off one's friends to actual violence between intimates and strangers – and, thus, something quite like pathology can live simultaneously at individual, familial, and community levels. Use of certain compounds, furthermore, produces other subjectivities, besides, 'high', 'able to get on with things', and 'junkie', such as 'buyer' and 'seller', even 'vigo'. Some of these roles can then become the basis of an often-dystopic local economy, but one with enough rewards, at least some of the time, to attract the intelligent, the ambitious, and the ruthless in different combinations. The drugs listed above, then, are at once individual and social things, their effects (for good and ill) are both biochemical and social-cultural, and, thus, 'drug-user' can look like a category too abstract for any useful local purpose, or so complicated that no apparatus of governance can productively engage it.

The Local Drugs Task Forces in the areas most afflicted by these problems have an intuitive feel for the complex intertwining of such issues with and within the lives of individuals, families, and the community, while having to understand and operationalize the seemingly clear-cut categories derived from policy. Their definition of 'services', therefore, often remains productively ambiguous. The disconnect that we alluded to in the Introduction seems to be between this local, largely tacit, understanding of 'drugs' and 'services' and the government's conception of the issue. It appears that government funders see the issue of problem drug use as one of treating a specific problem in specific communities with specific programmes, which leave obvious evidential signatures, rather like how an infection is treated in a patient, with a therapy whose effectiveness can be easily measured. The CTL is a good example of this vision. Everyone on this list is, by definition, 'in treatment', and the number 'in treatment' has clearly levelled off in this area; therefore, the problem appears to be coming under control. From this vantage point, certain social facts are invisible, such as the protestation of more than half of our sample that they do not consider 'phoy' treatment (e.g., 'I'm a government junkie'), as well as the widely-known, but rarely discussed, social reality that at any one time probably up to half of the CTL is also using heroin, and, in any event, nearly all of them are using lots of other drugs. Without underplaying the obvious good that MMT does in many cases, methadone is at best at the starting point of services for an opiate user, not its conclusion, and, of course, many people with serious issues with drugs besides heroin will never take methadone.

On the other hand, the Local Drugs Task Forces are comfortable with a much broader understanding of interventions in the lives of users. To change our medical metaphor, from ground level, the types of problem drug use that we discuss in this report look more like a diagnostic dye than an infection as such, highlighting an area that may require several, simultaneous interventions. No one drug is 'the problem': instead, several interlocking issues need to be addressed, issues that

dense concentrations of drug abuse highlight. The flip side of this broadness of vision, however, is that the service profile that emerges is always at risk of a management-speak critique (and associated threats to funding). Youth groups, theatre, art projects, job counselling and life skills can be seen to 'dilute the focus' of a Local Drugs Task Force's Mission. Such activities are logically in the remit of other organizations, getting funding from, and reporting to, other ministries. The paradox is that the closer one gets to the ground, the more this flexible approach to service-provision makes sense, while the farther away from the local level one goes, the harder it is to articulate, in terms meaningful to policy-makers, why exactly it does so.

The relative maturity of many of the opiate users in the Canal Communities area, as well as, the relatively robust development of the formal infrastructure addressing opiate use presents a chance for the Task Force to begin resolving this paradox. The stabilization of lives on the CTL, coupled with the evident expansion of other drugs, provides an opportunity for reflecting on the question of 'What's next?' in a way that would be difficult for other areas and other Local Drugs Task Forces who are still coping with increasing numbers of new heroin-users clamouring for the expansion of the Methadone Protocol. Our data, for example, show clearly that moral panic drugs, like cocaine, are in fact an issue for people successfully using methadone (sometimes for years), as well as for people well outside of the formal treatment services. At the same time, we demonstrate that to be 'in treatment' is itself an achievement for both the recipient and provider of services; it does not automatically follow from one's induction onto a list. Thus, more meaningful markers of successful treatment are needed, ones that take into account people's actual lives, rather than simply their blood chemistry. Human beings not chemicals, then, are the objects of treatment, and one of the things that treatment must clearly do is assist a particular person in developing another orientation not just to drugs, but to life.

APPENDIX

RESULTS OF THE QUANTITATIVE SURVEY

The target population for the quantitative survey was service-based. People included in the survey were those using heroin or methadone. Respondents were recruited in through drop-ins, Community Drug Teams, needle exchanges, GP surgeries, treatment clinics, and from referrals from outreach workers and primary respondents within the Canal Communities area. The survey instrument was administered by the Field Researcher, with the assistance of a trained research assistant.

One hundred people were recruited, 63% male and 37% female at the different sites. Eight questionnaires were deleted from the analysis as they were either repeats or the respondent no longer used methadone or heroin.

DEMOGRAPHICS

Age by sex

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Age Group	<21	2	3.4%	0	.0%	2	2.2%
	22-27	9	15.5%	7	20.6%	16	17.4%
	28-34	23	39.7%	16	47.1%	39	42.4%
	34-40	13	22.4%	8	23.5%	21	22.8%
	41+	11	19.0%	3	8.8%	14	15.2%

Age group by location

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Locale	Inchicore (Kavanagh House, Health Centre, referral)	19	32.8%	8	23.5%	27	29.3%
	Rialto (St Andrews & referral)	12	20.7%	11	32.4%	23	25.0%
	Bluebell (GP, homes, outreach)	10	17.2%	4	11.8%	14	15.2%
	Dr. Steeven's Clinic (Ailsling & Castle St)	17	29.4%	11	32.4%	28	30.4%

Education

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Highest level of education completed	Lower sec.	28	48.3%	24	72.7%	52	57.1%
	Primary	16	27.6%	3	9.1%	19	20.9%
	Upper sec.	7	12.1%	6	18.2%	13	14.3%
	No formal education	6	10.3%	0	.0%	6	6.6%
	Third level	1	1.7%	0	.0%	1	1.1%

With whom do you live?

		Gender				Total	
		Male		Female		Count	Table %
		Count	Table %	Count	Table %		
With whom do you live	Partner	4	4.3%	3	3.3%	7	7.6%
	Children	0	.0%	10	10.9%	10	10.9%
	Parents	10	10.9%	0	.0%	10	10.9%
	Sibling(s)	3	3.3%	0	.0%	3	3.3%
	Other family	2	2.2%	0	.0%	2	2.2%
	Alone	11	12.0%	5	5.4%	16	17.4%
	Partner and kids	15	16.3%	5	5.4%	20	21.7%
	Parent(s) sibs	5	5.4%	2	2.2%	7	7.6%
	Homeless accom.	3	3.3%	4	4.3%	7	7.6%
	Kids other family	5	5.4%	5	5.4%	10	10.9%

Children

Seventy-six per cent of those interviewed said they had children giving a total of 156 children. Of these, about half (76) were living with the respondents.

SOCIO-ECONOMICS

Social grade and employment

		Gender				Total	
		Male		Female		Count	Table %
		Count	Table %	Count	Table %		
Social Grade Definition	B	1	1.1%	0	.0%	1	1.1%
	C	1	1.1%	0	.0%	1	1.1%
	C1	5	5.5%	1	1.1%	6	6.6%
	C2	3	3.3%	0	.0%	3	3.3%
	D	3	3.3%	4	4.4%	7	7.7%
	E	45	49.5%	28	30.8%	73	80.2%

Employment history in the past 3 months

		Gender				Total	
		Male		Female		Count	Table %
		Count	Table %	Count	Table %		
A5i. In the past 3 months, have you had paid legal employment at any time?	Yes	14	15%	5	5%	19	21%
	No	44	48%	29	32%	73	79%
A6i. In the past 3 months, have earned any money through casual or cash-in-hand work?	Yes	8	9%	0	0%	8	9%
	No	50	54%	34	37%	84	91%
A7ai. In the past 3 months, have you earned any money from crime or illegal activities?	Yes	10	11%	6	7%	16	17%
	No	48	52%	28	30%	76	83%
A7bi. Are you currently in paid employment?	Yes	9	10%	1	1%	10	11%
	No	49	53%	33	36%	82	89%

Money earned over the past three months

	N	Minimum	Maximum	Mean	Std. Deviation
A5ii. For those who had worked in the past three months, how many weeks worked?	17	4.00	12.00	10.5882	2.42536
A5iii. Approximate salary per week?	16	185.00	800.00	304.0625	169.25542
A6ii. If earned money through casual work, how much money did you earn in the last month?	7	30.00	800.00	357.1429	315.31541
A7aii. If earned money through crime, how much money did you earn in the last month?	15	80.00	6000.00	1412.0000	1628.98391
A8. In the past three months, on average how much money have you had to live on each week (approx.)?	92	100.00	1500.00	262.2391	170.62943

DRUG USE

Nearly all of the respondents (98%) were being prescribed methadone at the time of questioning. The average number of days on methadone over the last three months was 86 days. The average amount prescribed was 86mls. Eighty-three respondents were prescribed methadone every day for the past three months. The most reported current (use in past three months) illicit drug used was heroin (63%) next was cannabis (60%). Half of those who smoked cannabis reported doing so daily. Forty-three per cent used heroin on twelve days or less over the previous three months while 33% used it more than sixty days during the three-month period. The next most used drugs were tranquillizers with 46% using illicit forms. Thirty percent had used crack in the past 3 months. Twenty-two percent had used cocaine powder, with more women using cocaine 26% than men 19%. Seventeen percent, moreover, had used methadone bought on the 'street' in the past three months

Illicit drugs ever used (n=92)

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Heroin	Yes	58	100%	34	100%	92	100%
Other opiates	Yes	28	49%	14	42%	42	47%
	No	29	51%	19	58%	48	53%
Cocaine powder	Yes	48	84%	25	76%	73	81%
	No	9	16%	8	24%	17	19%
Crack cocaine	Yes	39	68%	16	48%	55	61%
	No	18	32%	17	52%	35	39%
Cannabis	Yes	54	95%	28	85%	82	91%
	No	3	5%	5	15%	8	9%
Street tranquillizers	Yes	43	75%	22	67%	65	72%
	No	14	25%	11	33%	25	28%
Street methadone	Yes	35	61%	12	36%	47	52%
	No	22	39%	21	64%	43	48%

Current illicit drug use (past three months) n=92

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Heroin	yes	36	62%	22	65%	58	63%
	no	22	38%	12	35%	34	37%
Other opiate	yes	1	2%	1	3%	2	2%
	no	57	98%	33	97%	90	98%
Cocaine powder	yes	11	19%	9	26%	20	22%
	no	47	81%	25	74%	72	78%
Crack cocaine	yes	19	33%	9	26%	28	30%
	no	39	67%	25	74%	64	70%
Cannabis	yes	37	64%	18	53%	55	60%
	no	21	36%	16	47%	37	40%
Street tranquillizers	yes	27	47%	15	44%	42	46%
	no	31	53%	19	56%	50	54%
Street methadone	yes	14	24%	2	6%	16	17%
	no	44	76%	32	94%	76	83%

Prescribed methadone and tranquilizers (past three months)

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Methadone	yes	56	97%	34	100%	90	98%
	no	2	3%			2	2%
Tranquillizers	yes	25	43%	21	62%	46	50%
	no	33	57%	13	38%	46	50%

Illicit drug use among those on prescribed Methadone for past three months (n=83)

		A1. Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Heroin	yes	28	56%	21	64%	49	59%
	no	22	44%	12	36%	34	41%
Cocaine powder	yes	9	18%	9	27%	18	22%
	no	41	82%	24	73%	65	78%
Crack cocaine	yes	16	32%	9	27%	25	30%
	no	34	68%	24	73%	58	70%
Cannabis	yes	32	64%	18	55%	50	60%
	no	18	36%	15	45%	33	40%
Street	yes	24	48%	15	45%	39	47%
Tranquillizers	no	26	52%	18	55%	44	53%
Street	yes	10	20%	2	6%	12	14%
methadone	no	40	80%	31	94%	71	86%

Number of days using illicit drugs over the past three months

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Heroin	1-12 days	14	39%	11	50%	25	43%
	12-30 days	5	14%	2	9%	7	12%
	31-60 days	5	14%	2	9%	7	12%
	61-90 days	12	33%	7	32%	19	33%
Total		36	100%	22	100%	58	100%
Cocaine powder	1-12 days	7	64%	7	78%	14	70%
	12-30 days	1	9%	1	11%	2	10%
	31-60 days	2	18%			2	10%
	61-90 days	1	9%	1	11%	2	10%
Total		11	100%	9	100%	20	100%
Crack cocaine	1-12 days	12	63%	4	44%	16	57%
	12-30 days	2	11%	1	11%	3	11%
	31-60 days	3	16%	3	33%	6	21%
	61-90 days	2	11%	1	11%	3	11%
Total		19	100%	9	100%	28	100%
Cannabis	1-12 days	9	24%	4	22%	13	24%
	12-30 days	5	14%	1	6%	6	11%
	31-60 days	5	14%	2	11%	7	13%
	61-90 days	18	49%	11	61%	29	53%
Total		37	100%	18	100%	55	100%

Street Tranquillizers	1-12 days	16	59%	5	33%	21	50%
	12-30 days	4	15%	2	13%	6	14%
	31-60 days	2	7%	3	20%	5	12%
	61-90 days	5	19%	5	33%	10	24%
Total		27	100%	15	100%	42	100%
Street Methadone	1-12 days	9	64%	2	100%	11	69%
	12-30 days	2	14%			2	13%
	31-60 days	2	14%			2	13%
	61-90 days	1	7%			1	6%
Total		14	100%	2	100%	16	100%

Illicit drug use (past three months) by those *not* prescribed tranquillizers n=46

		Gender				Total (n=46)	
		Male (n=33)		Female (n=13)		Count	Col %
		Count	Col %	Count	Col %		
Heroin	yes	21	64%	9	69%	30	65%
Other opiates	yes	1	3%			1	2%
Cocaine powder	yes	7	21%	4	31%	11	24%
Crack cocaine	yes	9	27%	1	8%	10	22%
Cannabis	yes	17	51%	6	46%	23	50%
Street Tranquillizers	yes	17	51%	5	38%	22	48%
Used street methadone	yes	9	27%			9	20%

Illicit drug use (past 3 months) by those prescribed tranquillizers n=46

		A1. Gender				Total (n=46)	
		Male (n=25)		Female (n=21)		Count	Col %
		Count	Col %	Count	Col %		
Heroin	yes	15	60%	13	62%	28	61%
Other opiates	yes			1	5%	1	2%
Cocaine powder	yes	4	16%	5	24%	9	20%
Crack cocaine	yes	10	40%	8	38%	18	39%
Cannabis	yes	20	80%	12	57%	32	70%
Street Tranquillizers	yes	10	40%	10	48%	20	43%
Street methadone	yes	5	20%	2	9%	7	27%

Women were more likely than men to be prescribed minor tranquilizers over the past three months (62% vs 43% P<0.5)

More respondents who used minor tranquilizers also used heroin in the past three months 71% vs. 56%. However this did not reach significance P=0.09

Crack use was associated with current heroin use, with 79% of those using crack in the past three months also using heroin, compared to 56% not using crack (p<0.05).

Gender was not associated with current heroin use 62% of men used heroin in the past three months compared with 65% of women.

Frequency of alcohol and tobacco consumption n=92

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Days used Alcohol in the past three months	.00	20	35.7%	10	32.3%	30	34.5%
	1-12 days	19	33.9%	10	32.3%	29	33.3%
	12-30 days	6	10.7%	6	19.4%	12	13.8%
	31-60 days	4	7.1%			4	4.6%
	61-90 days	7	12.5%	5	16.1%	12	13.8%
Total		56	100.0%	31	100.0%	87	100.0%
Days used Cigarettes in the past three months	.00	2	3.9%	1	4.2%	3	4.0%
	1-12 days	1	2.0%			1	1.3%
	61-90 days	48	94.1%	23	95.8%	71	94.7%
Total		51	100.0%	24	100.0%	75	100.0%

Excluding alcohol and cigarettes, have you taken non-prescribed drug in last three days?

		A1. Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
B4.	Yes	34	60%	22	69%	56	63%
	No	23	40%	10	31%	33	37%
Total		57	100%	32	100%	89	100%

1Amount spent on drugs in an average week

		Gender				Total	
		Male		Female		Count	Col %
		Count	Col %	Count	Col %		
Euros	Nothing	7	12.1%	6	17.6%	13	14.1%
	Less than 30	5	8.6%	2	5.9%	7	7.6%
	30 to 59	9	15.5%	4	11.8%	13	14.1%
	60 to 119	23	39.7%	10	29.4%	33	35.9%
	120 to 249	5	8.6%	5	14.7%	10	10.9%
	250 to 1000	9	15.5%	7	20.6%	16	17.4%
Total		58	100.0%	34	100.0%	92	100.0%

Females were more likely to be prescribed minor tranquilizers (62%) compared to males (43%)

CRIME

Eighty-seven per cent of the respondents reported having been involved in crime at some time in the past. The most prevalent crime was theft from a commercial property; however, this was more prevalent in the oldest age group. The next most prevalent crime was drug-selling (58%). All crimes, bar prostitution, were reported more often by men. Only two respondents reported soliciting or prostitution, which we feel represents an under-report of how commonly sex is directly exchanged for cash or goods.

One-third of respondents had committed at least one of the listed crimes within the last 3 months. The younger respondents were more likely to have committed *recent* crimes.

One-third of the young age group reported selling or supplying drugs compared to 11% of the middle age group and 18% of the older age group. All crimes bar *theft from a commercial property, fraud,* and *soliciting/prostitution* were committed more frequently over the past three months by men. There was a relationship between recent crack use and money made recently through crime.

Have you ever been involved in crime?

		Frequency	Percent	Valid Percent	Cumulative Percent
E1.	Yes	80	87.0	87.9	87.9
	No	11	12.0	12.1	100.0
Total		91	98.9	100.0	

Selling and supplying drugs, ever committed?

		Frequency	Percent	Valid Percent	Cumulative Percent
E2ai.	Yes	53	57.6	66.3	66.3
	No	27	29.3	33.8	100.0
Total		80	87.0	100.0	

Have you ever served a custodial sentence?

		Frequency	Percent	Valid Percent	Cumulative Percent
E3i.	Yes	52	56.5	57.1	57.1
	No	39	42.4	42.9	100.0
Total		91	98.9	100.0	

Risky behaviour by those who have injected in the past three months

Seventy-seven per cent of the respondents had snorted cocaine in the past, with 53% having shared snorting paraphernalia. Seventy per cent had injected drugs in the past, with 27% having injecting in the past three months. On average, those who injected drugs did so for forty-one of the previous ninety days. This was highest among the youngest age group and the oldest age group. Women who injected did so over twice as many times per day as men.

How many days have you injected in the last three months?

		Frequency	Percent	Valid Percent	Cumulative Percent
C2iii.	<=7	8	320	13.0	34.8
	8-35	4	16.0	17.3	52.2
	36-60	3	12	12.9	65.2
	90.00	8	32.0	34.8	100.0
	Total	23	92.0	100.0	

Have you ever used a needle or syringe that may have been used by someone else?

		Frequency	Percent	Valid Percent	Cumulative Percent
C5ai.	Yes	15	60.0	60.0	60.0
	No	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

No one had used a needle or syringe that may have been used by someone else in the past month.

Have you ever passed a used needle or syringe on to someone else?

		Frequency	Percent	Valid Percent	Cumulative Percent
C5bi	Yes	12	48.0	48.0	48.0
	No	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

No one has passed on a used needle or syringe in the past month.

Have you ever reused own needles?

		Frequency	Percent	Valid Percent	Cumulative Percent
C6i.	Yes	24	96.0	96.0	96.0
	No	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Fourteen re-used own needles in the past month

Have you ever used a filter, spoon or flush water that may have been used by someone else?

		Frequency	Percent	Valid Percent	Cumulative Percent
C7i	Yes	14	56.0	56.0	56.0
	No	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

Nine had shared works in the past month (filter, spoon, flush water, someone else)?

Have you had sex in the last three months?

		Frequency	Percent	Valid Percent	Cumulative Percent
C8i.	Yes	17	68.0	68.0	68.0
	No	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

If yes, did you use a condom?

		Frequency	Percent	Valid Percent	Cumulative Percent
C8ii.	Always	3	12.0	17.6	17.6
	Sometimes	8	32.0	47.1	64.7
	Never	6	24.0	35.3	100.0
	Total	17	68.0	100.0	

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Canal Communities
Local Drugs Task Force

c/o Bridge House, Cherry Orchard Hospital,
Ballyfermot, Dublin 10
Tel: 01 6206455 /6206413
e-mail: elaine.whelan1@hse.ie / mary.ryder2@hse.ie

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