

# **Providing Primary Health Care to Drug Users in Clondalkin**

**By**

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**Funded by the Clondalkin Drugs Task Force**

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The views expressed are those of the author and do not necessarily reflect the views of the Clondalkin Drugs Task Force or Merchants Quay Ireland.

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## Executive Summary

In 2001 the Clondalkin Drugs Task Force prepared and oversaw the implementation of an updated Area Action Plan. One of the gaps highlighted in the Plan was the limited capacity of existing services to respond to the primary health care needs of drug users in the locality. In response, the Task Force commissioned the Research Department of Merchants Quay Ireland to carry out a research study to address this issue.

## Research Objectives

The overall aim of this research was to identify an appropriate model that would facilitate the provision of a primary health care service to problematic drug users in the Clondalkin area. The objectives of the research study were:

- to obtain a profile of the primary health care needs of problematic drug users in the Clondalkin area;
- to document the nature and extent of existing primary health care services and identify gaps in both statutory and non-mainstream services;
- to investigate the issues and barriers for the target group in accessing mainstream services;
- to identify a range of models of good practice at local, national and international level; and

- to identify an appropriate operational model to respond to the primary health care needs of drug users in Clondalkin.

## Research Methodology

Both qualitative and quantitative methodologies were employed in this research. At the beginning of the research a focus group was carried out with a group of 6 drug users from Clondalkin to gather qualitative information on their health care needs as well as identifying barriers in accessing mainstream services. This qualitative information informed the design of the survey. A convenience sample of 30 drug users were interviewed using a questionnaire. A purposive sample of 15 professionals participated in the in-depth interviews. These included 5 GPs, 4 service planners, 3 drug service providers, 2 health care professionals and 1 policy maker. Several local GPs refused to participate in the study due to heavy workloads.

The results from the questionnaire were entered directly into SPSS for Windows. All percentages are based on valid responses, adjusted for missing data. The focus group and in-depth interviews were transcribed verbatim and coded into relevant themes and patterns using the computer package Nud\*st 6.

## Results

### Demographics

- Two-thirds of the respondents were male (n = 20, 67%) and one third was female (n = 10; 33%)
- The mean age of respondents was 27.4 years.
- Two-fifths of the respondents (n = 12, 40%) had children.
- One-third (33%, n = 10) of the respondents were from north Clondalkin, 40% (n = 12) were from south-west Clondalkin, while over a quarter of the respondents (27%, n = 8) were originally from Clondalkin but living in another part of Dublin city.
- Over two-fifths (n = 13, 43%) of respondents were living in their family home, while over one-fifth (n = 7, 23%) were living in local authority accommodation. Five (17%) were living in private rented accommodation, while almost one fifth (n = 5, 17%) were homeless.
- Over half (n = 14, 56%) reported that their accommodation was temporary, while 3 (12%) regarded their accommodation as overcrowded.
- Two-fifths (n = 12, 40%) of respondents were early school leavers.
- Over half (n = 17, 57%) the respondents were unavailable for work or on disability allowance, while over a quarter (n = 8, 27%) were unemployed.
- Almost three-quarters (n = 21, 70%) of respondents had spent some time in prison

### Alcohol and Drug Use

- Almost all the respondents were teenagers when they first used illicit drugs, and the majority (n = 21, 70%) reported that cannabis was the first illicit drug they used.<sup>1</sup>
- The vast majority (n = 26, 87%) had injected drugs at some point during their drug using career. The mean age of first injecting was 18.4 years and the majority (n = 21, 81%) reported heroin as being the first drug they took intravenously.
- Two-fifths (n = 12, 40%) of respondents reported injecting in the 4 weeks prior to interview.
- Twenty-one respondents (70%) were using both licit and illicit drugs. The vast majority of those interviewed were polydrug users (n = 28, 93%).
- During the 4 weeks prior to interview, the most commonly used drug was methadone (n = 26, 87%). The vast majority (n = 24, 92%) were prescribed it. Half those interviewed (n = 15, 50%) were currently using methadone and heroin, 13 (43%) were currently using methadone and cocaine, while 20 (67%) were currently using methadone and sedatives/tranquilisers/anti-depressants.
- Almost three-quarters of those interviewed (n = 22, 73%) reported currently using sedatives/tranquilisers/anti-depressants and cannabis respectively
- Almost two-thirds of respondents reported currently using heroin (n = 19, 63%) while almost a half were using cocaine (n = 14, 47%). Over a third of the sample (n = 11, 37%) were currently using both heroin and cocaine.
- Two-thirds of the respondents (n = 20, 67%) were regular drinkers, with one third of the sample (n = 9, 30%) drinking over the recommended weekly limits of alcohol.

### *Risk Behaviour and Health*

- Over two-fifths (n = 5, 42%) of current injectors reported injecting in their arm, while a third stated they injected in their groin (n = 4, 34%).
- Two-thirds of current injectors (n = 8, 67%) reported that they had shared injecting paraphernalia (i.e. spoons and filters) in the 4 weeks prior to interview, while a third (n = 4, 33%) had borrowed injecting equipment and a quarter of current injectors (n = 3, 25%) had lent their injecting equipment to someone else. A third of current injectors (n = 4, 33%) had shared a needle at least once during the 4 weeks prior to interview.
- The majority of those who were sexually active (n = 9, 60%) used condoms as a method of contraception, while over a quarter of those (n = 4, 26%) who were sexually active never used any means of contraception.
- The vast majority (n = 25, 83%) of respondents reported that they had had a HIV test in the past.
- The majority of respondents had been tested for Hepatitis B (n = 25, 83%) and also vaccinated against the virus (n = 24, 80%). Over half (n = 16, 53%) reported that their Hepatitis B status was negative, while 14 (47%) were unsure of their status.

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<sup>1</sup> It is likely that alcohol was the first drug used by participants, but alcohol was not included in this question.



- Most of the respondents (n = 27, 90%) had been tested for Hepatitis C. The vast majority tested positive (n = 18, 60%), while 5 respondents (17%) had a negative status. Almost a quarter (n = 7, 23%) were unaware of their status.
- Over half the respondents (n = 16, 53%) requested more information on Hepatitis C.
- The majority (n = 21, 70%) of respondents reported suffering from 5 or more physical complaints. The mean number of physical conditions reported was 7.
- Over half of the respondents complained of headaches, weight problems, constant fatigue, sleep problems and poor appetite, while 14 (47%) reported having dental problems.
- Levels of reported mental health complaints were extremely high.

### *Service Provision in Clondalkin*

- There are a range of drug services available to drug users in Clondalkin and the vast majority of GPs in the vicinity are willing to provide primary health care to this target group.
- However a number of gaps were highlighted including: the absence of a needle exchange and centralised drugs clinic; no service to meet the immediate health care needs of more chaotic drug users, difficulties accessing psychiatric care; and a lack of follow-on care for those who were Hepatitis C positive.

### *Drug Service Provision*

- All current injectors (n = 12) had been to a needle exchange in the 6 months prior to interview. The most frequently attended needle exchange (n = 6, 50%) was at Merchants Quay Ireland.
- Two-thirds of current injectors (n = 8, 67%) reported that they had difficulties accessing clean injecting equipment. The most common complaint was that there was no needle exchange in Clondalkin and they had to travel to the city centre.
- All current injectors (n = 12, 100%) interviewed believed that there was a need for a place where they could inject drugs safely (i.e. a safe injecting room) and most of them (n = 11, 92%) reported that they would use such a facility.
- Among those who had ever been prescribed methadone (n = 28), 14 (50%) experienced difficulties accessing a programme. The main difficulty reported (n = 12) was long waiting lists. Key informants also cited long waiting lists as the main barrier to methadone maintenance as well as the assessment procedure, urinalysis, sanctions and the fact that some GPs are abstinence oriented.
- Over half (n = 16, 53%) of respondents attempted to detoxify from their drug use during the preceding 12 months. Among those who had attempted a detox, over two-thirds (n = 11, 69%) experienced difficulties.
- The vast majority (n = 25, 83%) of respondents reported that they had previously had some counselling related to their drug use. Two-thirds (n = 17, 68%) reported that they had gained some benefits, primarily by being able to talk to someone openly.
- All respondents (n = 30, 100%) felt that drug services could be improved for drug users from Clondalkin. The most frequently cited

recommendations were the need to increase the number of places on methadone maintenance programmes (n = 16, 53%) and to set up a needle exchange in Clondalkin (n = 11, 37%). These recommendations were echoed by key informants.

### *Access to Health Services*

- Half the respondents (n = 15, 50%) reported that they would go to their drugs clinic to obtain information on health.
- The vast majority (n = 25, 83%) of respondents had a medical card. Those who did not have a medical card were less likely to be registered with a GP or to have been to a GP in the previous 6 months.
- In the 6 months prior to interview, two-thirds (n = 20, 67%) of respondents had accessed the health services via GP, A&E or outpatient services.
- Level of contact and satisfaction with GPs was high among the sample. The overwhelming majority (n = 27, 90%) were registered with a GP and the majority of respondents (n = 18, 60%) reported that they would go to their GP if they had a medical problem. Over half (n = 17, 57%) of respondents had been to a GP in the last 6 months. The majority of respondents (n = 12, 71%) reported that they were very/quite satisfied with their GP.
- Despite the vast majority of respondents being registered with a GP, a substantial minority (n = 13, 43%) had not been to a GP in the last 6 months. Furthermore, the majority of those who had visited a GP had been for repeat prescription or administrative purposes. This would indicate that despite the existence of a range of health problems, as already mentioned, drug users are not addressing these issues within the primary health care setting.
- Real or perceived barriers for drug users accessing primary health care in this study included: the failure to view their health as a priority; the difficulty of adhering to strict appointment times; the negative attitude of some GPs towards drug users; and the fear of attending GP surgeries because they might be treated differently; and because of negative experiences in the past.
- It transpired during the in-depth interviews that some primary health care professionals were unwilling to work with drug users for a range of reasons. The main barrier was lack of understanding, due to lack of training. Occupational constraints mentioned included the fact that drug users were perceived as being time consuming and costly. Behavioural problems, cited as issues for primary health care providers, included violence, aggression and being demanding and difficult. Some primary health care professionals may have had a bad experience in the past, were concerned that drug users would put other patients off going to the surgery or were abstinence oriented and did not favour harm reduction. The main barrier for primary health care professionals who willingly worked with drug users was that they felt they were working in isolation due to lack of co-ordination.
- Overall the respondents were not satisfied with A&E services. The majority (n = 7, 59%) who attended A&E in the previous 6 months stated that they were very/quite dissatisfied with the service they received. Several felt they were treated particularly unfairly at A&E because they were drug users. However one fifth (n = 6, 20%) stated that they would go to A&E if they had a medical problem.

- Almost a third (n = 9, 30%) of respondents had attended an outpatient department in the previous 6 months and they were generally satisfied with outpatient services.
- Analysis revealed that homeless drug users had more difficulty accessing health services. Respondents who were homeless were less likely to have a medical card, to be registered with a GP and to have seen a GP in the previous 6 months. They were also proportionately less likely to have had contact with any health service.
- The majority of respondents (n = 18, 60%) did not believe that those who provided a health service (including GPs, pharmacists and general services) had enough knowledge of and training about drug users and drug using issues. There was also a general consensus among key informants that GPs were insufficiently trained in relation to drug issues.

### *Designing a Model for Primary Health Care*

- Respondents were equally divided on whether they would prefer specialised or generalist medical services. Nevertheless the vast majority of respondents (n = 27, 90%) stated that they would use a specialist health service if it existed.
- Overall, key informants did not support the establishment of a specialised service. They felt that specialised care might be expensive to operate, that it might not be as comprehensive as mainstream services, that it might be difficult to find health care professionals to work in such a service and that mainstream service providers might be able to avoid dealing with the target group. Furthermore, they felt it could further marginalise, stigmatise and isolate drug users and it was also not compatible with the latest primary health care strategy.<sup>2</sup>
- The vast majority of drug users surveyed showed a desire to access a range of services including general medical advice and information, hepatitis testing, counselling, STI screening, nutritional advice, methadone maintenance, acupuncture and detox. In addition to these services, key informants recommended that the following services be provided: immunisations; follow-on care for those with hepatitis or HIV; treatment for abscesses; safe injecting advice; services linking drug users with psychiatric services; social support and assistance for drug users in applying for medical cards and registering with a GP.
- All current injectors reported that they would use a needle exchange service in Clondalkin if it were provided.
- All drug users thought that it was essential that a nurse, GP, addiction counsellor and social worker should be part of a primary health care service for drug users. The vast majority also expressed a need for a psychiatric nurse, an outreach worker and a community welfare officer. Other suggested staff were peer workers, therapist in complementary medicine, chiropodist, psychiatrist, advocacy worker and family support worker. These professionals were also suggested in the in-depth interviews with key informants who generally felt that a multi-disciplinary approach was the most appropriate way of dealing with the multitude of issues with which drug users present.

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<sup>2</sup> Department of Health and Children. (DOHC). 2001. *Primary Care: A New Direction. Quality and Fairness – A Health System for You Health Strategy*. Dublin: Stationery Office.

- All the key informants supported the idea of having a 'liaison' or 'links' nurse in Clondalkin.
- Respondents felt it was most important that when providing health care for drug users to treat them with respect and to remain flexible, anonymous, professional and accessible. Moreover, the services should be staffed by professionals with a good knowledge of drug issues. Similarly, key informants felt that it was necessary that any health care provision be flexible, relaxed, holistic, accessible, confidential and comprehensive.

### *Proposed model for Primary Health Care for Drug Users in Clondalkin*

- A full-time Drugs Liaison Nurse should be recruited by the Clondalkin Drugs Task Force. The role of the Drugs Liaison Nurse will be three-fold:
  1. To address the immediate health care needs of drug users in Clondalkin.
  2. To support primary health care professionals in Clondalkin in providing care to drug users in the locality.
  3. To support co-ordination between those providing services to drug users in Clondalkin.

## **Chapter One**

### **Introduction**

Clondalkin lies 7 miles to the south west of Dublin City Centre. In 1997 a local Drugs Task Force was set up in the area. The role of the Drug Task Force is to facilitate a more effective response to the drug problem in the local area. It comprises a partnership between the statutory, voluntary and community sectors. In 2001, the Clondalkin Drugs Task Force prepared and oversaw the implementation of an updated Area Action Plan. One of the gaps highlighted in the Plan was the limited capacity of existing services to respond to the primary health care needs of drug users.<sup>3</sup> In response, the Task Force commissioned the Research Department of Merchants Quay Ireland to carry out a research study to address this issue.

#### **1.1 Aims and Objectives**

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<sup>3</sup> Primary health care generally refers to 'the roles and functions of general medical practitioners, in association with other locally-based non-specialists in the paramedical field' (Butler, 2002b: 220).

The overall aim of this research was to identify an appropriate model that would facilitate the provision of primary health care to problematic drug users in the Clondalkin area. More specifically, the objectives of the study were:

- to obtain a profile of the primary health care needs of problematic drug users in the Clondalkin area;
- to document the nature and extent of existing primary health care services and identify gaps in both statutory and non-mainstream services;
- to investigate the issues and barriers for the target group in accessing mainstream services;
- to identify a range of models of good practice at local, national and international level; and
- to identify an appropriate operational model to respond to the primary health care needs of drug users in Clondalkin.

## 1.2 Outline of the Report

- Chapter Two reviews national and international research on the links between problematic drug use and health problems.
- Chapter Three focuses on the research methods employed in carrying out the research.
- Chapters Four, Five, Six, Seven and Eight present an analysis of the quantitative and qualitative data collected during the research.
- Chapter Nine examines some models of best practice in relation to providing primary health care to drug users.
- Chapter 10 outlines a model for providing primary health care to drug users in Clondalkin.

## Chapter Two

### Literature Review

This chapter reviews existing research on the health status and health care needs of drug users. The chapter commences with an overview of opiate use in Ireland and continues with a discussion on determinants of drug-related health problems (i.e. injecting risk behaviour and sexual risk behaviour). The following section examines the health consequences of problematic drug use (in particular HIV and Hepatitis B and C infection). The chapter concludes with an overview of the barriers faced by drug users in accessing primary health care and examines the merits of addressing the health issues of problematic drug users within a primary health care setting.

#### 2.1 Opiate Use in Ireland

It was not until the late 1970s that the use of opiates in Ireland was brought to public attention by health and social workers (O’Gorman, 1998). The proliferation of heroin use and its wider availability in the UK and the rest of Europe during the 1960s and 1970s meant that it was almost inevitable that it would filter through to Ireland. The first study carried out in Ireland by the Medico-Social Research Board on the prevalence of heroin use in Dublin estimated that 10% of those in the 15 – 24 age group had used heroin in the previous year (Butler, 1991). Recently, Kelly *et al.* (2003) estimated that there

were 14,452 opiate users in Ireland, of which 12,456 were in Dublin.<sup>4</sup> This indicates a decrease from the 13,460 opiate users estimated in the Greater Dublin Area in 1996 (Comiskey, 1998).

Treatment figures are the most reliable data available in relation to problematic drug use in Ireland.<sup>5</sup> Although treatment figures only indicate the number of opiate users in contact with drug services, the trends reflect what is happening among the general opiate using population. Treatment figures indicate that since the 1980s there has been a steady increase in heroin use in Dublin. In 1979 the Jervis Street Centre treated 55 heroin users, by 1980 the figure was 213 and by 1981, 417 (Dean *et al.*, 1985). In 1990, there were 1,752 people receiving treatment in Dublin, 574 for the first time (O'Hare and O'Brien, 1992). In 80% of the cases, heroin was the primary drug of use. The latest figures from the National Drug Treatment Reporting System (NDTRS) show an increase among those seeking treatment from the Eastern Regional Health Authority (ERHA) from 5,083 in 1998 to 6,248 in 2002.<sup>6</sup> This increase can be attributed to either an increase in drug use, service provision, or the numbers of services providing information on clients (O'Brien *et al.*, 2003).

Similarly, the number of those accessing drug treatment from the Clondalkin Task Force Area has been steadily increasing. The numbers of those seeking treatment from Clondalkin increased from 393 in 1998 to 493 in 2002, 60 of whom were receiving treatment for the first time. Therefore 8% of those receiving treatment in the ERHA were from the Clondalkin Task Force Area. The vast majority (n = 486, 98.6%) were receiving treatment for opiate use, while 7 (1.4%) were receiving treatment for cannabis use. Two-thirds (n = 326, 66%) of those in treatment from the Clondalkin Task Force Area were polydrug users.

The Irish government's main approach to treatment for heroin use is methadone maintenance. A register of those in receipt of methadone is kept on the Central Methadone Treatment List. These data are confidential and used to avoid duplication of methadone prescription. In August 2004, there were 7,190 heroin users on methadone maintenance programmes in Ireland. Among them 471 were from Dublin 22 (Clondalkin) representing 6.6% of the total number.

Treatment figures do not include clients who attend needle exchange services. Merchants Quay Ireland is the largest needle exchange in Ireland. In the year previous to this study (1<sup>st</sup> September 2003 – 31<sup>st</sup> August, 2004), there were 26,387 visits to the needle exchange. Visits from those residing in Dublin 22 (Clondalkin) represented 5% (n = 1,345) of the total visits.

## 2.2 Injecting Risk Behaviour

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<sup>4</sup> Current figures for the Local Drug Task Force areas, including Clondalkin, were not available at the time of study.

<sup>5</sup> Treatment refers to one or more of the following: detoxification; methadone reduction and substitution; addiction counselling; group therapy; psychotherapy; and/or life skills training.

<sup>6</sup> These figures refer to unpublished analysis from the National Drug Treatment Reporting System (NDTRS). The NDTRS is an epidemiological database on treated drug use in the Republic of Ireland. It is co-ordinated by the Drug Misuse Research Division of the Health Research Board.

Research carried out in Ireland during the last decade has shown that injecting drug users continue to engage in risky injecting practices. One of the early studies carried out among 106 attendees at a Dublin needle exchange in 1991 found that 34% of clients had shared injecting equipment with 2 or more people in the 28 days prior to interview (Johnson *et al.*, 1994). A more recent study undertaken at the needle exchange at Merchants Quay Ireland among 1,323 injecting drug users, found that 59% had shared injecting equipment at some stage in their injecting career, with 29% sharing in the 4 weeks prior to interview (Cox and Lawless, 2000). Another study carried out at Merchants Quay Ireland found that young injectors (i.e. those under the age of 25) were significantly more likely to have reported both lending and borrowing used needles and syringes in the 4 weeks prior to contact and were more likely to have shared injecting paraphernalia (i.e. spoons and filters) (Cassin *et al.*, 1998). As well as young injectors, female injectors (Cox and Lawless, 2000), homeless drug users (Cox and Lawless, 1999) and injecting drug users in prison (Long *et al.*, 2001) have also been found to be high risk groups.

### 2.3 Sexual Risk Behaviour

Research studies have found that injecting drug users practise unsafe sexual behaviour as well as unsafe injecting behaviour. Among their cohort of 106 attendees at a Dublin needle exchange, Johnson *et al.* (1994) found that only a quarter of them reported using condoms, although half of the sample said they had had multiple partners in the previous month. Research carried out among new attendees at Merchants Quay Ireland's needle exchange, found that 35% who were sexually active reported never using condoms, while 30% reported sometimes using condoms. Further analysis revealed that clients who reported having a regular sexual partner were significantly more likely to report never using a condom. The authors concluded that clients may find it difficult to introduce the use of condoms into a long-term relationship (Cox and Lawless, 2000). Drug users who work in the sex industry are at higher risk of the contraction of sexually transmitted diseases, as well as a greater risk of violence and sexual assault (Rowe, 2003).

### 2.4 Opiate Use and Health

Often drug users present with an array of health problems ranging from minor injecting-related injuries to severe chronic illnesses (Speed and Janikiewicz, 2000). Common health problems for problematic drug users include dental problems, respiratory conditions (such as bronchitis) and tuberculosis. Injecting drugs can also cause bacterial infections such as septicaemia, endocarditis and joint abscesses as well as potential vascular complications (Reid *et al.*, 2000). Phlebitis, an infection of the veins, is also relatively common, especially among injectors of benzodiazepines (Rowe, 2003). Other health complaints include skin diseases and gynaecological complaints (Reid *et al.*, 2000). Street-based drug-injectors are at higher risk of drug-related harm than other drug users including a higher risk of overdose, blood-borne viruses, violence, malnutrition and mental health issues (Rowe, 2003). Women are another high-risk group. A study carried out among 934 new attendees at the needle exchange at Merchants Quay Ireland between 1997 and 1998 found that female clients were more likely to report having abscesses, to be suffering from weight loss and to suffer depression (Geoghegan *et al.*, 1999). Furthermore, female

injectors are likely to suffer from amenorrhoea (the cessation of the menstrual cycle) (Rowe, 2003).

The link between injecting drug use and HIV (Human Immunodeficiency Virus) was established in the 1980s. In Ireland, statistics on newly diagnosed cases of HIV are available from the National Disease Surveillance Centre. In 2003, there were 399 new cases of HIV in Ireland. There were 47 new diagnoses among injecting drug users in 2003, compared to 50 in 2002 and 38 in 2001. This represented 11.8% of new diagnoses of HIV in 2003. The cumulative figures for the positive cases of HIV from the start of data collection in 1982 show that 33.2% (n = 1131) of all positive cases (n = 3408) were attributed to injecting drug use.

Research studies carried out to estimate the prevalence of HIV among particular cohorts of drug users have estimated HIV rates varying from 12% (O’Gorman, 1998) to 14.8% (Johnson *et al.*, 1994). Studies have also found that female injectors may be at increased risk of HIV transmission relative to their male counterparts (Barnard, 1993). O’Gorman (1998) warns that injecting drug users not in treatment are more likely to engage in HIV risk behaviour and consequently have a higher prevalence of HIV. Furthermore, she points out that HIV risk to drug injectors through sexual transmission is often overlooked.

As well as HIV, injecting drug users are at risk of Hepatitis C, which can be spread very readily via the sharing of needles, syringes and other paraphernalia. Hepatitis C has only recently become a notifiable disease, so there is no information collected to date on the number of positive tests in Ireland. However, research studies have found the prevalence of Hepatitis C among injecting drug users in Ireland to be extremely high. Among a group of 272 injecting drug users attending the National Drug Treatment Centre in 1995, Smyth *et al.* (1995) found that, among those who had been injecting for 2 years or more, 95% had Hepatitis C compared to 70% among those who had been injecting for 2 years or less. Moreover, Smyth *et al.* (1995) found that female injectors may be at more risk of Hepatitis infection than their male counterparts. They concluded that Hepatitis C rates were still quite high as harm reduction programmes had assisted in reducing unsafe injecting practices but had not succeeded in reducing risk factors associated with Hepatitis C (Smyth *et al.*, 1999).

Overall, opiate users have a mortality rate of up to 20 times higher than that of the general population of the same age. Overdoses (either fatal or non-fatal) among injecting drug users are often due to using heroin with alcohol, benzodiazepines and/or methadone (Strang *et al.*, 1999). The number of acute drug-related deaths (‘overdoses’) is a source of social and political concern (EMCDDA, 2001). Between the 1<sup>st</sup> January 1998 and 31<sup>st</sup> December 2001 the Dublin City and County Coroners investigated 332 opiate-related deaths. The vast majority (88.6%) of those who died resided within Local Drugs Task Force Areas (Byrne, 2002).

## 2.5 Barriers to Accessing Health Care

As the foregoing evidence indicates, drug users present with a wide range of health problems. However, often drug users do not address their health care needs because of a number of perceived or real barriers to accessing primary



health care. For instance, in a survey of 196 drug users in Sydney, 49% reported being reluctant to use health care services and 69% reported experiencing discrimination by health care services (Reid *et al.*, 2000). Drug users fail to use health services adequately often because they perceive general health services to be judgemental, inaccessible or inappropriate for their needs (Reid *et al.*, 2000). They also often distrust health services and fear breaches of confidentiality (Reid *et al.*, 2000). They are sometimes deterred by the negative attitude of some health care providers and rightly or wrongly, may often feel misled, dismissed and threatened by those they see as unfeeling and bigoted health care professionals' (Sherratt and Jones, 2003: 93).

Drug users are often deterred by procedural obstacles including waiting times, appointment schedules and financial barriers (Elion, 1990; Rowe, 2003, Speed and Janikiewicz, 2000). Furthermore, they feel that there is restricted time to speak about their problems and they fear being misunderstood or rejected by health care professionals (Reid *et al.*, 2000). There is sometimes a perception among drug users that preferential treatment is given to other clients (Speed and Janikiewicz, 2000). International research has also found that too much focus on abstinence can lead to conflict and repeated breakdown of treatment (Reid *et al.*, 2000; Speed and Janikiewicz, 2000). Nevertheless, British research has found that often the main aim for GPs for prescribing methadone is to get drug users "off drugs" (Watson, 2000).

Research has found that primary health care services are even more inaccessible for more chaotic drug users, such as street-based injectors and homeless drug users. In a study among street-based injectors in Australia, a number of barriers were reported to accessing health care. They were sometimes perceived as discriminatory, prohibitively costly, inaccessible when needed and inconvenient for those living transient lifestyles, or in need of immediate medical care (Rowe, 2003).

Providing primary health care to drug users is undoubtedly challenging and studies have found that GPs are often less willing to work with opiate users than other groups (Deehan *et al.*, 1997). Mistral and Velleman (2001: 70) concluded that even though there are very real and practical difficulties with treating drug users in primary care, 'the majority of GPs may experience a greater reluctance to work with illicit drug users than is justified by the numbers they see, or the problems they encountered'. There has been no published research in Ireland into the attitudes of GPs towards drug users. Anecdotal evidence prior to the introduction of the Methadone Protocol in 1998 suggested that;

most Irish GPs were disinterested in, if not antipathetic to, the idea that they should play a major role in the management of opiate dependency, some were enthusiastic about working with drug users and committed to doing so to a high professional standard and there was anecdotal evidence that a small but indeterminate number of 'rogue' doctors was exacerbating societal opiate problems and bringing their profession into disrepute through irresponsible prescribing of methadone (Butler, 2002a: 310 - 311).

International research has consistently cited numerous reasons why GPs are reluctant to work with drug users. One of the main reasons given is that GPs feel ill-equipped to deal with drug users due to lack of training (Sherratt and

Jones, 2003; Smith and Mistral, 2003). They feel they lack the knowledge and skills to treat drug users (Reid *et al.*, 2000). There are also occupational constraints. Reid *et al.* (2000) found that GPs complained that drug users were too costly in both time and money and were generally too difficult a group to serve. For instance, in a survey among 457 GPs in Edinburgh, Watson (2000) found that 53% felt that drug users took up a disproportionate amount of time. In a survey of 103 GPs in Wiltshire, England, 74% complained that illicit drug users failed to keep appointments, while 67% reported that drug users were particularly time-consuming (Mistral and Velleman, 2001). Violence and aggression are other pertinent issues for health care professionals. Sherratt and Jones (2003) found that 80% of professionals working in primary health care settings had experienced aggressive behaviour from drug users. Furthermore GPs are also concerned about the risk this poses to other patients and staff (Smith and Mistral, 2003) and they fear that other patients might be frightened away by the presence of drug users in the surgery (Greenwood, 1992a). In sum, Sherratt and Jones (2003: 92) concluded that 'GPs may have negative perceptions towards many drug abusers, fearing disruption at the surgery, abuse of themselves or surgery staff, lateness, missed appointments and unresolved demands, including those for replacement of lost script or medication'.

Some GPs have also admitted that they are reluctant to prescribe methadone as they are concerned that it could be subsequently leaked onto the black market. They feel it would encourage continued drug use and attract more drug users into the practice (Groves and Strang, 2001; Watson, 2000). Groves and Strang (2001) also found that reasons given by GPs for never prescribing methadone included the belief that patients could go to a specialist service to receive their prescription, problems in the past with opiate users and a general perception that problematic drug use was not a medical problem. In fact, Gabbay and Carnwath (2000: 92 – 3) found that primary health care professionals felt they are being 'expected to carry the burden for what is primarily a social problem'. As a result, many GPs advocate detox and abstinence rather than harm reduction and maintenance, even though, according to Groves and Strang (2001) this approach can lead to disillusionment. Despite the reluctance of some GPs to prescribe methadone maintenance, research has shown that those GPs who do, can produce significant harm reduction outcomes for clients. British research has found that providing methadone maintenance within primary health care has been shown to reduce mortality and morbidity among heroin users (Keen *et al.*, 2002). Moreover, in a longitudinal study of 65 heroin users receiving methadone maintenance treatment at a GP surgery in Sheffield, Keen *et al.* (2003) found a significant improvement in illicit drug use, risk-taking behaviour, crime and physical health.

Opiate use can cause dental problems. As well as primary health care services, drug users often avoid dentists because of limited income, fear of dentists and having to wait long periods for appointments (Reid *et al.*, 2000). Furthermore, drug users may neglect their oral hygiene as their drug use often kills the pain of dental problems (Wodak, 1998).

Despite these barriers there are primary health care professionals who are willing to work with opiate users and some have high involvement with this group (Groves and Strang, 2001). Factors which help GPs become more involved with drug users include: establishing a good rapport with the client;

receiving support; developing a more holistic view of drug users; and believing that treatment will benefit clients and the wider community (Groves and Strang, 2001; Groves *et al.*, 2002).

## 2.6 Primary Health Care

In its strategy *Primary Care: A New Direction* the Irish government laid out its model for primary health care. The government put primary health care as the central focus of the health system as this should lead to 'better outcomes, better health status and better cost-effectiveness' (2001: 7). This *Strategy* marked a shift from over-reliance on acute services to one-stop shop where clients can access a range of health and social care professionals. However, despite the fact that national and international literature has demonstrated that drug users experience health inequalities and inequities, they are not mentioned as a particular group in national health strategies (DOHC, 2001) or proposed local community initiatives (Cosgrove, 2003).

It is generally considered that primary health care is the most appropriate way of meeting the health care needs of drug users, although some commentators such as Merrill and Ruben (2000: 204), argue that there is a dearth of evidence to support this view as 'treatments have varied considerably and outcomes have been inconsistent and ill-defined'. Nevertheless, research has generally found that GPs are better placed to monitor general medical needs than a specialist drug service (Carnwath *et al.*, 2000). Similar to other countries in the late 1980s, Irish healthcare policy 'began to swing towards the view that family doctors had a role to play in the management of drug problems' (Butler, 2002b: 221). However, involving GPs in methadone prescribing was not easy in Ireland and Butler (2002b: 221) describes it as 'a difficult and complex one which was tackled in a relatively covert way through small policy-making networks co-ordinated by the Department of Health'.

The provision of primary care for drug users does require GPs to be flexible, supportive and non-judgemental (Elion, 1990). However, if only a few GPs take part in providing primary health care services to drug users they become overburdened and feel they are working in isolation (Carnwath *et al.*, 2000; Mistral and Velleman, 2001). When health services are more accessible for drug users, there is usually an overall decrease in medical costs for the government (Reid and Crofts, 2000).

## 2.7 Summary and Conclusions

Since the late 1970s, the number of heroin users has been increasing in Ireland. Treatment figures are the most reliable data available in relation to problematic drug use and these indicate that the number of those accessing treatment from the Clondalkin Task Force Area increased from 393 in 1998 to 493 in 2002, 60 of whom were receiving treatment for the first time. This represents 8% of all those receiving treatment from the Eastern Regional Health Authority. Furthermore drug users from Clondalkin represent 6.6% of the total number accessing methadone maintenance programmes in Ireland.

Research carried out in Ireland has found that a substantial proportion of drug users in Ireland engage in injecting risk behaviour and sexual risk behaviour which have implications for Hepatitis and HIV. Prevalence rates of HIV among

injecting drug users have been estimated between 12% and 14.8%, while research has found much higher levels of Hepatitis C ranging from 70% to 95%. Drug users are also at risk of a number of other health problems ranging from minor injecting-related injuries to severe chronic illnesses.

Although drug users present with a wide range of health problems, often they do not address their health care needs because of a number of perceived or real barriers to accessing primary health care. International research has consistently found that a substantial proportion of GPs and other health care professionals unwilling to work with drug users for a range of reasons. Nevertheless, generally research has found that primary health care is the most appropriate way of meeting the needs of drug users and this is reflected in national and international health policies.

## **Chapter Three**

### **Methodology**

This chapter outlines the research methodology which was employed to achieve the objectives of the study. The chapter delineates the research instruments that were used and describes how the data were analysed.

#### **3.1 Sample**

Thirty drug users from Clondalkin were interviewed using a questionnaire. The development of a representative sample among drug users is problematic in view of the difficulty in accurately determining the numbers and characteristics of the sample size. Consequently convenience sampling is often the most appropriate method. This involves 'choosing the nearest and most convenient person to act as respondents. The process is continued until the required

sample size has been reached' (Robson, 1993: 141). Convenience sampling is often criticised on the basis that it is biased and can influence who is included in the sample. Therefore to reduce sampling bias, interviews were conducted in different locations and at different times during the day.

A purposive sample of 15 professionals participated in the in-depth interviews. Purposive sampling involves selecting respondents based on a known characteristic (May, 1997). For this study, individuals were chosen on the basis of their understanding and knowledge of drug-related issues and/or providing primary health care to marginalised groups. These included 5 GPs, 4 service planners, 3 drug service providers, 2 health care professionals and 1 policy maker. Several local GPs refused to participate in the study due to heavy workload.

## 3.2 Data Collection

Both quantitative and qualitative research methodologies were employed in this research.

### 3.2.1 Focus Groups

At the beginning of the research, a focus group was carried out with a group of 6 drug users from Clondalkin to gather qualitative information on their health care needs as well as identifying barriers accessing mainstream services. Focus groups were used as they 'are ideal for exploring people's experiences, opinions, wishes and concerns' (Kitzinger and Barbour, 1999: 5). Carrying out focus groups before the design of the questionnaire also gave the drug users a voice in the design and implementation of the research.

### 3.2.2 Survey

A questionnaire was designed based on the themes that evolved in the focus group and the review of the literature.<sup>7</sup> The data were collected using an interviewer-administered questionnaire to ensure that drug users with any literacy problems were not excluded. The questionnaire was arranged into the following content subsections, using some questions standardised in research literature.

#### *a) Demographic Information*

Demographic questions were asked on respondents' age, nationality, marital status, children, educational attainment, employment status and criminal history. These questions were asked to give further insight into the characteristics and needs of the client group which will help drug and health services develop to meet their needs.

#### *b) Drug using patterns and alcohol use*

Detailed questions were asked about respondents' current and past drug use, as problematic drug use is associated with increased health risks.

#### *c) Risk behaviour and health status*

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<sup>7</sup> See Appendix 1 for copy of the questionnaire.

These questions were asked in order to identify drug users' primary health care needs. The questions on risk behaviour and health were self-reported while an objective evaluation was carried out of respondents' psychiatric health status. A 21-item physical checklist was used to record health complaints.

#### *d) Use of drug services and health services*

The participants' contact with drug and health services was measured by examining medical card ownership and frequency of attendance at GP, accident and emergency (A&E), outpatients' clinics and a range of drug services. The questions were designed to assess drug users' awareness of services in the area and determine whether they use these services. Respondents were also asked to identify (real or perceived) barriers which prevented or discouraged them from using services.

### *3.2.3 In-depth Interviews*

In-depth interviews were carried out with 15 key informants.<sup>8</sup> An interview schedule was devised based on findings from international literature including:

- Existing policy and practice in working with drug users;
- Issues surrounding health care provision for drug users;
- The adequacy of primary care services for drug users and suggestions for improvement;
- Views on alternative models of primary health care provision; and
- Issues surrounding the establishment of a targeted primary health care service for problematic drug users in the locality.

### *3.3 Data Analysis*

The results from the questionnaire were entered directly into SPSS for Windows. All percentages are based on valid responses adjusted for missing data. Given the small sample size (n = 30) no statistical test could be carried out on the data. However, gender and age were considered important variables in the analysis and any relevant differences are presented. Open-ended questions were coded into categories that were both exhaustive and mutually exclusive. The qualitative data were converted into numerical codes in order to perform quantitative analysis. However, open responses were also used as verbatim comments within the report to illustrate points rather than reducing them just to numerically coded categories.

Participants' permission was given to tape the focus group and in-depth interviews and these were subsequently transcribed. The whole dataset was coded into relevant themes and patterns using the computer package Nud\*st 6. According to Silverman (2000: 186 – 187), 'computer-assisted recording and analysis of data means that one could be more confident that the patterns reported actually existed throughout the data rather than in favourable examples'. The questions in the interview guide acted as the analytical framework, although these initial questions were developed and refined in the light of new and emerging ideas. Quotes used in the analysis were chosen to represent typical or common responses. However any variations or negative cases are also described and explained. This is deemed the most systematic

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<sup>8</sup> See Appendix 2 for copy of the Interview Guide.

and reliable way of treating qualitative data as the findings become more fully 'explored, explained and evidenced' (Dixon, 2004: 19).

### 3.4 Ethical Issues

All respondents were assured that the data collected were anonymous and confidential. Furthermore, participants were offered 15 euro in cash on completion of the questionnaire in order to show that the researcher valued the time the respondents contributed to the research.

## Chapter 4

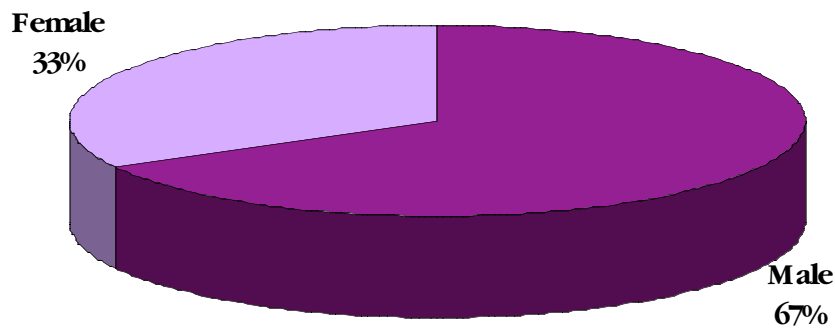
### Profile of Drug Users in Clondalkin

This chapter presents an analysis of the demographic characteristics of the 30 drug users who agreed to take part in the study. The data herein provide comprehensive information on the respondents' socio-demographic details including, gender, age, housing, education, employment and legal status. A detailed demographic profile of drug users will assist service planners to tailor services to meet their clients' needs.

#### 4.1 Demographic Profile

All the respondents identified themselves as Irish (n = 30, 100%) and their ethnic background as white (n = 30, 100%). Figure 4.1 illustrates that of the 30 drug users interviewed, two-thirds were male (n = 20, 67%) and one third was female (n = 10, 33%).

**Figure 4.1 Gender of Respondents**



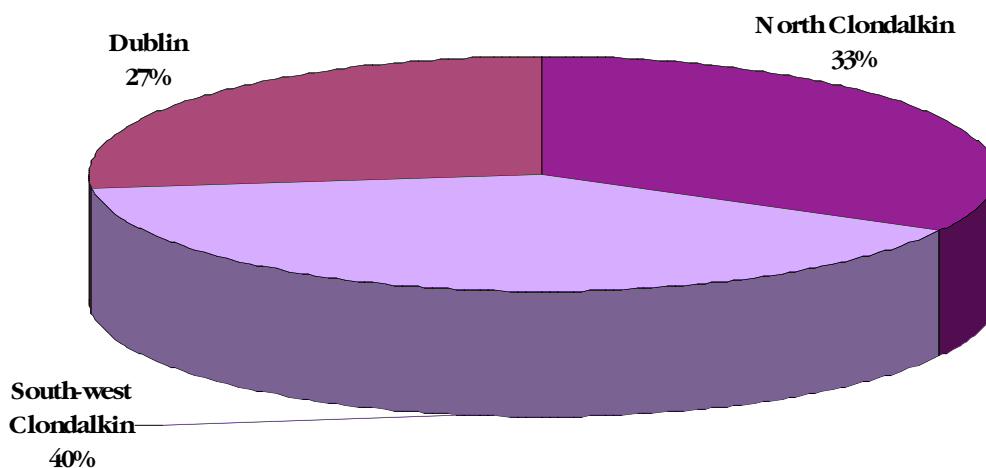
The mean age of respondents was 27.4 years (median = 26.5 years; mode = 23 years; range 20 – 43 years). Half the respondents (n = 15, 50%) were 26 years or younger.

Two-fifths of the respondents (n = 12, 40%) had children. Family size ranged from 1 to 6 children (mean = 2; median = 2; mode = 1<sup>9</sup>). All the respondents had children in the dependent category (under 18 years of age), while one respondent also had 4 children over 18 years of age. There was a total number of 20 children in the dependent category, 12 of whom were living with their parent at the time of interview.

#### 4.2 Housing

All respondents were asked in which area of Dublin they lived. As Figure 4.2 demonstrates, one-third (33%, n = 10) of the respondents were from north Clondalkin, 40% (n = 12) were from south-west Clondalkin, while over a quarter of the respondents (27%, n = 8) were originally from Clondalkin but living in another part of Dublin city.

**Figure 4.2 Area of Residence**



<sup>9</sup> Multiple modes exist. The smallest value is shown.



All respondents were asked where they were living at the time of interview. The following table shows the types of accommodation used.

**Table 4.1 Living Arrangements of Respondents**

<b>Accommodation</b>	<b>Number (n)</b>	<b>Percentage (%)</b>
Family home	13	43
Local Authority	7	23
Private Rented	5	17
Hostel/shelter	2	7
Sleeping rough	2	7
With friends/relatives	1	3
<b>Total</b>	<b>30</b>	<b>100</b>

Table 4.1 shows that over two-fifths (n = 13, 43%) of respondents were living in their family home, while over one-fifth (n = 7, 23%) were living in local authority accommodation. A further 5 (17%) were living in private rented accommodation. The remaining respondents (n = 5, 17%) were homeless.<sup>10</sup> Two respondents (7%) respectively reported staying in a hostel/shelter or sleeping rough, while 1 respondent was staying with friends and relatives. All those who reported being homeless were male (n = 5, 17%). Analysis also revealed that male respondents were more likely to be living in their family home or in private rented accommodation, while female respondents were more likely to be living in local authority accommodation.

In order to estimate the extent to which respondents are 'at risk' of becoming homeless all respondents who were *housed* (n = 25) were asked whether they regarded their current accommodation as temporary or overcrowded.

**Table 4.2 Accommodation Type**

	<b>Temporary Accommodation</b>		<b>Overcrowded Accommodation</b>	
	<b>(n)</b>	<b>(%)</b>	<b>(n)</b>	<b>(%)</b>
Yes	14	56	3	12
No	11	44	22	88
<b>Total</b>	<b>25</b>	<b>100</b>	<b>25</b>	<b>100</b>

An examination of those who were *housed* revealed that many of them felt insecure in their accommodation as over half (n = 14, 56%) reported that their accommodation was temporary, while 3 (12%) regarded their accommodation as overcrowded. Further analysis revealed that all those who reported living in overcrowded accommodation were living in their family home. Furthermore, among the 14 who reported living in temporary accommodation, 8 were living

<sup>10</sup> For the purpose of this research, homeless people are defined as those who reported living in emergency accommodation, a squat, staying with friends or sleeping rough.

in their family home, 3 were living in private rented and 3 were living in local authority accommodation.

Those that were *housed* were also asked if they were living with another drug user. Almost a quarter (n = 6, 24%) reported sharing accommodation with another drug user.

### 4.3 Education and Employment

The mean age at which respondents left school was 14.8 years (mode = 15; median = 15). The youngest school leaving age reported was 12 years (n = 3, 10%), while one respondent stayed in full-time education until he was 19 years. Two-fifths (n = 12, 40%) of respondents were early school leavers (i.e. had left school before they were 15 years).

Table 4.3 shows that one-fifth (n = 6, 20%) of respondents left school with no formal qualifications. Almost three-quarters (n = 21, 70%) of the respondents had reached lower second level education, while a further 3 (10%) had reached upper second level.

**Table 4.3 Educational Level of Respondents**

<b>Educational Level</b>	<b>Number</b>	<b>Percentage (%)</b>	<b>Cumulative Percentage (%)</b>
Primary education or less	6	20	20
Lower second level	21	70	90
Upper second level	3	10	100
<b>Total</b>	<b>30</b>	<b>100</b>	<b>100</b>

As Table 4.4 demonstrates none of the respondents was in full-time employment. Over half were unavailable for work or on disability allowance (n = 17, 57%), while over a quarter (n = 8, 27%) were unemployed. Three of the respondents were involved in childcare, 1 respondent was on a FAS training scheme, while the remaining respondent was in part-time employment.

**Table 4.4 Employment Status**

<b>Employment Status</b>	<b>Number (n)</b>	<b>Percentage (%)</b>
Unavailable for work/Disability Allowance	17	57
Unemployed	8	27
Childcare/childrearing	3	10
FAS/training	1	3
Part-time employment	1	3
<b>Total</b>	<b>30</b>	<b>100</b>

### 4.4 Sources of Income

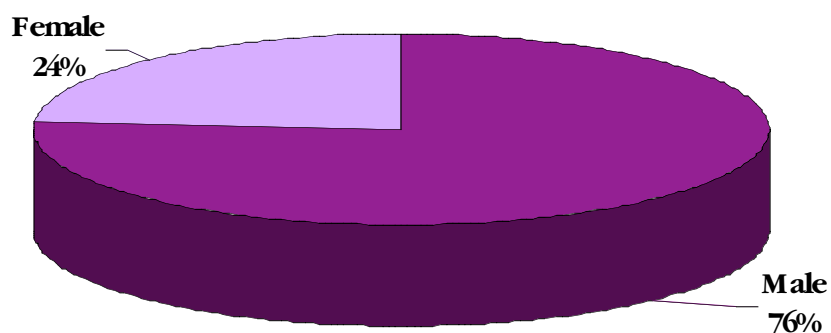
All individuals were asked to report their various sources of income. Multiple responses were allowed. Government benefits were cited by the majority of respondents (n = 29, 97%), while 3 (10%) respondents also reported they got income from criminal activities and training courses. One respondent received income from regular part-time employment.

Respondents were also asked their primary source of income. The vast majority of respondents (n = 24, 80%) cited government benefits as their main source of income, while 2 (7%) respondents respectively reported that they received most of their income from odd jobs and criminal activities.

#### 4.5 Legal Status

Respondents were asked about their experience of imprisonment. Almost three-quarters (n = 21, 70%) had spent some time in prison. Male respondents were much more likely to have spent time in prison compared to female respondents (80% vs. 50%). Figure 4.3 shows that among those who reported spending time in prison, 76% (n = 16) were male and 24% (n = 5) were female.

**Figure 4.3 Imprisonment by Gender**



#### 4.6 Summary and Conclusions

The typical profile of drug users in Clondalkin shows that they are young, unemployed, with low educational levels. The majority was male (67%), while a substantial minority was female (33%). The link between poverty and ill-health has been well established in health research. These social determinants (early school-leaving and unemployment) have the potential to impact negatively on a person's health.

Over two-fifths (n = 13; 43%) of respondents were living in their family home, while over one-fifth (n = 7; 23%) were living in local authority accommodation. Five (17%) were living in private rented accommodation, while almost one fifth

(n = 5, 17%) were homeless. Other studies in Dublin have found that the majority of heroin users live in socially deprived areas, mainly in local authority housing (Hogan, 1997). However, research would also indicate that homelessness among drug users is increasing. For instance, Cox and Lawless (1999) found in a study of problem drug users that 93% had experienced homelessness at some point in time and 63% reported being homeless at the time of interview. The experience of homelessness can expose individuals to a range of heightened health risks related to unhygienic and unstable living conditions (Rowe, 2003).

Almost three-quarters (n = 21, 70%) of the respondents from Clondalkin had spent some time in prison. In a study of prisoners in Mountjoy Prison, O'Mahony (1997) found that 66% had a history of opiate use. Experience of prison may have a positive impact on a drug user's health. Cox and Lawless (2000) found that drug users who had experience of prison were significantly more likely to have been vaccinated against Hepatitis B. Furthermore, research carried out by Corr (2003) indicated that time spent in prison also seemed to act as a catalyst for clients in attempting to modify or abstain from drug use. Conversely, other studies have found that high sexual and intravenous risk behaviour among prisoners puts them at risk of HIV and Hepatitis C transmission. In a recent qualitative study carried out in Dublin prisons, injecting drug users reported increased risk behaviour (including changing from smoking to injecting, sharing or renting out injecting equipment and lack of cleaning of injecting equipment) (Long *et al.*, 2004). This was due to low availability of drugs in prison and the scarcity of clean injecting equipment. Furthermore, Lines (2002: 4) argues that the Irish Prisons Service's 'provisions of HIV and Hepatitis C prevention measures falls far short of the best practice model in other European and North American jurisdictions' and 'the provision of health care services results in inconsistent and inadequate access to care for prisoners living with HIV/AIDS and/or Hepatitis C'.

## Chapter Five

### Alcohol and Drug Use

This chapter examines the patterns of alcohol use among respondents and gives detailed information on the nature and extent of drug use. This information is important in designing primary health care services as problematic drug use can have a number of serious consequences for the health of drug users.

#### 5.1 Drug Using History

Respondents were asked an open-ended question concerning the first illicit drug they ever used.<sup>11</sup> As Table 5.1 shows, the majority of respondents (n = 21, 70%) reported that cannabis was the first drug they used, while 4 (13%) reported that they commenced their drug using career with solvents.<sup>12</sup> No respondents reported initiating drug use with heroin.

**Table 5.1 First Drug Used**

First drug used	Number (n)	Percentage (%)
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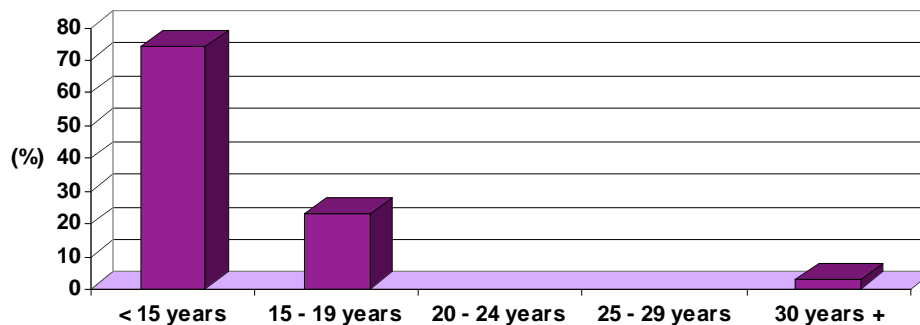
<sup>11</sup> Illicit drugs are drugs of which the production, sale, possession or use is prohibited. For the purpose of this study, illicit drug use refers to cannabis, ecstasy, amphetamines, crack, cocaine powder, heroin, hallucinogens (LSD, poppers and magic mushrooms) and solvents.

<sup>12</sup> It is likely that alcohol was the first drug used by participants, but this was not included in this question.

Cannabis	21	70
Solvents	4	13
Benzodiazepines	2	7
Ecstasy	1	3
DF118s (Dihydrocodeine Tartrate)	1	3
Methadone	1	3
<b>Total</b>	<b>30</b>	<b>100</b>

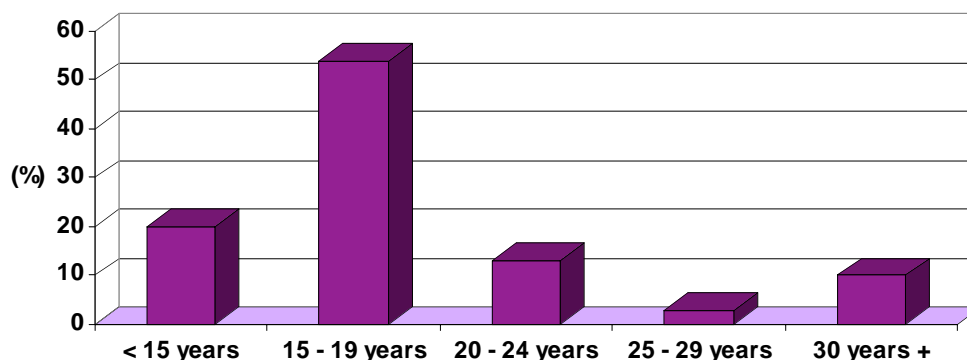
Respondents were also asked at what age they first used drugs. Figure 5.1 illustrates that almost all the respondents (n = 29, 97%) were teenagers when they first used drugs. The mean age of first drug use was 13.9 years (median = 13.5 years; mode = 13 years). There was a very wide age range, from 6 years to 32 years. Furthermore, male respondents reported initiating drug use at a younger age than their female counterparts (13 years vs. 15.7 years).

**Figure 5.1 Age First Used Drugs**



Respondents were also asked if they had ever injected drugs. The vast majority (n = 26, 87%) reported injecting drugs at some time during their drug using career. The age at which respondents initiated intravenous drug use is illustrated in Figure 5.2. The mean age of first injecting was 18.4 years (median = 17 years; mode = 17 years). Therefore, these respondents initiated intravenous use on average 4.4 years after they first used drugs.

**Figure 5.2 Age First Injected**



Respondents were also asked to cite the first drug they ever injected. As Table 5.2 shows, the vast majority of those who had injected (n = 21, 81%) reported heroin as being the first drug they took intravenously. The remaining clients first injected with N.A.P.S. (n = 4, 15%) and one respondent initiated his injecting career with Dalmane.

**Table 5.2 First Drug Injected**

First drug injected	Number (n)	Percentage (%)
Heroin	21	81
N.A.P.S. (morphine sulphate tablets)	4	15
Dalmane	1	4
<b>Total</b>	<b>26</b>	<b>100</b>

### 5.2 Current Drug Use

Respondents were asked in detail about their current drug use, both licit and illicit.<sup>15</sup> As Table 5.3 shows, over four-fifths (n = 26, 87%) of the respondents reported currently using illicit drugs, while 25 (83%) reported current licit drug use. In total, 70% (n = 21) of the respondents were using both licit and illicit drugs.

**Table 5.3 Current Drug Use**

Current drug use	Number (n)	Percentage (%)
Current use – illicit drugs	26	87
Current use – licit drugs	25	83
Current use – both licit and illicit	21	70

<sup>15</sup> For the purpose of this study, licit drug use refers to the use of pharmaceutical drugs (i.e. drugs available through a pharmacy including over-the-counter and prescription medicines). Tobacco and alcohol are also licit drugs but their use is not included here.

Table 5.4 shows the lifetime, recent and current prevalence figures for all drug types. During the 4 weeks prior to interview, the most commonly used drug was methadone (n = 26; 87%). The vast majority of those using methadone (n = 24, 92%) were prescribed it, while 2 respondents were using street methadone. The mean number of millilitres of methadone prescribed was 73.6 (mode = 80; median = 80; range 21 – 97).

**Table 5.4 Drug Prevalence Rates<sup>14</sup>**

Drugs	Lifetime Use		Recent Use		Current Use	
	(n)	(%)	(n)	(%)	(n)	(%)
Methadone	30	100	29	97	26	87
Sedatives/tranquilisers/ anti-depressants	25	83	23	77	22	73
Cannabis	29	97	27	90	22	73
Heroin	30	100	25	83	19	63
Cocaine	29	97	22	73	14	47
Ecstasy	29	97	10	33	7	23
Crack cocaine	22	73	13	43	6	20
Steroids	2	7	1	3	1	3
Other opiates	17	57	2	7	1	3
Hallucinogens	25	83	2	7	-	-
Amphetamines	25	83	2	7	-	-
Solvents	20	67	-	-	-	-
Other drugs	5	17	2	7	1	3

Almost three-quarters of those interviewed (n = 22, 73%) reported currently using sedatives/tranquilisers/anti-depressants and cannabis respectively. Just over half (n = 17, 57%) were prescribed sedatives/tranquilisers/anti-depressants by a doctor. The mean number of sedatives/tranquilisers/anti-depressants used was 3 (median = 3; mode = 3; range 1 – 6). Many of the key informants interviewed had noticed an increase in prescription drug use and perceived their use as widespread. Some key informants, and most of the drug users, felt that some GPs were prescribing irresponsibly, as explained by the following respondent:

*When I was fifteen years of age I went round to the doctor and I said to him I couldn't sleep and he prescribed me Dalmane, Ryhypnol and Valium and I hadn't a bleedin' clue what they were. I used to take two of them and I would be walkin' around like that [demonstrates someone 'high' on drugs] and then I'd take more and take more and then after a couple of months I stopped going round to him and I started getting the shakes. I couldn't hold a cup of tea straight. I went back to him and he said it wasn't his problem.*

(Male, 26 years)

Almost two-thirds of the respondents reported currently using heroin (n = 19, 63%), while almost half were using cocaine (n = 14, 47%). A substantial

<sup>14</sup> It is necessary to distinguish use at the present time from use that may have taken place in the past and discontinued after some time. Therefore 'lifetime' use refers to 'ever' used, 'recent' use refers to use in the last 12 months and 'current' use refers to use within the last month.



proportion of those interviewed also reported current ecstasy (n = 7, 23%) and crack cocaine use (n = 6, 20%).

Overall, the vast majority of those interviewed were polydrug users<sup>15</sup> (n = 28, 93%), using a mean of 5 drugs (median = 6; mode = 7; range 2 – 10). Over a third of the sample (n = 11, 37%) were currently using both heroin and cocaine. Moreover, half those interviewed (n = 15, 50%) were currently using methadone and heroin, 13 (43%) were currently using methadone and cocaine, while 20 (67%) were currently using methadone and sedatives/tranquilisers/anti-depressants. Most of the key informants had noticed a continual increase in polydrug use. The general consensus was that most of those on methadone maintenance were using other drugs, especially benzodiazepines. For many key informants, this was making their work more challenging.

*Their addiction seems much worse when they are on tablets because there are no restrictions on what they say any more; their boundaries are totally gone and you can see how people get into trouble. Even going into services you can see that they don't seem to be able to control their own boundaries. When they are on heroin that doesn't seem to be an issue for them. Physically, you can see the difference.*

(Drug service provider)

Some gender differences were noted in relation to current drug use. There were proportionately more female respondents than male respondents using methadone, while proportionately more male respondents than female respondents reported using cannabis, cocaine, crack cocaine, heroin and sedatives/tranquilisers/anti-depressants. Moreover, only male respondents reported current use of ecstasy.

Table 5.5 details respondents' primary drug of choice. The majority of respondents reported methadone (n = 21, 70%) as their primary drug, while one-fifth of respondents (n = 6, 20%) reported heroin as their drug of choice.

**Table 5.5 Primary Drug Used**

	<b>Number (n)</b>	<b>Percentage (%)</b>
Methadone	21	70
Heroin	6	20
Cocaine	2	7
Cannabis	1	3
<b>Total</b>	<b>30</b>	<b>100</b>

As already stated, 28 (93%) of respondents were polydrug users. Table 5.6 illustrates respondents' secondary drug of choice. As opiates were largely the primary drug of choice, levels of opiate use were much lower when secondary drug use was examined. Conversely, levels of prescribed medication and cannabis use were higher.

<sup>15</sup> Polydrug users regularly use other drugs apart from their primary drug of choice.

**Table 5.6 Secondary Drug Used**

	<b>Number (n)</b>	<b>Percentage (%)</b>
Sedatives/tranquilisers/anti-depressants	11	39
Cannabis	8	29
Methadone	4	14
Heroin	3	11
Cocaine	2	7
<b>Total</b>	<b>28</b>	<b>100</b>

Respondents who had used any drugs in the last month were asked to specify their frequency of use. Table 5.7 illustrates how often individuals reported the use of their specified drugs over the four weeks prior to contact.

**Table 5.7 Frequency of Use over Past Month**

	<b>Daily</b>		<b>2 – 3 times a week</b>		<b>Weekly</b>		<b>2 – 3 times a month</b>		<b>Less than once a month</b>	
	<b>(n)</b>	<b>(%)</b>	<b>(n)</b>	<b>(%)</b>	<b>(n)</b>	<b>(%)</b>	<b>(n)</b>	<b>(%)</b>	<b>(n)</b>	<b>(%)</b>
Methadone	26	100	-	-	-	-	-	-	-	-
Sedatives/tranquilisers/ anti-depressants	18	82	3	13	-	-	1	5	-	-
Cannabis	17	77	1	5	-	-	2	9	2	9
Heroin	9	46	3	16	2	11	2	11	3	16
Cocaine	2	14	1	7	-	-	6	43	5	36
Ecstasy	-	-	-	-	-	-	5	83	1	17
Crack cocaine	-	-	-	-	-	-	3	50	3	50

Table 5.7 shows that among those who used methadone, all of them took it daily. The data also indicate high levels of daily use for sedatives/tranquilisers/anti-depressants and cannabis. Less than half those who currently used heroin (n = 9, 47%) used it everyday. Furthermore, the majority of those who used cocaine, ecstasy and crack cocaine used it weekly or less.

All respondents were asked how they administered their different drugs. Overall two-fifths (n = 12, 40%) of respondents reported injecting in the 4 weeks prior to interview, 63% (n = 12) of those using heroin, 71% (n = 10) of those using cocaine and 1 person using crack cocaine administered them intravenously.

### 5.3 Alcohol Consumption

When asked how long ago they had consumed alcohol, 18 (60%) respondents replied 'in the last week'. Overall two-thirds of the respondents (n = 20, 67%) were regular drinkers.<sup>16</sup> Almost half the sample (n = 14, 47%) reported that they typically consumed alcohol every week. Among the 14 respondents who reported drinking in a typical week, on a typical occasion they consumed on average 12.3 alcoholic drinks. From the reported number of drinks on a typical occasion and the number of days a week a person drank, the number of units per week can be calculated. The international recommended drinking levels per week are 14 units for a woman and 21 for a man. Analysis revealed that almost one third of the sample (n = 9, 30%) drank over the recommended weekly limits of alcohol. Male respondents were proportionately more likely to consume beyond their recommended weekly limits than female respondents.

Further analysis revealed that over half those using heroin (n = 11, 58%) reported drinking alcohol in a typical week, as did almost half of those currently using methadone (n = 12, 46%), cocaine (n = 7, 50%) and sedatives/tranquilisers/anti-depressants (n = 9, 41%). According to key informants, there are high levels of alcohol use among drug users, especially among those who are on methadone maintenance.

*When they get stable they tend to get quite addicted to alcohol. It is as if they supplement one addiction for the other.*

(GP)

### 5.4 Summary and Conclusions

Almost all the respondents were teenagers when they first used drugs, and the majority (n = 21, 70%) reported that cannabis was the first drug they used.<sup>17</sup> The vast majority (n = 26, 87%) of respondents in this study had injected drugs at some point during their drug\_using career. The mean age of first injecting was 18.4 years and the majority (n = 21, 80%) reported heroin as being the first drug they took intravenously. Two-fifths (n = 12, 40%) of respondents reported injecting in the 4 weeks prior to interview. The age at which drug users in Clondalkin initiated intravenous drug use is very young. This a cause for concern as Irish research has found that younger injectors are significantly more likely to be involved in HIV risk behaviour. For instance, Cox and Lawless (2000) found that among new attendees at Merchants Quay Ireland's needle exchange, young injectors were significantly more likely to have borrowed injecting equipment and to have shared injecting paraphernalia. Moreover, Cassin *et al.* (1999) concluded that harm reduction messages were not reaching young recent injectors.

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<sup>16</sup> Friel *et al.* (1999) define regular drinkers as those who consumed alcohol in the previous month.

<sup>17</sup> It is likely that alcohol was the first drug used by participants, but this was not included in this question.

Twenty-one respondents (70%) were using both licit and illicit drugs, while 93% (n = 28) were polydrug users. According to figures from the NDTRS (National Drug Treatment Reporting System), the majority (66%) of those in treatment from Clondalkin in 2002 were polydrug users. Research studies would indicate that levels of polydrug use among problematic drug users in Ireland are increasing. For instance, in a study of outreach work in Dublin, Corr (2003) found that new clients were significantly more likely to be polydrug users and concluded that this trend may continue.

During the 4 weeks prior to interview, the most commonly used drug was methadone (n = 26, 87%). Drug users from Clondalkin represent 6.6% of the total number of people accessing methadone maintenance programmes in Ireland. There were also high levels of sedatives/tranquilisers/anti-depressants, cannabis, heroin and cocaine use reported in this study. High levels of heroin among this cohort are reflected in treatment figures as the vast majority of those accessing treatment from the Clondalkin Task Force Area in 2002 were receiving treatment for opiate use (n = 486, 98.6%). Increasing levels of cocaine use have also been noted among other groups of traditional opiate users in Dublin. Recent research would indicate that although heroin is still the dominant drug of choice among those accessing low threshold services in Dublin, cocaine is becoming more popular (Corr and Lawless, 2003). Furthermore, in a study on the use and misuse of benzodiazepines within the Ballymun community, the Ballymun Youth Action Project (2004) concluded that there was a relationship between socio-economic disadvantage and benzodiazepine use and the level of benzodiazepine prescribing in Ballymun may be notably higher than the national level. It is likely that this may also be the case for Clondalkin. High levels of cannabis use are not surprising given that cannabis is the most commonly used illegal drug in Ireland (NACD & DAIRU, 2003).

## Chapter Six

### Risk Behaviour and Health

This chapter examines respondents' injecting behaviour and levels of sharing of injecting equipment and injecting paraphernalia as they can be associated with a number of health problems. The chapter concludes with an examination of respondents' physical and mental health issues.

#### 6.1 Injecting Risk Behaviour

All current injectors (n = 12, 40%) were asked for detailed information on their injecting practices. Firstly they were asked whether they usually injected themselves (as opposed to being injected by another person). As Table 6.1 shows, the vast majority (n = 10, 83%) always injected themselves, while only 2 respondents reported never injecting themselves.

**Table 6.1 Inject Self**

<b>Inject Self</b>	<b>Number (n)</b>	<b>Percentage (%)</b>
Always	10	83
Never	2	17
<b>Total</b>	<b>12</b>	<b>100</b>

Current injectors were also asked to state at what part of the body they injected. This was asked to ascertain whether individuals were injecting in any particularly dangerous sites. As Table 6.2 illustrates, over two-fifths (n = 5, 42%) of current injectors reported injecting in their arm. A cause for concern is that a

third of current injectors stated they injected in their groin (n = 4, 34%), which is particularly dangerous. Female injectors were more likely to inject in their groin.

**Table 6.2 Injecting sites**

Injecting Site	Number (n)	Percentage (%)
Arms	5	42
Groin	4	34
Legs	1	8
Feet	1	8
Hands	1	8
<b>Total</b>	<b>12</b>	<b>100</b>

Current injectors were asked if they had any problems finding an injecting site. Half (n = 6, 50%) reported *always* having difficulties, while 2 (19%) *sometimes* had difficulties injecting.

Regarding injecting risk behaviour, all current injectors were asked about the sharing of injecting equipment in the four weeks prior to interview. As Table 6.3 reveals, two-thirds of them (n = 8, 67%) reported that they had shared injecting paraphernalia in the 4 weeks prior to interview, while a third (n = 4, 33%) had borrowed injecting equipment and a quarter (n = 3, 25%) had lent their injecting equipment to someone else.

**Table 6.3 Recent Sharing Behaviour**

Recent Sharing Behaviour	Number (n)	Percentage (%)
Shared IV Paraphernalia <sup>18</sup>	8	67
Lent used IV Equipment <sup>19</sup>	3	25
Borrowed Used IV Equipment <sup>20</sup>	4	33

Another measure to determine the intensity of sharing equipment was employed by asking current injectors if they had used a needle after someone else had used it. Two-thirds (n = 8, 67%) reported that they had *never* used someone else's needle in the 4 weeks prior to interview. Two respondents had shared a needle twice in the 4 weeks prior to interview, while 1 person had used someone else's needle 3 – 5 times. One person, who was homeless, had used someone else's needle more than 10 times.

All respondents were asked with whom they usually injected. Figure 6.1 illustrates that nearly three-quarters of current injectors (n = 9, 75%) usually

<sup>18</sup> Injecting paraphernalia refers to filters, swabs, spoons etc.

<sup>19</sup> The lending of injecting equipment occurs when an individual is asked to make his/her injecting equipment available to another person. Thus, the practice carries with it little personal risk for the lender.

<sup>20</sup> Borrowing used injecting equipment involves high risk, especially if the lender has HIV or Hepatitis C.

injected with others, while the remaining quarter (n = 3, 25%) usually injected alone.

**Figure 6.1 Injecting Company**

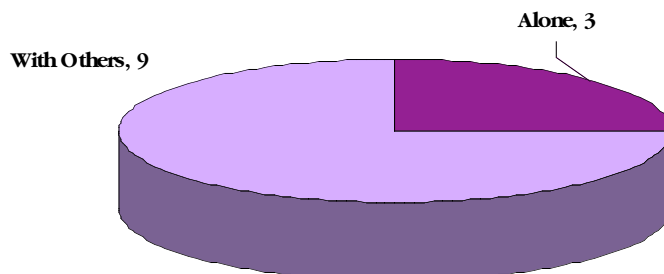


Table 6.4 illustrates various injecting difficulties reported by current injectors within the last three months. More than two-thirds (n = 8, 67%) experienced scarring or bruising of the injecting site and collapsed veins, while 5 (42%) experienced dirty hits. Four current injectors (33%) had abscesses in the last 3 months, while 1 person had an accidental overdose.

**Table 6.4 Injecting Difficulties within the Past Three Months**

Injecting Difficulties	Current Injectors	
	(n)	(%)
Scarring/bruising	8	67
Collapsed Veins	8	67
Dirty hits <sup>21</sup>	5	42
Abscesses	4	33
Accidental overdose	1	8

## 6.2 Sexual Health

Information was also collected on respondents' sexual behaviour. Half (n = 15, 50%) reported that they were sexually active. Male respondents were twice more likely to be sexually active than their female counterparts. Among those who were sexually active, over a quarter (n = 4, 27%) had more than 1 sexual partner in the last 3 months. All those who had more than 1 sexual partner were male. The majority of those who were sexually active also had a regular sexual partner (n = 11, 73%), none of whom was an injecting drug user.

Table 6.5 demonstrates the method of contraception used by those who were sexually active. The most commonly used method was condoms (n = 9, 60%), while 1 female respondent used the natural method and another used the combined pill. Four (26%) of those who were sexually active never used any means of contraception.

**Table 6.5 Use of Contraception**

<sup>21</sup> Dirt, bacteria, fungi and other micro-organisms in and on the needle can cause bends (i.e. a dirty hit).

	Male Respondents		Female Respondents		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Condom	8	67	1	33.3	9	60
None	4	33	-	-	4	26
Natural	-	-	1	33.3	1	7
Combined Pill			1	33.3	1	7
<b>Total</b>	<b>12</b>	<b>100</b>	<b>3</b>	<b>100</b>	<b>15</b>	<b>100</b>

Only 2 sexually active respondents had ever had a sexually transmitted disease, and only one had a sexually transmitted disease in the last year.

Some of the key informants mentioned sexual health as a major health care need among drug users and they were concerned about the proportion of drug users who did not practise safe sex:

*The other problem then would be that if they are still chaotic in the early stages they don't take any precautions. They have unprotected sex which leads to a lot of sexually transmitted diseases – HIV included. But they get other diseases and when they do become stable they regret and they end up in St. James in the special clinic.*

(GP)

### 6.3 HIV and Hepatitis

All respondents were asked whether they ever had a HIV test. The vast majority (n = 25, 83%) reported that they had had a HIV test in the past. Almost two-thirds (n = 12, 64%) of those who ever had a test had been tested within the last year. In terms of HIV status, respondents were provided with the opportunity to volunteer their result. Of those who volunteered their result, 4 reported that their HIV status was negative, while one did not know.

Although no respondents volunteered that they were HIV positive, some key informants from Clondalkin did say that they were aware of some of their clients being HIV positive.

Respondents were asked to state whether or not they had ever been tested or vaccinated for Hepatitis B. The vast majority had been tested for Hepatitis B (n = 25, 83%) and also vaccinated against the virus (n = 24, 80%). Over half (n = 16, 53%) reported that their Hepatitis B status was negative, while 14 (47%) were unsure of their status.

**Table 6.6 Hepatitis B**

	Number (n)	Percentage (%)
Hepatitis B Test	25	83
Hepatitis B Vaccination	24	80
Hepatitis B status – negative	16	53
Hepatitis B status - unsure	14	47

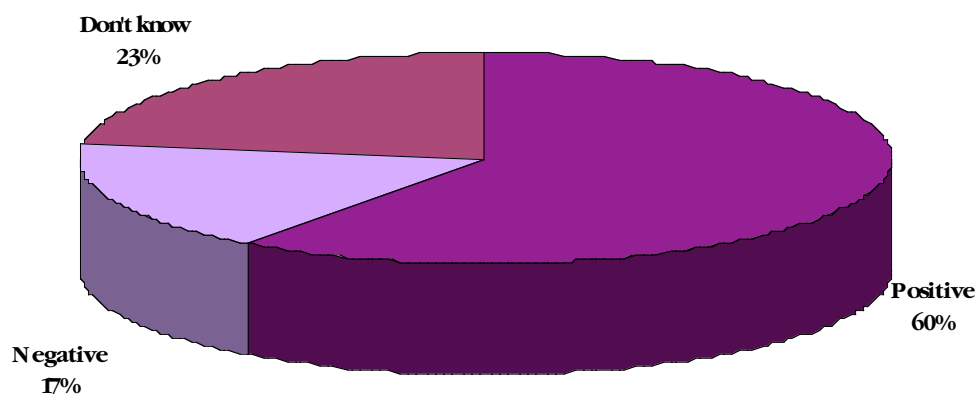


In relation to Hepatitis C, most of the respondents (n = 27, 90%) had been tested. As Figure 6.4 reveals the vast majority tested positive (n = 18, 60%), while 5 respondents (17%) had a negative status. However, almost a quarter (n = 7, 23%) were unaware of their status. Among those who were Hepatitis C positive, 9 (64%) reported drinking alcohol in a typical week.<sup>22</sup> Many key informants were concerned about the implications this could have for those who are Hepatitis C positive.

*Given that 85% of them are Hepatitis C positive – they are running into huge problems in terms of liver disease.*

(GP)

**Figure 6.2 Hepatitis C Status**



During the in-depth interviews, key informants were more concerned about Hepatitis C than any other health issue and they believed the prevalence of Hepatitis C to be as high as between 70% - 90% among drug users in Clondalkin. One drug service provider explained why a substantial proportion of drug users would be unaware of their status:

*With hepatitis they are in denial about getting it checked out or checking the levels – it's a kind of a cultural thing. It's a kind of a resistance – they would rather live in ignorance because they are afraid of finding out or getting treatment.*

(Drug service provider)

Among those (n = 18) who were hepatitis C positive, just over a fifth (n = 4, 22%) were receiving treatment. Three respondents were attending the hepatology department at St. James Hospital, while one respondent had been on Interferon treatment and was hoping to recommence it.

<sup>22</sup> Hepatitis C is inflammation of the liver. Medical practitioners advise that alcohol should not be drunk at all by people who are Hepatitis C positive as this increases the problems in the liver.

Therefore, the majority of those who were Hepatitis C positive (n = 14, 78%) were not receiving follow-up care. Key informants explained that it was difficult to encourage people to follow through on treatment for Hepatitis C, because the perception among drug users often is that the treatment is too difficult.

*Chasing people to follow up on hepatology appointments and getting tested is absolutely diabolical.*

(GP)

The vast majority (n = 26, 87%) of respondents reported that they were aware of how Hepatitis C is transmitted. However over half the respondents (n = 16, 53%) requested more information on Hepatitis C and key informants also felt this was necessary as there was a perception that there was a lack of knowledge around the issue.

*For example most addicts have got their Hepatitis C from sharing spoons or filters - they say I never shared a needle but they shared some paraphernalia. We had a girl who never used a needle but she shared spoons and she got Hepatitis C from it. It's hard to explain to someone that a microscopic dot of blood can transmit a virus.*

(Health care professional)

#### 6.4 Physical Health

Respondents were asked about their perceptions of their health status and what conditions, if any, they were suffering from. The following table shows respondents' perceptions of their health.

**Table 6.7 Perceptions of Health**

	Number (n)	Percentage (%)	Cumulative Percentage (%)
Very good	1	3	3
Good	8	27	30
Fair	6	20	50
Bad	13	43	93
Very bad	2	7	100
<b>Total</b>	30	100	100

The above table shows that half the respondents (n = 15, 50%) perceived their health as bad/very bad, while almost one third (n = 9, 30%) felt that their health was good/very good.

Only one respondent reported having no health complaints, while over two-thirds (n = 21, 70%) reported suffering from 5 or more complaints. The mean number of conditions reported was 7 (range = 0 – 17). The physical health complaints are listed in Table 6.8 in order of decreasing frequency. None of the respondents reported suffering from dermatitis or jaundice.

Table 6.8 reveals that over half of the respondents complained of headaches, weight problems, constant fatigue, sleep problems and poor appetite, while 14

(47%) reported having dental problems. During the in-depth interviews, the key informants were most concerned about respiratory problems, dental problems, weight problems and eating disorders.

Half (n = 5, 50%) of the female respondents had undergone a smear test in the last 3 months

**Table 6.8 Frequency of Health Complaints**

	<b>Number (n)</b>	<b>Percentage (%)</b>
<b>Physical symptoms</b>		
Poor appetite	21	70
Sleep problems	20	67
Constant fatigue	18	60
Weight problems	17	57
Headaches	15	50
Dizziness/faintness	14	47
Shortness of breath	12	40
Back pain	12	40
Nausea	11	37
Stomach pain	9	30
Eye/ear complaints	9	30
Skin wounds/infections	8	27
Foot problems	6	20
<b>Dental Problems</b>		
Dental Problems	14	47
<b>Chronic physical health problems</b>		
Bronchitis	4	13
Gastroenteritis	3	10
Septicaemia	1	3
Pneumonia	1	3
<b>Other complaints</b>		
Other	13	43

## 6.5 Psychological well-being

Nearly half the respondents (n=14, 47%) reported having concerns regarding their psychiatric health<sup>23</sup> and almost two-thirds (n = 9, 64%) had sought help.

<sup>23</sup> These included feeling suicidal (n = 3), feeling depressed (n = 3), panic attacks (n = 2), going mad (n = 2), self-mutilation (n = 1), "off their heads" on tablets (n = 1), nervous breakdown (n = 1) and schizophrenia (n =1).

As Table 6.9, reveals the levels of reported mental health complaints were extremely high. The vast majority of respondents (n = 26, 87%) reported suffering from at least one mental health complaint in the 3 months prior to interview.

**Table 6.9 Mental Health Complaints**

	<b>Number (n)</b>	<b>Percentage (%)</b>
Feeling isolated	24	80
Depression	23	77
Feeling unable to cope	20	67
Anxiety	17	57

Three main questions were asked in order to ascertain respondents' general mental health status. As Table 6.10 shows, over half (n =17, 57%) had undergone a psychiatric assessment, over a quarter (n = 8, 27%) had been admitted to a psychiatric hospital, while one third (n = 10, 33%) had been diagnosed with a psychiatric illness.

**Table 6.10 Experience of Psychiatric Services**

	<b>Number (n)</b>	<b>Percentage (%)</b>
Ever undergone a psychiatric assessment	17	57
Ever been admitted to a psychiatric hospital	8	27
Ever been diagnosed with a psychiatric illness	10	33

Among those (n = 10) diagnosed with a psychiatric illness, 6 (60%) were receiving treatment. Five respondents were being prescribed anti-depressants, while 1 respondent was receiving medication for schizophrenia.

The prevalent feeling among key informants was that psychiatric problems were a serious issue for the drug using community. However, there were diverse opinions on the nature of these problems. Some believed drug users felt depressed because of their social situation, while others felt there was a prevalence of clinical psychiatric problems. This is illustrated by the following quotes:

*I have to say that by and large I've watched the use of anti depressants in a lot of these patients and I haven't seen a really remarkable improvement in most of them. The truth is they are depressed because their social and family lives in general are just awful and no tablet is going to change that.*  
(GP)

*I think quite clearly and all the research would show that a minimum of 15% of addiction is dual diagnosis. I think it clearly exists irrespective of social problems.*

(Service planner)

## 6.6 Summary and Conclusions

Among those who currently injected, risk behaviour was very high. One third of current injectors stated they injected in their groin (n = 4, 34%), which is particularly dangerous. Furthermore, two-thirds of current injectors (n = 8, 67%) reported that they had shared injecting paraphernalia (i.e. spoons and filters) in the 4 weeks prior to interview, while a third of current injectors (n = 4, 33%) had shared a needle at least once during the 4 weeks prior to interview. These findings are consistent with national (Cox and Lawless, 2000) and international research (Gossop *et al.*, 1997) which shows that injecting drug users are less discriminatory about the sharing of injecting paraphernalia, than is the case for needles and syringes. Research studies have found that often the primary reason why injecting equipment or paraphernalia is shared is difficulty in obtaining new injecting equipment (Ross *et al.*, 1994). As the following chapter reveals, the lack of a needle exchange in Clondalkin does impact on drug users' risk behaviour. However other influential factors include 'situational availability' (i.e. availability at the time and place of injecting) as well as the social environment (e.g. homelessness or imprisonment).

The majority of those who were sexually active (n = 9, 60%) used condoms as a method of contraception, while over a quarter of those (n = 4, 26%) who were sexually active never used any means of contraception. The lack of 'safe' or protected sex among a substantial minority of the respondents is concerning as sexual transmission may become the primary cause of HIV infection among drug users, given that they continue to reduce the risks directly associated with drug use (Cox and Lawless, 2000). None of the respondents reported having a sexual partner who was an injecting drug user. This is reassuring, as both national (Cox and Lawless, 2000) and international (Darke *et al.*, 1994) research has found that drug users, in particular female drug users, are more likely to report the sharing of injecting equipment and injecting paraphernalia with injecting partners. However, it also means that there is the potential for the spread of HIV from intravenous drug users to non-intravenous drug users. Research has found that it is more difficult to change the sexual risk behaviour of drug users than their injecting risk behaviour (Cox and Lawless, 2000). This issue would need to be addressed by primary health care services.

The vast majority (n = 25, 83%) of respondents reported that they had a HIV test in the past. However, research has shown that young injectors and those not in treatment are less likely to have been tested for HIV (Cox and Lawless, 2000; O'Gorman, 1998).

The majority of respondents had been tested for Hepatitis B (n = 25, 83%) and Hepatitis C (n = 27, 90%). However over half of respondents (n = 16, 53%) were unaware of their Hepatitis B status and a quarter (n = 7, 23%) were unaware of their Hepatitis C status. The lack of knowledge around status could

suggest that a substantial number of individuals may not have had their results disclosed to them once tested. Alternatively, it could be that their status is unknown given the length of time which has lapsed since the last test was undertaken.

The vast majority of respondents in this study tested positive (n = 18, 60%) for Hepatitis C. Over half the respondents (n = 16, 53%) requested more information on Hepatitis C. Providing accessible information on Hepatitis C is crucial as British research has found that young injectors, in particular, failed to understand Hepatitis C and 'that such misunderstandings were contextualised by wider uncertainty and indeterminacy concerning HCV knowledge' (Davis and Rhodes, 2004: 123). These authors advised that Hepatitis C prevention requires interventions that are different to those that have worked for HIV as many young injectors perceived Hepatitis as an inevitable consequence of drug taking.

The results show that drug users from Clondalkin suffer from a range of physical and mental health issues. Many of these are directly related to problematic patterns of drug use. These include headaches, weight problems, constant fatigue, sleep problems, poor appetite and dental problems.

The high levels of risk behaviour and physical and mental health issues among this cohort of drug users in Clondalkin indicate that they should be linked into a range of drug and health services. Drug users often face a number of perceived or real barriers to accessing drug services and primary health care and these are addressed in the following chapter.

## Chapter 7

### Drugs and Health Service Provision

The following chapter details the level of service provision in Clondalkin, respondents' contact with drugs and health services and examines barriers they might encounter in accessing these services. The nature of drug users' current involvement with drug and health services is useful information in determining their primary health care needs.

#### 7.1 Service Provision in Clondalkin

Key informants outlined a range of drug services available to drug users in Clondalkin. These include outreach services, methadone maintenance and methadone detoxes as well as home detoxes and residential treatment. Furthermore there are aftercare programmes, family support services, mediation services and training programmes. Through these programmes drug users can also access counselling, personal development courses, life skills training, complementary therapy and group work.

In relation to primary health care, there are 12 GP practices in the Clondalkin area, 9 of which are willing to provide primary health care to drug users, methadone maintenance and referrals to more specialised care (such as the Hepatology Department in St James and psychiatric services).

However, key informants pointed out a number of gaps in service provision in Clondalkin. One of the major gaps was the absence of a needle exchange facility. Key informants were concerned that this was causing drug users to engage in risk behaviour and was contributing to large amounts of discarded injecting equipment being left in public places.

*Obviously, they are at risk of sharing needles and overdosing and using dirty needles in the absence of a needle exchange.*

(GP)

*We went up to [a local area in Clondalkin] about four weeks ago and there were hundreds of needles. I don't know whether they will put in a needle exchange. It would not stop all of the needles being left lying about but it would stop quite a lot of them.*

(Drug service provider)

The fact that there was no centralised prescribing clinic in Clondalkin was seen as another serious gap. However, according to service planners, planning permission has been granted for such a service.

Key informants were concerned that chaotic drug users were less likely to be in contact with any services, in particular health services. Many of the local service providers stated that previously there had been a nurse linked into local

drug services who had been in a position to address the immediate health care needs of this group. This nurse has not been replaced and service providers felt that as a result, the health care needs of their more chaotic clients were going unmet. This is illustrated by the following quote:

*When we had the nurse, the people knew he was available so they would drop down and they would come in to see him and get what they needed done. Since [the nurse] has gone there is nobody – they have nowhere to go. So they just won't go anywhere. One of the lads who was in with you this morning [referring to a client who had an abscess covering his whole leg but was refusing to go to hospital to get it checked] – he is in an awful state – absolutely disgraceful [...] He should have never got to that stage. If [the nurse] was here he would have come down because he is someone he knows and he trusts. Trying to get him off to the hospital today is just impossible.*

(Drug service provider)

During the focus groups with drug users, the absence of a nurse, linked in with drug services, showed a deficit in service provision:

*We don't even have a nurse on a daily basis. We have a nurse who comes in on a Thursday night for an hour. What good is that if you're up there and you need to talk or come in for blood or something? It's no good. Are you going to say "come back Thursday night"?*

(Female, 30 years)

There were divergent opinions among key informants regarding access to psychiatric care for drug users. While some believed psychiatric service provision was adequate, others did feel that it was difficult for drug users to get a referral or an appointment with a psychiatrist. Furthermore, some of the key informants pointed out that, when drug users were seen by a psychiatrist, their mental health problems would often be attributed to their drug use.

*If you have a drug problem you can bet your bottom dollar you won't get [psychiatric] care – you are sent back out. My experience with people who have self harmed – they haven't even been offered counselling sessions in hospitals – they haven't even been offered psychiatric help – that is fact, not fiction.*

(Health care professional)

*Obviously some form of depression would not be surprising and it is probably under diagnosed as well because they are focusing very much on the drug issue and do not sometimes notice all the rest.*

(GP)

Other gaps mentioned less frequently included the lack of follow-on care for those who were Hepatitis C positive and the absence of any service that would address alcohol and drug use simultaneously or offer services to cocaine users.

## 7.2 Drug Services

### 7.2.1 Needle Exchange Programmes



All current injectors (n = 12) had been to a needle exchange in the 6 months prior to interview. The most frequently attended needle exchange (n = 6, 50%) was Merchants Quay Ireland in the city centre, followed by Ballyfermot (n = 4, 33%) and Inchicore (n = 4, 33%).

Over half of current injectors (n = 7, 58%) reported that the access times to clean injecting equipment suited their needs. The five (42%) respondents whom the opening times did not suit complained that most needle exchanges were open only in the morning or afternoon.

*It would be better if they were open in the late afternoon. We need needle exchanges open every day and all day.*

(Male, 26 years)

*I'm usually using in the morning and they're only open on the afternoon.*

(Male, 27 years)

Two-thirds of current injectors (n = 8, 67%) reported that they had difficulties accessing clean injecting equipment. Almost all of them (n = 7) complained that there was no needle exchange in Clondalkin and they had to travel to the city centre (i.e. 7 miles) to access clean injecting equipment. This is illustrated by the following quotes:

*I have to go to town which is a long way to go.*

(Female, 27 years)

*It's hard to remember what times everywhere is open. I try not to go into town as that's how it all started.*

(Male, 27 years)

*You're either too late or you have to go into town which is too far so we'd all end up using after each other.*

(Female, 27 years)

Nevertheless, during the preceding year, the vast majority did get most of their works from a needle exchange (n = 11, 92%), while the remaining person got works from a friend.

All current injectors (n = 12, 100%) believed that there was a need for a place where they could inject drugs safely (i.e. a safe injecting room) and most of them (n = 11, 92%) reported that they would use such a facility.

### **7.2.2 Methadone Maintenance Programmes**

Among those (n = 28) who had ever been prescribed methadone, 14 (50%) experienced difficulties accessing a programme. Male respondents were proportionately more likely to have experienced difficulties accessing a methadone programme than their female counterparts (56% vs. 40%). The main difficulty the majority experienced (n = 12) was the existence of long waiting lists.

*I was suicidal waiting for so long to get on a course.*

(Female, 27 years)

*I had to wait 2 years to get on methadone maintenance.*

(Male 25 years)

*I had to wait 2 years. I got strung out <sup>24</sup>waiting for it.*

(Male, 23 years)

These views were echoed by key informants who also felt that waiting lists for methadone maintenance were too long (ranging sometimes from 8 months to 2 years). Key informants were concerned that waiting for treatment causes great anguish to family members, can lead to deteriorating drug use for individuals involved and may lead to drug users resorting to desperate measures (as many would be aware that priority is given to pregnant drug users and those that are HIV positive).

*I know one case of someone who claimed they were pregnant in the hopes of getting on to the clinic and that is seen as being a nuisance – where all I see in that is desperation [...] but you should not, no matter who you are, have to wait that long to get treatment. You wonder where someone's addiction has gone in those eighteen months.*

(Drug service provider)

Other difficulties reported by drug users were that they had to attempt detoxes before they were given maintenance (n = 2) and one person was told that he was too violent. Key informants also reported that the assessment procedure, urinalysis<sup>25</sup> and sanctions also acted as barriers to methadone treatment for drug users. Furthermore, one health care professional pointed out that some GPs were abstinence oriented and would only provide methadone detoxes.

*One doctor who takes patients on – his aim would be to detox. They are brought on, on a definite contract. It is not methadone maintenance. The agreement is that you will be detoxing. So how best do we deal with this?*

(Health care professional)

Among those who picked up their methadone script at a pharmacist (n = 8), a quarter (n = 2, 25%) felt that they were discriminated against by pharmacists or pharmacy staff dispensing methadone.

Table 7.1 shows the length of time it took respondents to travel to pick up their methadone. The majority of those on methadone (n = 15, 63%) only had to travel for up to 15 minutes. However a fifth of those on methadone (n = 5, 21%) felt that the length or time it took them to pick up their script was too long.

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<sup>24</sup> Physically and psychologically addicted to drugs.

<sup>25</sup> As a condition of methadone maintenance and detox, clients are required to provide urine samples when requested. These samples are tested for the presence of non-prescribed drugs.

**Table 7.1 Length of Time to Travel for Methadone**

<b>Length of time</b>	<b>Number (n)</b>	<b>Percentage (%)</b>
Up to 15 minutes	15	63
16 – 30 minutes	4	17
31 – 45 minutes	1	4
46 – 60 minutes	2	8
Over 60 minutes	2	8
<b>Total</b>	<b>24</b>	<b>100</b>

### *7.2.3 Detox Programmes*

Over half (n = 16, 53%) of respondents had attempted to detoxify from their drug use during the preceding 12 months. Male respondents were twice as likely as their female counterparts to have tried detoxification (65% vs. 30%). Analysis revealed that those who tried to detox were substantially younger than those who had not (25.4 yrs vs. 29.6 yrs).

Among those who had attempted a detox, over two-thirds (n = 11, 69%) experienced difficulties. A range of different reasons were given including boredom, detox programmes were too short, difficulties managing withdrawals, fear of totally detoxing or not being able to detox themselves. Similarly, several of the key informants felt that detox programmes were too short and not flexible enough to cater for individual needs.

*It is a set programme for everybody so it doesn't cater for any individual differences. Everybody gets the same – so it is quite hard. You may get one or two who make it through to the end and go into rehab – I think for most people who do a detox for the first time, it's a shock. To ask them to change their lifestyle in a matter of eight to twelve weeks is quite a hard task.*

(Health care professional)

Some of the key informants also felt that more support and preparation should be offered to those entering into a detox (residential or home detox) as well as aftercare support once a detox is completed.

### *7.2.4 Counselling*

The vast majority (n = 25, 83%) of respondents reported that they had previously had some counselling related to their drug use. All female respondents and three-quarters of male respondents previously had counselling. Of the 25 who stated that they had counselling, over two-thirds (n = 17, 68%) reported that they had gained some benefits. The most common benefit (n = 8, 47%) was being able to talk to someone openly.

*I was able to talk about my feelings*

(Male, 32 years)

*I was able to open up about sexual abuse within my family.*

(Female, 27 years)

*You can get whatever's on your mind off your chest.*

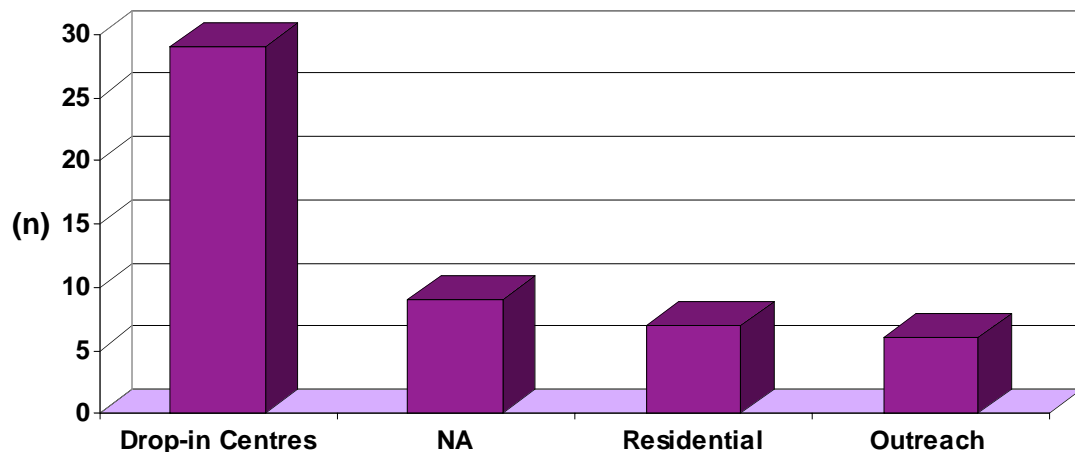
(Male 24 years)

Among those who had some counselling, only 3 (12%) had difficulties finding a counsellor when required.

### 7.2.5 Other Drug Services

Figure 7.1 demonstrates the contact respondents had with other drug services in the preceding year. It reveals that the vast majority (n = 29, 97%) had been in contact with drop-in centres. The one person who was not in contact with any drop-in service was homeless. Almost a third (n = 9, 30%) of respondents had attended Narcotics Anonymous, while 7 (23%) had been in contact with a residential programme and 6 (20%) were in contact with outreach workers. Analysis revealed that male respondents were 3 times more likely to have been to a residential programme in the previous year (30% vs. 10%). Moreover, respondents who had been to a residential programme were proportionately younger (24.4 yrs vs. 28.3 yrs).

**Figure 7.1 Contact with Other Drug Services**



### 7.2.6 Developing Drug Services in Clondalkin

All respondents (n = 30, 100%) felt that drug services could be improved upon for drug users from Clondalkin. The most frequently cited recommendations (n = 16, 53%) were to increase the number of places on methadone maintenance programmes, in particular to increase the number of GPs prescribing methadone for the more stable users, as well as to establish a prescribing clinic in Clondalkin for those who are less stable.

*We need more GPs to take on clients on methadone maintenance instead of clinics, as clinics are a bad environment.*

(Male, 28 years)

*There's nothing in Clondalkin. We need a place like Fortune House in Clondalkin – a place where they can give out phy [methadone].*

(Male, 23 years)

These recommendations were also advocated during the in-depth interviews with key informants. The following quotes sum up the general attitude of key informants:

*There's a need to stabilise people and move them away from drug clinics and allow them to attend their general practitioner - the same as anybody else attends them for their primary care. Then their drug addiction is at a level that can be managed in primary care – to me that is the ideal.*

(Service planner)

*We will always need clinics like these – you will always need clinics for chaotic drug users whom you cannot send out to a community pharmacy. It is not just the GP you see – the GP has to be happy that they will behave themselves in a community setting i.e. the pharmacy [...] we will always need those clinics to bring them in off the streets and stabilise them and get them sorted.*

(GP)

During the focus group, drug users advocated more flexible prescribing practices:

*In the [drugs clinic] if you are on a maintenance you can actually drop yourself slowly and gradually and if you are on 80 mls, after a couple of months you could find yourself on 20 and you can say – well, I'm happy on 20 mls. I could keep this up for a while or you could go the whole way, in your own time – instead of having a doctor in your ear saying “well, in seven days you have to drop a ml. a day”.*

Over a third of those interviewed (n = 11, 37%) expressed the need for a needle exchange in Clondalkin. In line with the views of key informants (see section 7.1) drug users reported that the lack of needle exchange in the area resulted in many drug users sharing injecting equipment.

*We need a needle exchange. We end up going into town and our drug use gets worse.*

(Male, 26 years)

*We need a needle exchange. They're people willing to use after other people and they're only kids.*

(Female, 32 years)

*There's a need for a needle exchange as most of us have to share.*

(Male, 23 years)

Many of the key informants felt that a needle exchange would be the most appropriate place to meet the immediate health care needs of chaotic drug users, to offer safe injecting advice and to link clients into mainstream services.

*A needle exchange would be a big incentive and then you would be able to treat all their health care needs. That would be the key to getting them in.*

(Drug service provider)

*I think the opportunities for education around safer injecting and many of the issues around drug use are better provided for in a setting probably outside the individual GPs.*

(Service planner)

Additional recommendations by drug users included the need for more drug services in the locality; anonymity and confidentiality in some drug services; and some workers needed to be more sensitive and less judgemental.

Factors mentioned less frequently by key informants included the feasibility of needle exchanges through community pharmacies at evenings and weekends; providing sharps boxes in drug services; more structured day programmes as well as evening services for those working; and increasing the availability of complementary therapy within drug services. Other comments included the need for services for cocaine users; crèche facilities in drug services for those with children; more support for families; and more prevention programmes in schools. It was also pointed out that for any recommendations to be implemented the relevant statutory organisations would need to provide sufficient staff and funding.

### 7.3 Health Services

Respondents were asked where they would usually go to obtain information on health issues. Half of those interviewed (n = 15, 50%) reported that they would get such information from their drugs clinic, while a fifth (n = 6, 20%) stated that they were not interested in information on health issues. A further five (17%) respondents reported that they would go to their GP for information on health.

Interviewees were also asked where they would go if they had a medical problem. As Table 7.2 shows, the majority of respondents (n = 18, 60%) would go to their GP, while one fifth (n = 6, 20%) would go to A&E.

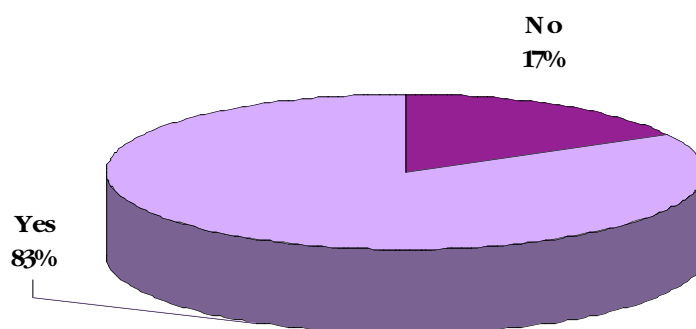
**Table 7.2 Addressing Medical Problems**

	Number (n)	Percentage (%)
GP	18	60
A&E	6	20
Nowhere	4	13
Consult drugs workers	2	7
<b>Total</b>	30	100

#### 7.3.1 Medical Card Ownership

Figure 7.2 shows that the vast majority (n = 25, 83%) of respondents had a medical card. Respondents who were homeless were less likely to have a medical card compared to their housed counterparts (60% vs. 88%). Moreover, none of those who had a medical card had any difficulties with the application process. Only 1 respondent did not know if he was eligible for a medical card or did not know where to get one.

**Figure 7.2 Medical Card Ownership**



### 7.3.2 Access to Health Services

In the 6 months prior to interview, two-thirds (n = 20, 67%) of respondents had accessed the health services via GP, A&E or outpatient services. As Table 7.3 demonstrates, GP was the most commonly used service with over half (n = 17, 57%) of respondents reporting having been to a GP in the last 6 months. Two-fifths (n = 12, 40%) of the respondents had been to A&E, while 9 (30%) had been to an outpatient clinic. Homeless respondents were proportionately less likely to have had contact with any health services (40% vs. 72%).

**Table 7.3 Use of Health Services in Previous 6 Months**

	Number (n)	Percentage (%)
<b>Any health service</b>	<b>20</b>	<b>67</b>
GP	17	57
A&E	12	40
Outpatient department	9	30

### 7.2.3 Access to GPs

An overwhelming majority of respondents (n = 27, 90%) were registered with a GP. Among those who were registered with a GP, 11 (41%) were registered in Clondalkin Village; while a further 4 (15%) were registered in Neilstown and Bawnogue respectively. Seven of the remaining respondents were registered in other areas of Clondalkin, while 1 person was registered in the city centre. All the respondents who were registered with a GP (n = 27, 100%) were able to do so straightaway and none of them reported any difficulties in registering.

Key informants explained that those who were not registered with a GP had not tried to register, had no medical card, or had been barred from GP surgeries.

Over half (n = 17, 57%) of respondents had been to a GP in the last 6 months. Those who did not have a medical card were proportionately less likely to be registered with a GP or to have been to a GP in the previous 6 months. Homeless respondents and female respondents were proportionately less likely to have seen a GP in the preceding 6 months.

Respondents were asked about their most recent visit to the GP. The most common reason was for methadone maintenance (n = 9, 53%). A further 4 respondents attended their GP for medication for different health problems, while 2 went to their GP for administrative purposes. While it is reassuring that so many drug users were registered and accessing a GP, these results indicate that drug users are not addressing their health care needs within primary health care but are more likely to be attending GPs for methadone maintenance and administrative purposes.

*The clients essentially want methadone, and when they get their methadone, really to get them to attend to anything else is very difficult - even to get tested for HIV is very difficult.*

(GP)

*Some people in addiction are reluctant to bring these problems associated with addiction to the doctor because they may not get care. Traditionally the reception has not been good, but I know that has changed and there are great doctors out there.*

(Health care professional)

However, during the focus group, drug users felt that the perception among health care professionals that they were constantly looking for prescriptions was unjustified.

*Every time I go round to my G.P. I knock at the door, your woman answers the door and she says "hang on" she closes the door and comes back out and says - "he says he will see you as long as you are not asking for tablets". I just say "no, I have an abscess" - that's how bad my doctor is.*

(Male, 26 years)

One drug service provider pointed out that those on methadone may be reluctant to bring any drug-related complaints to the attention of their GP, even though this could have serious health consequences:

*Then there is the whole health issue around what way they are using and if it is not safe to say to your doctor you have an abscess what happens if you get bad heroin and it turns into something more serious again. The relationship should be able to stand all of that and even if it means harm reduction for a while on the methadone but I know every time you have a conversation with someone who has an abscess it is not straightforward.*

(Drug service provider)



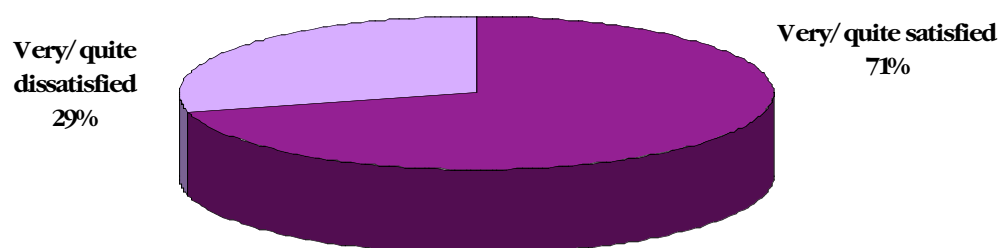
As Figure 7.3 reveals overall the respondents were satisfied with their most recent visit to GPs. Four respondents (24%) were extremely satisfied, while almost half (n = 8, 47%) were quite satisfied. In response to an open-ended question, respondents explained their level of satisfaction with their GP. The main reason for feeling very/quite satisfied with a GP depended on the attitude of the GP, the time given to each client and how he/she treated drug using clients. This is exemplified in the following quotes:

*He asks you everything about your health. Everyone who goes in is there for about 20 minutes. He doesn't treat you differently although other doctors do.*  
(Male, 34 years)

*He was helpful with the problems I had – other doctor wouldn't help me in any way at all.*  
(Male 25 years)

*The GP treats me very well and does her best to help.*  
(Male, 28 years)

**Figure 7.3 Satisfaction with GPs**



The main reason for respondents feeling quite/very dissatisfied with their GP was that they felt they were treated differently, as explained by the following respondent:

*I told him I had arthritis and he laughed at me because I took drugs he looked down at me.*  
(Female, 27 years)

A substantial minority of respondents (n = 13, 47%) had not been to a GP in the previous 6 months. Key informants suggested that two of the main barriers to accessing primary health care for drug users were that they did not view their health as a priority and they found it difficult to adhere strictly to appointment times.

*It is part of the way they live their lives. They are chaotic. When you are using drugs the first thing you think of in the morning is where am I going to get my money to get my fix [...] So having a GP is certainly way down in their priorities*  
(GP)

*I suppose the services that are offered might not necessarily be appropriate to drug users' needs – they are fairly structured in their approach [...] Inflexibility on the part of the primary health care services could be a factor as well.*

(Service planner)

Consistent with the comments made by drug users, key informants felt that drug users feared attending GP surgeries because of feeling that they might be treated differently or because of negative experiences in the past. Furthermore, the attitude of some GPs was also reported as deterring drug users from accessing their surgery. Some GPs were described as being 'discriminatory', 'judgemental' and 'prejudiced' against drug users and generally 'not user friendly'. One GP who was interviewed commented on the negative attitude among her medical colleagues in relation to drug users:

*I don't think the world over you will ever change people's attitudes to drug users and you have to work in the area because a lot of my GP colleagues just cannot understand why I work in this area. When you try and explain to them the things that attract you to it in terms of the psycho-social element and the deprivation and try to start at the unusual level to this vicious social cycle they don't go there at all. If our own colleagues have that negative attitude, it is very difficult to change.*

(GP)

It was generally considered that it was more difficult for homeless drug users to access health services as they were more chaotic, more vulnerable and did not have an address which made it more difficult to register with a GP.

*When they are both drug users and homeless they are obviously more vulnerable generally but also more vulnerable in terms of losing contact with services. That would be our experience [...] Once people are homeless it is very hard to sign up with a GP just in terms of the bureaucracy – you are supposed to give an address because there are all kinds of stipulations about living within a certain catchment area of a GP [...] even if you have an address there are the other issues of attitudes and prejudices and discrimination at times which is a bit sad.*

(GP)

During the in-depth interviews with key informants, it transpired that some health care professionals were unwilling to work with drug users for a range of reasons. Only 1 key informant did not agree with this perception. The main reason given why GPs and other primary health care professionals were unwilling to work with drug users was lack of understanding due, largely, to lack of training.

*Most of us were not trained virtually at all on drug abuse in medical school [...] from a training point of view and from the establishment point of view we were never really encouraged to take these people on.*

(GP)

*GPs are afraid they won't be able to cope with the issues; afraid they won't have any understanding; afraid that they will be disempowered by taking people on. They are also afraid that they won't be any good at it, won't be*

*able to relate to the people and won't be able to understand the reality of it. That's being nice.*

(GP)

Occupational constraints mentioned by key informants included the cost of dealing with drug users and that primary health care staff felt overstretched with insufficient time to treat drug users.

*Time is a big issue. We see a lot of patients in the methadone clinic and there are people clambering to get into it. So we feel under pressure to see as many people as possible and there is a limit to how many people you can see but you still end up being very busy seeing them. So time is a big issue.*

(GP)

*The second thing is that it is unprofitable as it doesn't have the ability to create as much wealth and profit as a regular patient would have. I think doctors have a cap on the number of medical card patients.*

(Service planner)

Violence and aggression were also cited as serious barriers to working with drug users. Some key informants felt that drug users behaved aggressively and posed a safety risk to other patients and staff.

*They [drug users] can be narky and aggressive sometimes and that doesn't go down well with people who are already stressed out and over-worked.*

(Drug service provider)

Some health care professionals felt that drug users exhibited behaviour which was described as 'demanding' and 'stressful'. Furthermore, some GPs did not want drug users in their surgeries because they may have had a bad experience in the past and they feared they could discuss inappropriate issues in the waiting room and subsequently put other patients off attending the surgery.

*If a drug user is sitting in the waiting room of a GP's surgery, and other people come, they may put other people off attending that surgery.*

(Service planner)

It was reported that many GPs would not promote harm reduction and would generally be abstinence-oriented and would therefore find it difficult to engage with drug users who lack the motivation to come off drugs. The GP quoted below realised at the start of her career that abstinence was not a realistic goal for many drug users and accepted methadone maintenance as an effective treatment in its own right.

*When I started off first I saw success as somebody detoxing completely and going into rehab. Over the years I have learnt that success in addiction is recognising the group that can do that [...] but recognising the group that you may have to stabilise for three or five years and recognising the group that cannot and will never do that. Once you accept that then you can work with these people.*

(GP)

Primary health care professionals who did work with drug users (in some cases very willingly and enthusiastically) felt that they were working in isolation mainly because of lack of co-ordination between primary health care professionals and other drug and health services.

*If you feel you are the only person dealing with this person that must put an added strain on the doctor.*

(Drug service provider)

Key informants explained that lack of co-ordination can lead to risk of double prescribing and makes it difficult for GPs to refer clients into residential treatment. However, some drug service providers complained that many primary health care professionals work within the medical model and might not always value the expertise of drug service providers, even though drug service providers were keen to work in partnership with them.

*It can be difficult at times in that they don't want to accept that we are an autonomous voluntary service and they would be very much pushing the medical model [...] There is a challenge for them to accept that the community sector has a vital role to play in drug services.*

(Drug service provider)

#### **7.3.4 Access to Accident and Emergency Services**

As already stated, two-fifths (n = 12, 40%) of respondents had been to A&E in the previous 6 months. The most common reason for last visit to A&E was a physical complaint (n = 8), while 3 respondents went with a drug-related complaint and 1 person had attempted suicide.

As Figure 7.4 shows, overall the respondents were not satisfied with A&E services. Among those who attended, a quarter (n = 3, 25%) were quite dissatisfied, while 4 (34%) were very dissatisfied. Three respondents were dissatisfied with the service at A&E as they had to wait long hours and did not get a bed. A further four respondents felt they were treated particularly unfairly because they were drug users. This is illustrated in the following comments:

*It was grand until the doctor told the nurse to give me 80 mls and she wouldn't give it to me for 2 hours. She was walking around with it for 2 hours in her pocket and she wouldn't give it to me.*

(Male, 32 years)

*I was pushed by one of the security guards. When they saw my legs [i.e. abscesses] they wouldn't admit me even though I can't walk with the pain.*

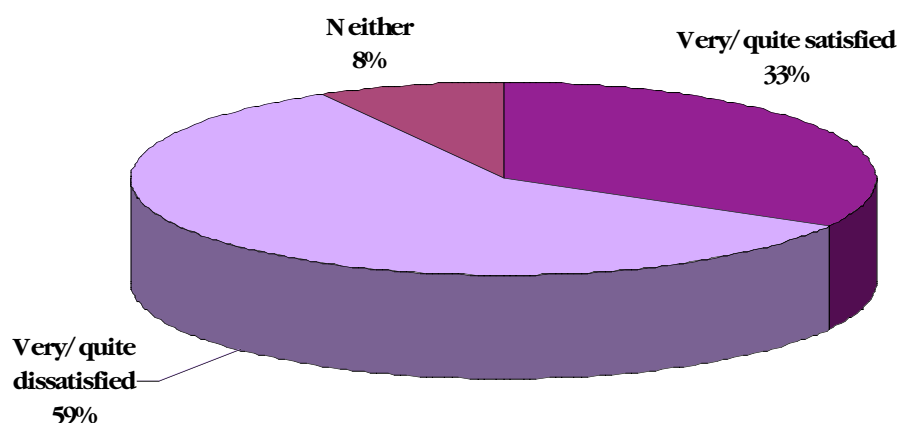
(Male, 25 years)

Some key informants also pointed out that drug users did not go to A&E as they were deterred by long waiting times and concerned that they would suffer from withdrawal if not given any methadone.

All of those (n= 4) who were very/quite satisfied with A&E explained that this was because they did not have to wait to be treated.

*I was admitted in pretty quickly because of the state of my wrist.*

**Figure 7.4** Satisfaction with Accident and Emergency Services

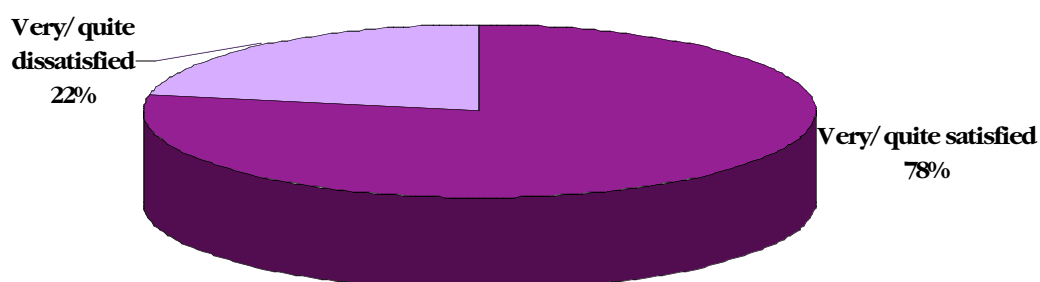


### 7.3.5 Access to Outpatient Clinics

As already stated, almost a third (n = 9, 30%) of respondents had attended an outpatient department in the previous 6 months. The majority (n = 7) had attended the hepatology clinic at St James Hospital, while 2 had been to a psychiatrist.

As Figure 7.5 shows, respondents were generally satisfied with outpatient services. One person reported being extremely satisfied, while 6 respondents (67%) were quite satisfied. The most common reason for feeling satisfied with the service was the attitude of the staff in these clinics.

**Figure 7.5** Satisfaction with Outpatient Services



### 7.3.6 General Health Services

Respondents were also asked if they had attended a list of other health services in the 6 previous months. As Table 7.4 highlights, over three-quarters had been to the pharmacist (n = 23, 77%), while over half the respondents (n = 16, 53%) had been to an addiction counsellor. A substantial number had visited a dentist

(n = 12, 40%), while 9 (n = 30) had stayed in hospital. Almost one quarter (n = 7, 23%) had also seen a psychiatrist.

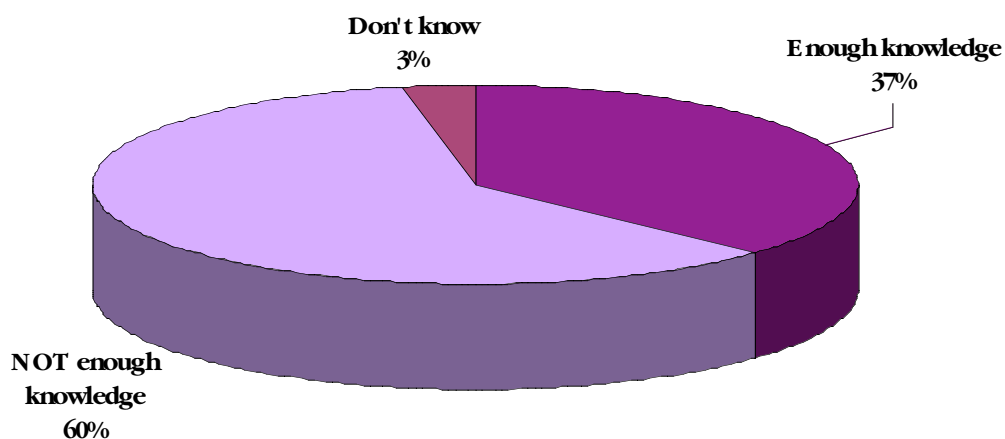
**Table 7.4 Use of Other Health Services**

	<b>Number (n)</b>	<b>Percentage (%)</b>
Pharmacist	23	77
Addiction counsellor	16	53
Dentist	12	40
Inpatient in hospital	9	30
Psychiatrist	7	23
GUM clinic	2	7
Physiotherapist	2	7

Homeless respondents were proportionately less likely to have been to a dentist, but more likely to have stayed in hospital or to have seen an addiction counsellor. There were also notable gender differences. Female respondents were proportionately more likely to have visited an addiction counsellor (70% vs. 45%), while male respondents were more likely to have gone to the dentist (50% vs. 20%). Furthermore, those who attended addiction counselling were proportionately younger than those who had not (25.8 years vs. 29.3 years).

Finally respondents were asked about the knowledge and training of health care professionals in relation to drug issues.

**Figure 7.6 Knowledge and Training of Health Care Professionals**



As Figure 7.6 shows the majority (n = 18, 60%) did not believe that those who provided a health service (including GPs, pharmacists and general services) had enough knowledge of and training about drug users and using issues. There was also a general consensus among key informants (including GPs themselves) that GPs were insufficiently trained in relation to drug issues.

## 7.4 Summary and Conclusion

*Needle exchanges:* All current injectors (n = 12) had been to a needle exchange in the 6 months prior to interview. The most frequently attended needle exchange (n = 6, 50%) was Merchants Quay Ireland in the city centre which meant that drug users had to travel 7 miles for clean injecting equipment. Figures from the needle exchange at Merchants Quay Ireland reflect the high numbers of drug users from Clondalkin accessing the service. In the year previous to this study (1<sup>st</sup> September 2003 – 31<sup>st</sup> August, 2004), visits from those residing in Dublin 22 (Clondalkin) represented 5% (n = 1,345) of the total visits to the needle exchange.

Two-thirds of current injectors (n = 8, 67%) reported that they had difficulties accessing clean injecting equipment. Both drug users and key informants felt that the absence of a needle exchange in Clondalkin was a serious gap in drug service provision. This is a cause for concern as British research has found that the absence of a needle exchange can lead to the development of 'shooting galleries' where many drug users end up congregating and using from the same set of works (Watson, 2000). Anecdotal evidence from key informants and drug users in this study would indicate that there are high levels of risk behaviour occurring among injectors due to the difficulty of accessing clean injecting equipment locally.

Both drug users and key informants recommended the establishment of a needle exchange in Clondalkin. Needle exchanges can be highly effective as a public health initiative (Cox *et al.*, 2000). For instance, the first ever Irish follow-up study on the effectiveness of syringe exchanges was carried out in collaboration with 370 injecting drug users who attended Merchants Quay Ireland's Health Promotion Unit (Cox *et al.*, 2000). This study found that syringe exchanges played an important role in significantly reducing the numbers reporting both the use of heroin as a primary drug and its frequency of use. Furthermore there were significant reductions in the reported borrowing and lending of used injecting equipment.

*Accessing methadone maintenance programmes:* Among those (n = 28) who had ever been prescribed methadone, 14 (50%) experienced difficulties accessing a programme. The main difficulty the majority experienced (n = 12) was the length of waiting lists and this was reiterated by comments made by key informants. Other research carried out in Dublin has suggested that long waiting lists (as well as lack of treatment options and respite care) are often the main barriers to sustaining positive behavioural changes among drug users (Corr, 2003). Other barriers mentioned in the current study (assessment procedure, urinalysis and sanctions) were also cited in a study carried out with drug users on methadone maintenance in Dublin. In focus groups facilitated by UISCE (2003), drug users reported that they had been at the receiving end of medical sanctions for what they described as minor infringements of their drug treatment and they had a lack of confidence in the urinalysis process. Both drug users and key informants recommended that a prescribing clinic should be established in Clondalkin.

*Medical Cards:* The vast majority (n = 25, 83%) of respondents had a medical card. Those who did not have a medical card were proportionately less likely to be registered with a GP or to have been to a GP in the previous 6 months. It is reassuring that the majority of respondents had a medical card. However,

these results indicate that medical card ownership can influence a person's behaviour in relation to accessing GPs. Similarly Bury *et al.* (1993) found, in a study carried out among 161 intravenous drug using clients at Dublin HIV Prevention Unit, that medical card holders were twice as likely to visit a GP as non-members.

*Health Services:* In the 6 months prior to interview, two-thirds (n = 20, 67%) of respondents had accessed the health services via GP, A&E or outpatient services. The contact with health services in Clondalkin was quite high which indicates that they are engaging with a substantial proportion of drug users from Clondalkin. This also opens up opportunities for education, health promotion and harm reduction.

*Contact with GPs:* Level of contact and satisfaction with GPs was high among the sample. An overwhelming majority (n = 27, 90%) were registered with a GP and over half (n = 17, 57%) of respondents had been to a GP in the last 6 months. The manner in which the GP treats and deals with his/her drug-using clients was the most pertinent issue for drug users. This is consistent with British research on primary health care which claims that drug users will access services if the attitude of health professionals and the service design are right (Lawrence, 2000). In particular drug users need to feel 'respected, cared for and feel free to discuss their addiction and medical problems without fears of judgement' (Elion, 1990: 261).

Despite the vast majority of respondents being registered with a GP, a substantial minority (n = 13, 43%) had not been to a GP in the last 6 months. International research would indicate that more chaotic drug users often delay seeking help for their health needs until they have reached 'crisis point' (Reid *et al.*, 2000). Furthermore, the majority of those who had visited a GP had been for repeat prescription or administrative purposes. So despite presenting with a range of health problems, as described in Chapter 6, drug users are not addressing these issues within the primary health care setting. Even when drug users are registered with a GP, the relationship between doctor and patient is not always easy or productive (Hindler *et al.*, 1996). The majority of respondents in this study were in receipt of methadone maintenance. Speed and Janikiewicz (2000) concluded that those on methadone maintenance may accept that any physical health problem is a consequence of their drug use and therefore do not report it to their GP for fear of conflict if the GP prescribes a substitute drug.

*Barriers to Health Care:* The real or perceived barriers for drug users accessing primary health care identified in this study are consistent with international research which have also found that drug users are often deterred from accessing health services because they do not view their health as a priority (Reid *et al.*, 2000), strict appointment times (Rowe, 2003), the fear of being treated differently (Reid *et al.*, 2000) and the negative and judgemental attitude of some health care professionals (Reid *et al.*, 2000; Sherrat and Jones, 2003).

The barriers to primary health care experienced by drug users identified in this study are also consistent with international research. Other studies found that the main barrier to involving GPs in primary health care is lack of knowledge due to lack of training (Reid *et al.*, 2000; Sherrat and Jones, 2003; Smith and



Mistral, 2003). Occupational constraints identified in this study (too costly both in time and money) have also been cited in other studies (Reid *et al.*, 2000; Watson, 2000). Butler (2002b: 220) explained that in Ireland 'general medical practice is based upon seeing large numbers of patients for relatively brief consultations, and the complex psychosocial issues raised by problem drinkers and problem drug users may not be readily managed within this context'. Furthermore, Butler (2002b) pointed out that financial implications are important for Irish GPs given that they are independent professionals rather than health service employees. The perceived threat of challenging and difficult behaviour (such as violence and aggression) is also a recurring theme within the literature (Greenwood, 1992a; Smith and Mistral, 2003). However, in a study of challenging behaviour in a GP practice in Leeds between July and September 1999, Thompson (2001) concluded that there was a relatively small difference in the rates of difficult behaviour from drug users and general patients and there was no physical aggression involving drug users during the study. While Sherratt and Jones (2003) see violence as a very real hazard, they advise that this can be addressed through training and 'useful generic guides'.<sup>26</sup>

The results from this study show that some GPs work within an abstinence model even though the introduction of the Methadone Protocol in 1998 meant that GPs in Ireland were going to have to work within a harm reduction model, at least in relation to drug users (Butler, 2002b). This was reflected in Irish health policy where 'total abstinence was no longer seen as the only acceptable treatment outcome for illicit drug users' (Butler, 2002b: 173). According to Speed and Janikiewicz (2000) if GPs adopt an abstinence-oriented approach, this can lead to conflict and repeated breakdown of treatment. Butler (2002b) agrees with the view of drug service providers in this study that GPs in Ireland still continue to work within a traditional biomedical model with an emphasis on curative functions. Finally, primary health care professionals currently working with drug users in Ireland often feel isolated due to lack of co-ordination. Groves *et al.*, (2002) recommended that although developing a trusting relationship between drug services and primary health care services is time consuming, it can be beneficial for both groups involved.

*Training:* The majority of respondents (n = 18, 60%) did not believe that those who provided a health service (including GPs, pharmacists and general services) had enough knowledge of and training about drug users and using issues. Similarly, there was also a general consensus among key informants that GPs were insufficiently trained in relation to drug issues. British research has also consistently found that GPs lack appropriate training in relation to drug issues. For instance, in a study of GPs in Harrow, Rylie *et al.* (1999) found that none of the GPs interviewed had received any pre-graduation training on drug issues. Even though appropriate training is generally viewed as vital for the successful running of primary health care for drug users (Lawrence, 2000), British research has found that it is difficult to engage GPs in training on drug issues (Deehan *et al.*, 1997; King *et al.*, 1998). Training of GPs and other health care professionals has the potential to change resistance to working with this

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<sup>26</sup> Sherratt and Jones (2003) recommend:

Breakwell, G. 1997. *Coping with Aggressive Behaviour*. Leicester: British Psychological Society.

Department of Health. 1999. *Drug Misuse and Dependence - Guidelines on Clinical Management*. London: The Stationery Office.

target group, to dismantling prejudices (Groves *et al.*, 2002; Lawrence, 2000), to increase GP involvement (King *et al.*, 1998; Rylie *et al.*, 1999) and to increase their effectiveness with this group (Mistral and Velleman, 1999).

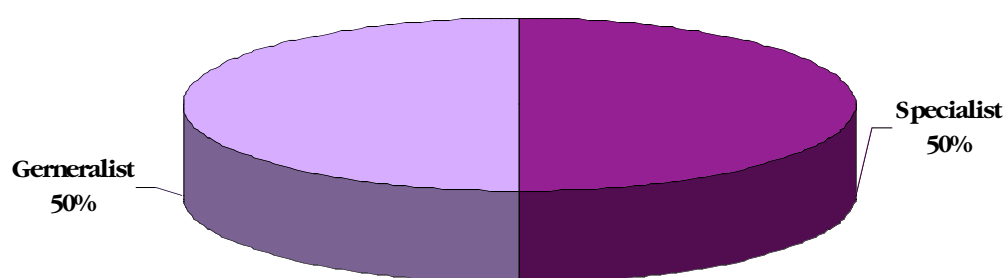
## Chapter 8

### Designing a Model of Primary Health Care

#### 8.1 Specialist or Generic?

A brief overview of a specialist health care service and how it would operate was explained to all participants. As Figure 8.1 indicates the respondents were equally divided on whether they would prefer specialised or generalist medical services.

**Figure 8.1 Preference for Specialist or Generalist Services**



The main reason (n = 9) respondents gave for supporting generalist services was that they did not want to be treated differently or have to mix solely with other drug users. This is illustrated by the following quotes.

*I don't think we need to be labelled as different*

(Female, 24 years)

*When you go to your own GP you're in a safe environment and you don't have to mix with other addicts.*

(Male, 28 years)

*Because you don't want to feel lower than everyone else.*

(Male, 23 years)

Other reasons given for preferring generalist services were that respondents were satisfied with their own GP, and generalist services protect their anonymity.

Conversely, the main reason (n = 10) given for preferring specialist services was that drug users would feel more comfortable in such environment.

*Because some people treat drug users differently and drug users should have somewhere to go where they're treated better.*

(Male, 28 years)

*I don't like going to health services as you're treated differently.*

(Female, 27 years)

A further 5 respondents felt that health care professionals working in a specialist service would have more knowledge about drug issues.

*I don't think there's enough services in the area for drug users. A lot are all family doctors and don't know enough about drugs.*

(Male, 26 years)

*Then they'd have more qualified people who understand about drug users. My own doctor doesn't give a bollocks.*

(Male, 23 years)

The vast majority of respondents (n = 27, 90%) stated that they would use a specialist health service if it existed.

During the in-depth interviews, there was a range of opinions on the provision of specialised health care to drug users. Professionals outlined several advantages of such a scheme, the main one being that it had the potential to appeal to hard-to-reach populations, in particular homeless drug users. Some of the professionals felt that specialised primary health care would enable drug users to get more expert health care, in a non-judgmental way, from health care providers who had a good understanding of drug issues. This would lead to drug users feeling more comfortable accessing primary health care and more at ease addressing drug-related issues.

*If there was a specialised service it could have some sort of induction or some sort of training or education that would train the professionals to be more understanding with drug users and have more empathy for them – to be able to understand the different issues that are affecting their lives – so that they could be trained to work in a non-judgemental way or an impartial way. I suppose as well if there was a specialised team – they are obviously going to be trained in how to deal specifically with drug users, so they themselves are going to be more comfortable in working with drug users and as a result of that confidence and that ability, drug users themselves are going to feel more comfortable in specialised services rather than in a regular primary health care service.*

(Service planner)

However, all professionals felt that a specialised service should only be used as an interim measure while trying to integrate drug users into mainstream health care provision. Professionals felt that a positive experience in specialised services would encourage drug users to access mainstream services.

Overall, most of the key informants did not support the establishment of a separate service in Clondalkin. Specialist services are generally designed for those not in contact with services. However, as the results of this research

show, the majority of drug users had a medical card and were registered with a GP. This was summed up by one GP:

*The vast majority of drug users would have access to a GMS card [...] There might be one or two GPs in Clondalkin who are just not user friendly but the vast majority of drug users in Clondalkin would have a medical card or a GP. So, I don't know really whether access to primary care is as big an issue.*

(GP)

It was also pointed out that a specialist service may be expensive to operate and may not be as comprehensive as mainstream services.

*It is very hard to be as comprehensive as the mainstream service. I'm not saying the mainstream services are great, but there is a certain range of services in the mainstream that is very hard to replicate for a minority group in a micro way – so that is a weakness of targeting as well.*

(GP)

Furthermore, interviewees commented that it would be difficult to find health care professionals to work in the service and specialist care would mean that mainstream service providers could avoid dealing with this group.

*It might be quite hard to get a GP to come in and work in a primary health care that is not part of an established surgery.*

(Health care professional)

Several respondents were concerned that specialist care would further marginalise, stigmatise and isolate drug users and prevent them from receiving 'normal' care.

*For some they just want to integrate and be part of society like any normal person. That is one of the big things you would see.*

(Drug service provider)

One policy maker highlighted the salient point that setting up specialist services is not congruent with the latest primary health care strategy.

*I think that the policy is not so much a matter of what I think. The established and decided Government policy is that we move towards enhancing the capacity of our primary care services so as to enable them to deliver, as I said, the core health and social care requirements within the primary care team to everyone.*

(Policy maker)

Finally the issue was raised that there may be community opposition as local residents might oppose the establishment of another service for drug users and they might feel drug users were getting preferential treatment

*Are you actually then discriminating against people who are not drug users? So could we have a situation where we have a state of the art primary care service for drug users and poor granny down the road cannot get a service?*

## 8.2 Preferred Health Care Services

Those (n = 27) who stated they would attend a health care service if it existed were given a list to ascertain which services they would be likely to use.

**Table 8.1 Preferred Health Care Services**

	Number (n)	Percentage (%)
General medical advice and information	26	96
Hepatitis Testing	24	89
Counselling	24	89
STI Screening	23	85
Nutritional Advice	23	85
Methadone Maintenance	21	78
Acupuncture	21	78
Detox	19	70
Needle exchange	12	44
Referral to specialist treatment	9	33
Other services	9	33

As Table 8.1 reveals, the most sought after services were general medical advice and information (n = 26, 96%), hepatitis testing (n = 24, 89%) and counselling (n = 24, 89%). A majority also stated that would use a health care service for STI Screening, nutritional advice, methadone maintenance, acupuncture and detox. All those who were current injectors reported that they would use a needle exchange and 2 non-injectors also emphasised the need for a needle exchange for injectors in Clondalkin.

Among the 9 who stated they would like referral to more specialist treatment, 4 showed a desire for psychiatric treatment, 2 for screening for cancer and 1 respondent respectively for alcohol detox, Hepatitis C treatment and chiropody. Other services sought by respondents were alternative approaches to methadone, crèche facilities in drug services, more family support and services for homeless drug users. In addition, key informants also recommended the following services: immunisations; follow-on care for those with Hepatitis or HIV; treatment for abscesses; safe injecting advice; linking drug users with psychiatric services; social support; and assisting drug users in applying for medical cards and registering with a GP.

The respondents, who were receiving methadone maintenance, were asked if they would have a problem accessing a health service which also provided a needle exchange. Only one fifth (n = 4, 20%) stated that they would, while 10 (80%) reported that they would not have a problem with it.

Respondents were also read a list of health care professionals in order to ascertain which professionals they would prefer in a health care service. As Table 8.2 reveals, all the respondents thought it essential that a nurse, GP, Addiction Counsellor and social worker should be part of a primary health care service for drug users. The vast majority also thought there was a need for a psychiatric nurse, outreach worker and community welfare officer. Other workers mentioned in an open ended question were peer workers, complementary therapist, chiroprapist, psychiatrist, advocacy worker and family support worker. These professionals were also mentioned in the in-depth interviews with key informants who generally felt that a multi-disciplinary approach was the most appropriate way to deal with the multitude of issues which drug users have.

**Table 8.2 Preferred Health Care Professionals**

	Number (n)	Percentage (%)
Nurse	27	100
GP	27	100
Addiction Counsellor	27	100
Social worker	27	100
Psychiatric Nurse	26	96
Outreach worker	25	93
Community Welfare Officer	24	89
Other workers	6	24

All key informants supported the idea of having a ‘liaison’ or ‘link’ worker who would offer support and advocacy to drug users. The general consensus was that the ‘link’ worker should be a nurse with the necessary clinical qualifications to address the health care needs of drug users. This would help, in particular, those not in contact with any services and enable them and support them to access primary health care services.

*It would have to be a nurse who could give advice on testing for hepatitis, different kinds of abscesses and stuff like that. He or she would then give that patient or client something to say to the doctor and try to convince the person to go and visit the doctor.*

(GP)

*I think there is the potential for some liaison work there at that kind of level with a professional person to link a person to their GP, maybe act as an advocate with the GP.*

(Service planner)

The idea of a ‘link’ worker was also suggested by drug users during the focus group, as long as the links worker was well informed, empathetic towards drug users and was able to advocate on their behalf.

Respondent 5      *It would be good to talk to someone.*

Interviewer      Do you mean a counsellor?

- Respondent 5      *No, not a counsellor.*
- Respondent 2      *Somebody to link in with.*
- Interviewer      *Some drugs worker?*
- Respondent 2      *Yes, a link worker for support.*
- Respondent 4      *A go between. Just as long as it is someone who really knows what he is talking about.*

While it was agreed that the primary role of the 'link' worker would be a 'clinical' one, GPs stated they would welcome extra support and advice.

*It would be useful sometimes to have a link worker or someone you could ring for advice.*

(GP)

*For example, there is a GP up in Clondalkin who is Level 2 who has no nurse and he obviously has to keep up to scratch with his 35 clients and their immunisation and everything and it is very, very easy to fall behind on them. So if a nurse had a dual role – she would be in a position to take bloods, oversee or help out with the virology and the immunisation and also provide a link between the GPs and the central services and other services - that would be very useful.*

(GP)

Finally, because they felt that there was a lack of co-ordination between existing services, some key informants suggested that a 'link' nurse could promote co-operation between primary health care providers and drug services.

*It means liaising with health service providers, liaising with other people who are statutorily related, liaising with NGO's, liaising with service people themselves and trying to rectify whatever the problem is.*

(Service planner)

*If a large body of people out here have an addiction problem and are not accessing primary care –I would like to see a link between drug services and the existing primary care networks.*

(Service planner)

It was also proposed that the ideal location for a 'link' worker would be at a drugs clinic, operating in a relaxed, flexible and comfortable atmosphere.

*If it is purely for drug users I would say you would probably get them into a place not connected to an existing health service. If it was somewhere different – like one of the drugs services.*

(Drug service provider)

However, the prevalent feeling among key informants was that the ultimate aim should be to link drug users into primary health care in the community.

*It is not about providing a parallel health care system. It is about recognising that at this point in time that is the only way they are going to access primary care. What you are hoping is that by meeting their health needs that they will start to deal with their accommodation needs and then they will link back to the community and access primary care in the normal way.*

(Service planner)

Many key informants pointed out that drug users from north Clondalkin were unlikely to use services in south-west Clondalkin and vice versa. Therefore, it would be necessary for a 'link' nurse to spend an equal amount of time between the two areas.

*There seems to be a tradition that people from north Clondalkin will rarely go to south-west Clondalkin to access services and vice versa [...] So I think it is about bringing the service into a location where everyone can identify with and that nobody can say this is limited only to north Clondalkin or south Clondalkin.*

(Service planner)

Drug users were asked what they thought were the most important issues to be considered when setting up a specialised health service for drug users. Twenty respondents made recommendations. Nine thought it important that anyone providing health care for drug users should treat them with respect, while 5 respondents felt that it was important that services should be flexible with no waiting times. Other respondents felt that a health service for drug users should be anonymous, accessible and staffed by professionals with a good knowledge about drug issues. Similarly, key informants felt that it was necessary that health care provision should be flexible, relaxed, holistic, accessible, confidential and comprehensive.

### 8.3 Summary and Conclusions

Drug users were equally divided on whether they would prefer specialised or generalist medical services. Nevertheless the vast majority of respondents (n = 27, 90%) stated that they would use a specialist health service if it existed. Overall, key informants did not support the establishment of a specialised service. Professionals were aware that it had several advantages, such as the potential to appeal to hard-to-reach populations. It would also enable drug users to get more expert health care, in a non-judgmental way, from health care providers with a good understanding of drug issues.

Conversely, key informants felt that specialised care might be expensive to operate, it might not be as comprehensive as mainstream services, it might be difficult to find health care professionals to work in such a service and mainstream service providers would be able to avoid dealing with the target group. Furthermore, it could further marginalise, stigmatise and isolate drug



users and it would also not be congruent with the latest Irish primary health care strategy<sup>27</sup>.

The vast majority of drug users interviewed showed a desire to access a range of services, including general medical advice and information, hepatitis testing, counselling, STI screening, nutritional advice, methadone maintenance, acupuncture and detox. In addition to these services, key informants recommended that the following services be provided: immunisations; follow-on care for those with Hepatitis or HIV; treatment for abscesses; safe injecting advice; referrals to psychiatric services; social support and assisting drug users in applying for medical cards and registering with a GP.

All respondents thought that it was essential that a nurse, GP, Addiction Counsellor and social worker be part of a primary health care service for drug users. The vast majority also expressed a need for a psychiatric nurse, outreach worker and community welfare officer. Other workers mentioned were peer workers, complimentary therapist, chiropodist, psychiatrist, advocacy worker and family support worker. These professionals were also mentioned in the in-depth interviews with key informants who generally felt that a multi-disciplinary approach was the most appropriate way in dealing with the many issues with which drug users present.

All the key informants supported the idea of having a 'liaison' or 'link' nurse in Clondalkin. Mistral and Velleman (2001) pointed out that giving greater clinical responsibility to nurses may reduce GPs' concerns about over-work, they are able to support GPs in relation to health promotion activities and, more importantly, nurses have demonstrated greater willingness than GPs to become professionally involved with drug users. Research carried out by the Kings Fund in London reviewed the role of link workers in primary care (Levenson and Gillian, 1998). The research shows that these workers are able to undertake a variety of roles and are employed by a range of organisations. Their role includes advocacy, promoting better health and making health care more accessible. While they were initially set up to address the health inequalities of minority ethnic groups in the UK, they also can be of particular value in the 'health promotion, screening, immunisation and advice session in disease management' of any disadvantaged group' (Levenson and Gillian, 1998: 3). The broad consensus was that the role of the 'link' nurse in Clondalkin should be three-fold. Generally it was agreed that the primary role of the 'link' nurse would be to address the health care needs of drug users in Clondalkin and advocate on their behalf. However, key informants also felt that there was a need to support primary health care professionals in Clondalkin in providing care to drug users and to encourage co-ordination between those providing services to drug users in the locality.

When providing health care to drug users respondents felt it was most important to treat them with respect and to remain flexible, anonymous and accessible. The services should be staffed by professionals with a good knowledge of drug issues. Similarly, key informants felt that any health care provision should be flexible, relaxed, holistic, accessible, confidential and

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<sup>27</sup> Department of Health and Children. (DOHC). 2001. Primary Care: A New Direction. Quality and Fairness – A Health System for You Health Strategy. Dublin: Stationery Office.

comprehensive. These views are consistent with findings from international literature that any type of health care provided to drug users needs to be carried out within a supportive, welcoming, safe and comfortable environment (Reid *et al.*, 2000).

## Chapter Nine

### Models of Providing Primary Health Care to Drug Users

#### 9.1 Shared Care

Few models have been developed internationally in relation to providing primary health care to drug users. Much of the international literature has centred on the merits of the shared care scheme (i.e. providing primary health care and addiction services simultaneously). This model is predominantly used in the UK and has been described as;

the joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for users with a drug misuse problem, informed by enhanced information exchange beyond routine and discharge letters. It may involve the day-to-day management by the GP of the users' medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the user's treatment and care.

(Department of Health, 1999).

Therefore, the main aim behind the shared scheme is to provide drug treatment and primary care to drug users in their local community. The British government has been supporting the shared care model within general practice as it is 'more convenient for the patient, cost-effective, safe and of a recognised standard' (Lawrence, 2000: 280). The main advantages of the shared care scheme are that it normalises drug users' care (Watson, 2000) and the physical, emotional and social well-being of clients improve (Gruer *et al.*, 1997).

Many different models have been produced based on the shared scheme, as shared care needs have been tailored to different areas with different demographics, services and expertise. *Case Study 1* shows how a shared care nurse role (which is what key informants proposed for Clondalkin) has the potential to improve satisfaction with primary care for both primary health care professionals and service users. It also demonstrates that GPs feel less isolated as a result of the shared care role which is also an issue for primary health care professionals in Clondalkin.

**Case 1: Rural Primary Care Group, Bath. UK**  
**See Smith and Mistral (2003)**

The rural primary care group in Bath developed a shared care nurse role to provide improved care for drug users and to support professionals in both primary and specialist care. During the pilot project the shared care nurse held 3 clinics in 3 GP practices. An evaluation of the service found that GPs felt less isolated and that their workload had decreased. As a result of the professional support given by the nurse, the primary care staff felt less pressure and GPs felt they could concentrate more on general medical care. As prescribing was more closely monitored, the number of clients 'topping up' decreased. Furthermore, pharmacists reported less confusion about the time when scripts were to be collected.

Smith and Mistral (2003) concluded that there was a clear improvement in satisfaction as a result of the shared care nurse, among both service providers and clients. Clients felt the service had improved and they valued the longer appointment they had with the nurse. However they did point out that waiting lists and clear referral pathways for drug treatment still needed to be addressed.

## 9.2 Providing Primary Health Care to Chaotic Drug Users

While the foregoing model of shared care offer guidelines on delivering primary health care to drug users, one disadvantage is that sometimes only 'stable' drug users are recommended for shared care. The problems with this are that the criteria for assessing stability varies and the primary health care needs of more chaotic drug users go unmet. Key informants were particularly concerned in the current study that the health care needs of less stable users (e.g. homeless drug users) were not being met by existing services. Both key informants and drug users supported the need for a needle exchange in Clondalkin. The following two case studies show that providing health care in, or in close proximity to, a needle exchange, can effectively engage traditionally 'hard-to-reach' drug users and address their immediate health care needs.

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**Case 2: Health Promotion Unit, Merchants Quay Ireland  
See Cox and Lawless (2000)**

The Health Promotion Unit was set up within the Merchants Quay Project in July 1992 to provide a model for working with the growing number of drug users who were engaged in both unsafe injecting and sexual risk behaviour. The service provides a low threshold, needle exchange and general health care service (including a first aid nursing service and general medical services and referrals). An evaluation of the service shows that the service is successful in attracting 'hard to reach' groups such as female drug users, young drug users and recent injectors. The evaluation found that 28% (n=370) of all first-time contacts that attended during the 18-month period, re-presented at the three-month follow-up. The evaluation also noted that 48% of clients reporting no contact with medical services at first contact reported such contact at follow-up. Medical services visited by first clients included GPs, Dentist, A&E and GUM clinic. 18% of attendees, who reported not having had a H.I.V. test at first visit, had done so by the three-month follow up period. 10% of those who reported not having a Hepatitis B vaccination at first contact reported having had one at follow-up. There was also a reduction in the numbers feeling anxious, isolated, reporting abscesses and weight loss. There was also a significant reduction in clients reporting both the lending and borrowing of injecting equipment, although there were no significant changes in sexual risk behaviour.

**Case 3: Health Information Exchange, St. Kilda, Australia  
See Rowe (2003)**

Australian drugs research found that the most appropriate way of meeting the primary health care needs of injecting drug users was in close proximity to existing needle exchange programmes. Rowe's (2003) research examined the feasibility of providing primary health care at the Health Information Exchange (HIE) at St Kilda. This service is primarily a needle exchange but it also provides information about safer drug use, blood-borne disease and treatment programmes. Furthermore it provides referrals to a range of health services. The vast majority (70%; n = 104) of street-based drug users interviewed favoured the establishment of a primary health care service at the HIE. Respondents also pointed out the need for services to be flexible, accessible and provided in a professional yet sympathetic manner. The research found that that most needed health care services for drug users were a medical doctor, drug and alcohol counselling and dental care. Rowe (2003) concluded that the varied health care needs of street-based injecting drug users was not being met and that the most appropriate point of access to primary health care for injecting drug users was at the HIE. However, the success of the service would depend upon its design, staffing and accessibility.

### 9.3 Summary and Conclusions

In this study respondents recommended establishing a position for a 'link' nurse in Clondalkin. *Case Study 1* highlights that as a result of a shared care nurse role GPs feel less isolated and client satisfaction with primary health care services increases. A similar position in Clondalkin should have comparable results. Supporting GPs and promoting co-ordination between drug services and primary health care teams, through a shared care nurse role, can address a number of barriers that were raised by respondents in Clondalkin. These include the normalisation of drug users' care (Watson, 2000), greater cost-effectiveness, and an improvement of the physical, emotional and social well-being of clients (Gruer *et al.*, 1997).

The research carried out in Clondalkin also indicated that a substantial minority of respondents had not been in contact with a GP in the 6 months previous to study and that the majority of those who had visited a GP had been for repeat prescription or administrative purposes and not for matters relating to health care. Key informants advocated that primary health care should be provided in drug services in Clondalkin. Case studies 2 and 3 show that if health care is provided for drug users linked to a drugs service (preferably a needle exchange) there is the potential to address many of the health care issues that respondents reported in this study (e.g. high levels of injecting and sexual risk behaviour) as well as increasing contact with generic medical services. Therefore, if a link nurse was appointed in Clondalkin, it would be important that he/she were linked into existing drug services and also a needle exchange if it were established in the locality.

## Chapter 10

### Proposed Model for Primary Health Care for Drug Users in Clondalkin

#### 10.1 Conclusions

This study found that drug users in Clondalkin presented with an array of social, physical and psychological problems. These include poor socio-economic status, widespread polydrug use and injecting risk behaviour, numerous attempts at detoxification, high prevalence of Hepatitis C and a range of self-reported physical and mental health problems.

There are a range of drug services available to drug users in Clondalkin. According to key informants, the vast majority of GPs in the vicinity are willing to provide primary health care for this target group. However a number of gaps were highlighted in local service provision by both key informants and drug users. These included the absence of a needle exchange, of and a centralised prescribing clinic and of a service to meet the immediate health care needs of more chaotic drug users. Overall, psychiatric care was deemed difficult to access and there was a lack of follow-on care for those who were Hepatitis C positive.

There were a number of real or perceived barriers identified for drug users accessing primary health care identified. Drug users did not view their health as a priority; they found it difficult to adhere to strict appointment times; they perceived a negative attitude of some GPs towards drug users; and they feared attending GP surgeries because they felt they might be treated differently or because they had negative experiences in the past.

A number of barriers were mentioned which make some primary health care providers less willing to work with drug users. Principally there was a lack of understanding, due to lack of training. There were also a number of occupational constraints (working with drug users was perceived as time consuming and costly) and behavioural problems (drug users were perceived as being violent, aggressive and demanding). Some primary health care professionals may have had a bad experience in the past, were concerned that drug users would put other patients off attending the surgery or were abstinence oriented and unwilling to promote harm reduction. The main barrier for primary health care professionals who willingly worked with drug users was that they were working in isolation due to lack of co-ordination.

These difficulties could be addressed by adopting good practice guidelines. Research has shown that a shared care nurse role (i.e. promoting co-ordination between primary health care providers and drug services) can result in GPs feeling less isolated and increase client satisfaction with primary health care services. The 'link' nurse role also has the potential to normalise drug users' care (Watson, 2000), is more cost-effective (Lawrence, 2000) and improves the physical, emotional and social well-being of drug users (Gruer *et al.*, 1997).

Less 'stable' and 'harder-to-reach' drug users are more likely to access health care through low threshold drugs services (e.g. needle exchanges). Through these services there is potential to address a number of health care issues, such as injecting and sexual risk behaviour, as well as increasing contact with generic medical services.

## 10.2 Recommended Primary Health Care Model

The following recommendations are based on the results of the research and international best practice guidelines. They also accord with current developments in Irish primary health care policy and drug policy.

### 10.2.1 Drugs Liaison Nurse

- **A full-time Drugs Liaison Nurse should be recruited by the Clondalkin Drugs Task Force.**

All the key informants supported the idea of having a 'liaison' or 'link' person in Clondalkin. The liaison person should be a nurse so that he/she would be able to provide health care to drug users as well as supporting GPs and promoting co-ordination between drug services and primary health care teams.

Several issues need to be addressed when recruiting a drugs liaison nurse. It is imperative that the liaison nurse should be well informed of, and empathetic towards the needs of drug users. Smith and Mistral (2003) also advise that a link worker should have good interpersonal skills and work in a flexible manner to accommodate clients' diverse needs. Unfortunately, the role of the link worker can be restricted by short-term funding and low salaries (Levenson and Gillian, 1998). It is important, therefore, that the role the 'link' worker does not develop in an *ad hoc* manner in Clondalkin, but is provided with the necessary funding and resources to insure its success.

**The role of the Drugs Liaison Nurse should be three-fold:<sup>28</sup>**

**1. The primary role of the Drugs Liaison Nurse should be to address the immediate health care needs of drug users in Clondalkin.**

Despite presenting with a range of physical and mental health issues, the primary health care needs of drug users in Clondalkin are not being met. A substantial minority (n = 13, 43%) had not been to a GP in the last 6 months, and those that had, were more likely to attend their GP for methadone maintenance or administrative purposes. Given the high levels of injecting and sexual risk behaviour it is necessary that the nurse should offer safe injecting and safe sex advice, STI screening and should deal with drug-related complaints such as abscesses. There is also a need for Hepatitis/HIV testing and follow-up care. Assistance, where necessary, should also be given in applying for medical cards and registering with a GP. Respondents also reported having difficulties accessing a range of drug services and the Drugs Liaison Nurse should help to address these issues.

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<sup>28</sup> These are summarised in Table 10.1

**2. The Drugs Liaison Nurse will support primary health care professionals in Clondalkin in providing care to drug users in the locality.**

In addition to his/her clinical role, the nurse should take on a consultative role for GPs and provide them with more support in meeting drug users' general primary care needs and specific drug-use related needs. Studies have found that GPs welcome expertise offered by drug services (Groves and Strang, 2001) and GPs feel less uncomfortable with prescribing methadone maintenance when they have received specialist help (Groves *et al.*, 2002). The Drugs Liaison Nurse should also assist GPs in developing protocols, procedures and contracts so that the primary health care needs of drug users are consistent and standardised. Research has found that GPs are often more open to working with opiate users when the practice has policies and guidelines to deal with drug users and when they receive the support of specialist workers (e.g. Drugs Liaison Nurse) (Gerada and Tighe, 1999; Ryrie *et al.*, 1999).

**3. The Drugs Liaison Nurse should also support co-ordination between those providing services to drug users in Clondalkin.**

Primary health care professions working with drug users in Clondalkin often felt isolated, mainly due to lack of co-ordination between services. Smith and Mistral (2003) reported that GPs in the UK felt communication improved between primary health care professionals and drug services when the support of a 'link' person was available.

**Table 10.1      Role of the Drugs Liaison Nurse**



<p><b>Addressing the health care needs of drug users in Clondalkin and advocating on their behalf</b></p>	<ul style="list-style-type: none"> <li>• provide a range of harm reduction services (including safe injecting advice, safe sex advice and information on polydrug use including overdose risks etc.)</li> <li>• promote strategies to reduce the risk of HIV and Hepatitis C and promote testing and follow-on care</li> <li>• assist those who wish to access methadone maintenance programmes and support them through the process</li> <li>• support respondents through detoxification</li> <li>• work with drug outreach workers to link those not in contact with services into health care services, in particular homeless drug users</li> <li>• look at the possibility of involving peer workers, recruited from the Clondalkin drug users' forum</li> <li>• advocate on behalf of those who have difficulties in accessing health care</li> <li>• link with a range of health care professionals in order to promote a multi-disciplinary approach to addressing the many needs of drug users</li> <li>• make links with local authorities, education and training programmes</li> </ul>
<p><b>Supporting primary health care professionals in Clondalkin in providing care to drug users in the locality</b></p>	<ul style="list-style-type: none"> <li>• work with GPs to encourage them to deliver addiction services as part of their work</li> <li>• encourage GPs to focus not only on abstinence but to offer a range of services</li> <li>• assist primary health care professionals in developing protocols, procedures and contracts in working with drug users</li> <li>• support the development of a GP network in Clondalkin</li> </ul>
<p><b>Promoting co-ordination of those providing services to drug users in Clondalkin</b></p>	<ul style="list-style-type: none"> <li>• liaise between local GPs and centralised drug clinics</li> <li>• promote effective collaboration between health care professionals, treatment agencies and voluntary and community groups</li> <li>• participate in any local community health forum to ensure that the health care needs of drug users in the area are taken into consideration</li> </ul>

### 10.3 Implications for Drugs Service Provision in Clondalkin

- **The findings emphasise the need for a needle exchange service in Clondalkin.**

There are several benefits to be derived from providing a needle exchange in Clondalkin. Both national (Cox and Lawless, 2000) and international (Rowe, 2003) research have shown that needle exchanges significantly reduce the number of injectors sharing injecting equipment. Furthermore, needle exchanges are the most appropriate place to address the immediate health care needs of chaotic drug users as well as acting as a gateway to more traditional forms of medical treatment (Cox *et al.*, 2000). Irish research has found that needle exchanges offer 'the possibility of making interventions in the overall health and welfare of clients' as well as 'significant health gain not only for the individual drug user but also in the wider public health context at a societal level' (Cox *et al.*, 2000).

- **This research supports the establishment of a drugs clinic in Clondalkin.**

According to service planners, planning permission has been granted for a prescribing clinic in Clondalkin. This research supports this move, in particular given the length of time drug users from Clondalkin have to wait to access a methadone maintenance programme.

#### 10.4 Implications for Health Care Professionals

- **There is a need for training targeted at GPs and all health care professionals who may come in contact with drug users**

The lack of training, knowledge and experience of GPs in working with drug users is pertinent in explaining why GPs are averse to treating drug users and why drug users are reluctant to access GPs. Training should be targeted at all primary health care providers including front-line staff and pharmacists (Sherratt and Jones (2003) as well as undergraduate medical students (Unwell *et al.*, 1999).

##### 10.2.4 Further Research

- **Research is needed on the attitudes of GPs and other health care who work with drug users. This research should also address the training needs of these professionals and what can be done to encourage them to work with drug-using clients.**

It is hoped the implementation of these recommendations will address health inequalities faced by drug users in Clondalkin, will improve their access to drug and health services and will facilitate more co-ordination between different service providers which will result in a more seamless range of care.

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## **APPENDIX 1**



**HEALTH STATUS AND HEALTH SERVICE  
UTILISATION AMONG DRUG USERS IN  
CLONDALKIN**

**Questionnaire No.** (*office use only*) \_\_\_\_\_

**Respondent's Initials**  
\_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Participant Identifier**  
\_\_\_\_\_

(*initials: gender: date of  
birth*)

**Consent Form Signed** (*tick as appropriate*)  
\_\_\_\_\_

**Recruitment Site** (*write in*)  
\_\_\_\_\_

**Date of Interview** \_\_\_\_\_

**Start Time of Interview** \_\_\_\_\_

**Finish Time of Interview** \_\_\_\_\_

**Section 1: Background**

**Q.1 Initials** \_\_\_\_\_

- Q. 2 Gender**
1. Male
  2. Female

**Q. 3 Age** \_\_\_\_\_ (years)

**Q.4 Date of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Day month year*

**Q.5 In which area of Dublin do you live?**

1. Clondalkin \_\_\_\_\_ (specify area)
2. Other part of Dublin \_\_\_\_\_ (specify post code)

**Section 2: Alcohol and Drug Use**

**Q.6 How long ago did you have an alcoholic drink?**

1. During the last week **Go to Q.7**
2. One week to 1 month ago **Go to Q.7**
3. One month to 3 months ago **Go to Q.7**
4. Three months to 12 months ago **Go to Q.10**
5. More than 12 months ago **Go to Q.10**
6. Never had alcohol beyond sips or tastes **Go to Q.10**

**Q.7 Thinking about drinking in the last year, did you usually drink alcohol in a typical week?**

1. Yes **Go to Q.8**
2. No **Go to Q.10**

**Q.8 On how many days during a typical week did you usually drink alcohol on average?**

\_\_\_\_\_ (number of days)

**Q.9 On the days that you drank alcohol, how many drinks did you have on average?**

\_\_\_\_\_ (number of drinks)<sup>29</sup>

**Q.10 The following are a list of substances which may or may not have been prescribed to you by a doctor. Have you (ever used/used in the last year/used in the last month) any of the following substances?**

	Lifetime Use <i>(ever)</i>	Recent Use <i>(last year)</i>	Current Use <i>(last month)</i>	Prescribed
Methadone				

<sup>29</sup> A drink = a half pint/glass of beer, lager, stout or cider  
 a single measure of spirits (whiskey, rum, vodka, gin)  
 a single glass of wine, sherry, port

				_____ <i>mls</i>
Other opiates ( <i>specify</i> ) <sup>30</sup> _____				
Sedatives, tranquilisers <sup>31</sup> / anti- depressants <sup>32</sup> ( <i>specify</i> ) _____ _____ _____ _____				
Steroids				
Other ( <i>specify</i> ) _____				

**Q.11 The following are a list of substances which are not available on prescription. Have you (ever used/used in the last year/used in the last month) any of the following substances?**

	<b>Lifetime Use</b> ( <i>ever</i> )	<b>Recent Use</b> ( <i>last year</i> )	<b>Current Use</b> ( <i>last month</i> )
Solvents			
Cannabis			
Hallucinogens <sup>33</sup>			
Amphetamines (i.e. speed)			
Ecstasy			
Cocaine Powder			
Crack			
Heroin			
Other ( <i>specify</i> ) _____			

**Q.12 In terms of your CURRENT DRUG USE [refer to those mentioned above], what is your main route of administration and frequency of use OVER THE LAST FOUR WEEKS?**

	<b>Route of administration</b>	<b>Frequency of Use in Last 4 Weeks</b>
	1 = intravenous 2 = intramuscular 3 = skin popping 4 = smoke 5 = ingest 6 = sniff 7 = don't know	1 = Daily 2 = 2 – 3 times a week 3 = weekly 4 = 2 – 3 times a month 5 = less than once a month

<sup>30</sup> E.g. Morphine, DF118, buprenorphine, NAPPs

<sup>31</sup> E.g. Benzodiazepines (diazepam, valium, dalmane), barbiturates (seconal, diazepam, valium), librium, roypnol (roche) etc.

<sup>32</sup> E.g. Prozac

<sup>33</sup> E.g. LSD, PCP, Magic Mushrooms, Ketamine

Methadone		
Sedatives/ tranquilisers/ anti-depressants		
Steroids		
Solvents		
Cannabis		
Hallucinogens		
Amphetamines (i.e. speed)		
Ecstasy		
Cocaine Powder		
Crack		
Heroin		
Other opiates		
Other		

**Q.13 What would you say is your primary drug of use?**

\_\_\_\_\_

**Q. 14 What would you say is your secondary drug of use?**

\_\_\_\_\_

**Q.15 What was the first drug you ever used?**

\_\_\_\_\_

**Q.16 What age were you when you first started using the drug?**

\_\_\_\_\_ *years*

### Section 3: Risk Behaviour

**Q.17 Have you ever injected drugs?**

1. Yes **Go to Q.18**
2. No **Go to Q.27**

**Q.18 What was the first drug you injected?** \_\_\_\_\_

**Q.19 How old were you when you first injected?** \_\_\_\_\_ *years*

**Q.20 Have you injected in the LAST 4 WEEKS?**

1. Yes **Go to Q. 21**
2. No **Go to Q.27**

**Q.21 Do you usually inject yourself:**

1. Always
2. Sometimes
3. Never

**Q.22 What is your most common injecting site?**

\_\_\_\_\_

**Q.23 Do you have difficulty in finding an injecting site?**

1. Always
2. Sometimes
3. Never

**Q.24 In the LAST 4 WEEKS have you done any of the following:**

1. Shared spoons/filters
2. Given anyone YOUR injecting equipment
3. Used OTHERS injecting equipment

**Q.25 In the LAST 4 WEEKS how many times have you used a needle after someone else has used it?**

1. Never
2. Once
3. Twice
4. 3 – 5 times
5. 6 – 10 times
6. More than 10 times
7. Don't know/Unsure

**Q.26 Do you usually inject:**

1. Alone
2. With others
3. With partner

**Section 4: Sexual Health**

**Q.27 Are you sexually active?**

1. Yes **Go to Q.28**
2. No **Go to Q.34**

**Q.28 In the last 3 months have you had more than one sexual partner?**

1. Yes
2. No

**Q.29 Do you have a regular sexual partner?**

1. Yes
2. No

**Is your partner an injecting drug user?**

1. Yes
2. No

**Q. 30**

<u>MALE RESPONDENTS</u>	<u>FEMALE RESPONDENTS</u>
<p><b>What method of contraception, if any, are you using at present?</b></p> <ol style="list-style-type: none"><li>1. Natural</li><li>2. Withdrawal</li><li>3. Condom</li><li>4. Sterilisation</li><li>5. None</li></ol>	<p><b>What method of contraception, if any, are you using at present?</b></p> <ol style="list-style-type: none"><li>1. Natural</li><li>2. Coil</li><li>3. Diaphragm</li><li>4. Withdrawal</li><li>5. Combined Pill</li><li>6. Mini Pill</li><li>7. Condom</li><li>8. Sterilisation</li><li>9. None</li></ol>

**Q.31 IF USE CONDOMS, how often do you use them?**

1. Always
2. Sometimes
3. Never

**Q.32 Have you ever had a sexually transmitted infection?**

1. Yes **Go to Q. 33**
2. No **Go to Q. 34**

**Q.33 Have you had a sexually transmitted infection in the last year?**

1. Yes
2. No

## **Section 4: Drug Services**

### ***IF CURRENTLY INJECTING***

**Q. 34 Have you been to a needle exchange in the last 6 months?**

1. Yes **Which needle exchange (s)?**

2. No **Go to Q.40**

**Q.35 Do the times when needle exchanges are open suit you?**

1. Yes

2. No

**Why not?**

\_\_\_\_\_

\_\_\_\_\_

**Q.36 Have you experienced any difficulties in accessing clean injecting equipment?**

1. Yes

**What difficulties?**

\_\_\_\_\_

2. No

\_\_\_\_\_

\_\_\_\_\_

**Q.37 In the last 12 months, did you get MOST of your works from:**

1. Needle exchange

2. Pharmacist

3. Partner

4. Friends

5. Dealer

6. Other (*specify*) \_\_\_\_\_

**Q.38 Do you think there is a need for a place where you can inject drugs safely and where you can relax after taking drugs?**

1. Yes

2. No

**Q.39 Would you use such a service?**

1. Yes

2. No

3. Sometimes

***IF EVER PRESCRIBED METHADONE MAINTENANCE***

**Q.40 Have you ever experienced any difficulties in accessing methadone maintenance programmes?**

1. Yes

**What difficulties?**

\_\_\_\_\_

2. No

\_\_\_\_\_

\_\_\_\_\_

**Q.41 Where do you usually pick up your methadone?**

- |                                   |             |
|-----------------------------------|-------------|
| 1. Drugs Clinic                   | Go to Q. 43 |
| 2. GP                             | Go to Q. 43 |
| 3. Pharmacist                     | Go to Q. 42 |
| 4. Other ( <i>specify</i> ) _____ | Go to Q. 43 |

**Q.42 Do you believe you have been discriminated against by pharmacists or pharmacy staff dispensing methadone in your area?**

1. Yes
2. No

**Q.43 How long do you have to travel to pick up your methadone?**

1. Up to 15 minutes
2. 16 – 30 minutes
3. 31 – 45 minutes
4. 46 – 60 minutes
5. Over 60 minutes

**Q.44 Is this too long?**

1. Yes
2. No

**Q.45 Have you tried to detox from your drug use in the last year?**

- |        |             |
|--------|-------------|
| 1. Yes | Go to Q. 46 |
| 2. No  | Go to Q. 47 |

**Q.46 Did you have any difficulties trying to detox off drugs?**

- |        |                    |
|--------|--------------------|
| 1. Yes | What difficulties? |
|--------|--------------------|

\_\_\_\_\_

2. No

\_\_\_\_\_

3. Sometimes

\_\_\_\_\_

**Q.47 Have you ever had counselling related to your drug use?**

- |        |             |
|--------|-------------|
| 1. Yes | Go to Q. 48 |
| 2. No  | Go to Q. 50 |

**Q.48 Were there any benefits gained?**

- |        |                |
|--------|----------------|
| 1. Yes | What benefits? |
|--------|----------------|

\_\_\_\_\_

2. No

\_\_\_\_\_

**Q.49 Have you had difficulties finding a counsellor when required?**



1. Yes **What difficulties?**

\_\_\_\_\_

2. No

\_\_\_\_\_

3. Sometimes

\_\_\_\_\_

**Q.50 Have you been in contact with any of the following drug services within the LAST YEAR?**

1. Outreach team
2. Drop-in Centre
3. Residential Drug Free Programme
4. Narcotics Anonymous
5. Other (*specify*) \_\_\_\_\_

**Q.51 Do you think drug services could be improved upon for drug users from Clondalkin?**

1. Yes **How?**

\_\_\_\_\_

2. No

\_\_\_\_\_

\_\_\_\_\_

## Section 6: Physical Health

**Q.52 Overall how would you rate your health?**

1. Very bad
2. bad
3. Okay
4. Good
5. Very good

**Q. 53 Do you currently suffer from any of the following complaints?**

*HEALTH COMPLAINTS*

1. Sleep problems
2. Weight problems
3. Constant fatigue
4. Back pain
5. Nausea/vomiting
6. Stomach pain
7. Poor appetite
8. Shortness of breath
9. Dizziness/faintness
10. Headaches
11. Dental problems
12. Skin wounds/infections
13. Eye/ear complaints
14. Foot problems
15. Jaundice
16. Pneumonia
17. Gastroenteritis<sup>34</sup>
18. Bronchitis<sup>35</sup>
19. Dermatitis<sup>36</sup>
20. Septicaemia<sup>37</sup>
16. Other (*specify*) \_\_\_\_\_

**FOR FEMALE RESPONDENTS ONLY**

**Q. 54 Have you ever had a cervical smear?**

Yes smear?	How long is it since you had your last
No	Less than 12 months
	1 – 2 years
	2 – 3 years
	More than 3 years

**ONLY IF INJECTS**

<sup>34</sup> An inflammation of the stomach and intestine resulting in diarrhea, with vomiting and cramps when irritation is excessive. When caused by an infectious agent, it is often associated with fever.

<sup>35</sup> An inflammation of the lungs, resulting in persistent cough that produces considerable quantities of phlegm

<sup>36</sup> An inflammation of the skin usually resulting in redness and pain, occasionally with itching.

<sup>37</sup> Poisoning of the blood

**Q. 55 In the LAST THREE MONTHS have you experienced any of the following injecting related complaints?**

- 1. Abscesses/Infections
- 2. Dirty Hit (made feel sick)
- 3. Accidental Overdose
- 4. Scarring/Bruising
- 5. Collapsed veins

**Q.56 Have you ever received a Hepatitis B vaccination?**

- 1. Yes
- 2. No

**Q.57 Have you ever had a Hepatitis B test?**

- 1. Yes                                      Length of time since last test?      \_\_\_\_\_ *years*  
\_\_\_\_\_ *months*
- 2. No

**Q.58 What is your current hepatitis B status?**

- 1. Positive                      **Go to Q.59**
- 2. Negative                      **Go to Q.60**
- 3. Not tested                      **Go to Q.60**
- 4. Don't Know                      **Go to Q.60**

**Q.59 Are you currently receiving any treatment?**

- 1. Yes                                      Type of treatment?  
\_\_\_\_\_
- 2. No

**Q.60 Have you ever had a Hepatitis C test?**

- 1. Yes                                      Length of time since last test?      \_\_\_\_\_ *years*  
\_\_\_\_\_ *months*
- 2. No

**Q.61 What is your current hepatitis C status?**

- 1. Positive                      **Go to Q.61**
- 2. Negative                      **Go to Q.63**
- 3. Not tested                      **Go to Q.63**
- 4. Don't Know                      **Go to Q.63**

**Q.62 Are you currently receiving any treatment?**

- 1. Yes                                      Type of treatment?  
\_\_\_\_\_
- 2. No

**Q.63 Do you know how Hepatitis C is transmitted?**

1. Yes

**How?**

2. No

**Q.64 Would you like more information about Hepatitis C?**

1. Yes

2. No

**Q.65 Have you ever had a HIV test?**

1. Yes Length of time since last test \_\_\_\_\_ *years* \_\_\_\_\_  
*months*

2. No

3. Don't know

Can volunteer result otherwise don't question their status?

**Q.66 What would you regard as your main health need at the moment?**

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## Section 7: Psychiatric Health

**Q.67 Have you ever had any concerns about your mental/psychiatric health?**

1. Yes

**a) What concerns?**

2. No

**b) Have you ever sought help for these concerns?**

1. Yes

2. No

**Q.68 In the last 3 months have you had any of the following?**

1. Depression

2. Anxiety

3. Feeling unable to cope

4. Feeling isolated

**Q.69 In terms of psychiatric health, have you ever:**

- 1. Undergone a psychiatric assessment **Go to Q. 71**
- 2. Been admitted to a psychiatric hospital **Go to Q. 71**
- 3. Been diagnosed with a psychiatric illness **Go to Q. 70**

**Q.70 Are you currently receiving any treatment for your psychiatric illness?**

1. Yes **What type of treatment?**

\_\_\_\_\_

2. No

\_\_\_\_\_

\_\_\_\_\_

**Section 8: Use of Health Services**

**Q.71 Where do you usually obtain information on health issues?**

**TICK ONE**

- 1. GP
- 2. Hospital
- 3. Health Centre
- 4. Family Planning Clinic
- 5. Public Health Nurse
- 6. Pharmacy
- 7. Family/friends
- 8. Books/magazines
- 9. Drugs Clinic
- 10. Other (*specify*) \_\_\_\_\_

**Q. 72 Where do you usually go if you have a medical problem?**

**TICK ONE**

- 1. Self-care
- 2. Family/friends
- 3. Consult drug workers
- 4. Pharmacist
- 5. GP
- 6. A&E
- 7. Don't know
- 8. Other (*specify*) \_\_\_\_\_

## Medical Cards

### Q.73 Do you have a CURRENT medical card?

1. Yes, current **Go to Q.74**
2. Yes, near expiry date **Go to Q.74**
3. Yes, out of date **Go to Q.74**
4. No can't get one **Go to Q.75**
5. No. don't need one **Go to Q.75**
6. Process of applying **Go to Q.74**
7. Other (*specify*) \_\_\_\_\_

### Q.74 Did you have any difficulties applying for a medical card?

1. Yes **a) What difficulties?**

- \_\_\_\_\_
2. No **Go to Q. 77**

\_\_\_\_\_ **Go to**  
\_\_\_\_\_ **Q. 77**

### Q. 75 Do you know if you are eligible for a medical card?

1. Yes I am eligible
2. No I am not eligible
3. Don't know

### Q.76 Do you know where to go to get a medical card?

1. Yes ***specify*** \_\_\_\_\_
2. No

## GP Services

### Q.77 Are you registered with a GP anywhere?

1. Yes ***specify where*** \_\_\_\_\_ **Go to Q. 78**
2. No **why not?** \_\_\_\_\_

\_\_\_\_\_ **Go to Q. 80**

### Q. 78 How long did it take you to get registered with a GP?

\_\_\_\_\_ *days* \_\_\_\_\_ *weeks* \_\_\_\_\_ *months*

### Q. 79 Did you have any difficulties registering with a GP?

1. Yes

a) What problems?

2. No

**Q.80 Have you been to a GP in the last 6 months?**

1. Yes                   **Go to Q. 81**

2. No                   **Go to Q. 84**

**Q.81 What was the reason for your last visit to the doctor's?**

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**Q.82 Thinking of your most recent visit, how satisfied were you with the visit?**

1. Extremely satisfied
2. Quite satisfied
3. Neither satisfied nor dissatisfied
4. Quite dissatisfied
5. Extremely dissatisfied

**Q.83 Please explain your answer.**

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### **A&E Services**

**Q.84 Have you been to A&E in the last 6 months?**

1. Yes                   **Go to Q.85**

2. No                   **Go to Q.85**

**Q.85 What was the reason for your last visit to A&E?**

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**Q.86 Thinking of your most recent visit, how satisfied were you with the visit?**

1. Extremely satisfied
2. Quite satisfied
3. Neither satisfied nor dissatisfied
4. Quite dissatisfied
5. Extremely dissatisfied

**Q.87 Please explain your answer.**

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**Outpatients Clinic**

**Q.88 Have you been to an outpatients clinic in the last 6 months?**

1. Yes                      **Go to Q. 89**
2. No                        **Go to Q. 92**

**Q.89 Which clinics were these appointments for?**

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**Q.90 Thinking of your most recent visit, how satisfied were you with the visit?**

1. Extremely satisfied
2. Quite satisfied
3. Neither satisfied nor dissatisfied
4. Quite dissatisfied



5. Extremely dissatisfied

**Q.91 Please explain your answer.**

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### **General Health Services**

**Q.92 In the last 6 months, what other health services have you used?**

1. GUM Clinic
2. Dentist
3. Pharmacist
4. Inpatient in hospital
5. Physiotherapist
6. Addiction counsellor
7. Psychiatrist
5. Other (*specify*) \_\_\_\_\_

**Q.93 Do you think all those who provide a health service (GP, pharmacists etc) have enough knowledge and training about drug using issues and drug users?**

1. Yes
2. No

**Q.94 Would you prefer to access a health service:**

1. Specifically for drug users
2. One that caters for everyone

**Q.95 Please explain your answer**

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**Q. 96 Would you use a health service in Clondalkin which was specifically targeted at drug users?**

1. Yes **Go to Q. 97**
2. No **Go to Q. 102**

**Q.97 If there was a specialist health service for drug users in Clondalkin, which of the following services would YOU ACCESS?**

1. Needle exchange
2. Methadone maintenance
3. Detox programme
4. Acupuncture
5. STI Screening
6. Hepatitis Testing
7. Nutritional Advice
8. General medical advice and information
9. Counselling
9. Referral to more specialised treatment *(specify)*

\_\_\_\_\_

**Q.98 What OTHER services would you like to be located in a health care service for drug users in Clondalkin?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***For those on methadone maintenance***

**Q. 99 Would you have a problem accessing a health service in Clondalkin which provided a needle exchange?**

1. Yes
2. No

**Please Explain your answer.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Q.100 If there was a specialist health service for drug users in Clondlakin, which of the following personnel would you like to see working there?**

1. Nurse
2. GP
3. Addiction counsellor
4. Psychiatric Nurse
5. Outreach worker
6. Social Worker
7. Community Welfare Officer
8. Other (*specify*) \_\_\_\_\_

**Q.101 What do you think are the most important issues that need to be considered when setting up a specialised health or health related service for drug users?**

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## Section 9: Demographics

**Q102 Where are you from?**

1. Ireland
2. Northern Ireland
3. UK England
4. UK Scotland
5. UK Wales
6. Other EU
7. Africa
8. Asia
9. USA
10. Australia

11. Other \_\_\_\_\_

**Q.103 How would you describe your ethnic background?**

1. White
2. Traveller
3. Black
4. Chinese
5. Asian
6. Mixed ethnic group
7. Other ethnic group \_\_\_\_\_

**Q.104 What type of accommodation are you currently living in?**

- |   |                     |
|---|---------------------|
| 1. Family home                            | <b>Go to Q. 105</b> |
| 2. Own home (owner-occupier)              | <b>Go to Q. 105</b> |
| 3. Private rented accommodation           | <b>Go to Q. 105</b> |
| 4. Local Authority accommodation          | <b>Go to Q. 105</b> |
| 5. Hostel/Shelter                         | <b>Go to Q. 108</b> |
| 6. B&B                                    | <b>Go to Q. 108</b> |
| 7. With Friends/Relatives                 | <b>Go to Q. 108</b> |
| 8. Sleeping rough                         | <b>Go to Q. 108</b> |
| 9. Squat                                  | <b>Go to Q. 108</b> |
| 10. Other ( <i>please specify</i> ) _____ | <b>Go to Q. 108</b> |

**Q. 105 Would you consider this accommodation overcrowded?**

1. Yes
2. No

**Q.106 Is your accommodation:**

1. Temporary
2. Permanent

**Q.107 Are you sharing with another drug user?**

1. Yes
2. No

**Q.108 Do you have children?**

- |        |                    |
|--------|--------------------|
| 1. Yes | <b>Go to Q.109</b> |
| 2. No  | <b>Go to Q.111</b> |

**Q.109 How many:** \_\_\_\_\_

- a) Under the age of 18? \_\_\_\_\_  
 b) Over the age of 18? \_\_\_\_\_

**Q. 110 How many of your children live with you?** \_\_\_\_\_ *(number)*

**Q.111 What is your highest level of education?**

1. Primary education or less
2. Lower Second level education (incl. group/inter/junior cert/GCSEs)
3. Upper Second level education (incl. leaving cert/A levels)
4. Higher Education (Third Level-Diploma Degree)
5. Other *(specify)* \_\_\_\_\_

**Q.112 How old were you when you left full-time education?** \_\_\_\_\_  
**years**

**Q.113 What is your current employment status?**

1. In Part-time Employment
2. In Full-time Employment
3. FAS/Training Course
4. Unemployed **Length of time** \_\_\_\_\_ *years* \_\_\_\_\_  
*months*
5. Unavailable for Work/Disability Allowance
6. Childcare/Childrearing
7. Other *(specify)* \_\_\_\_\_

**Q.114 Which of the following sources of income do you have?**

1. Regular employment
2. Odd jobs/occasional labour
3. Government benefits/payments **specify**  
 \_\_\_\_\_
4. Relatives/partners/friends
5. Begging
- 6 Criminal activities
7. Other *(specify)* \_\_\_\_\_

**Q.115 Where do you get MOST of your money from?**

1. Regular employment
2. Odd jobs/occasional labour
3. Government benefits/payments **specify**  
 \_\_\_\_\_

4. Relatives/partners/friends
5. Begging
- 6 Criminal activities
7. Other (*specify*) \_\_\_\_\_

**Q.116 Have you ever spent any time in prison?**

1. Yes
2. No

**Q.117 What is your current legal status at the moment?**

1. No legal trouble
2. Contact with probation/community services
3. On bail awaiting trial/sentencing
4. Outstanding warrants
5. Outstanding fines
6. Temporary release
7. Suspended sentence
8. Other (*specify*) \_\_\_\_\_

***Thank interviewee for participating in the research***

**Signature to confirm that payment (15 euro) was provided upon completion of interview.**

\_\_\_\_\_  
*Initials of Interviewee*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of interviewer*

\_\_\_\_\_  
*Date*

**Any additional information Interviewer may think pertinent**

*(Record any observations, thoughts, impressions or questions arising from the interview)*

## **APPENDIX 2**

### **INTERVIEW GUIDE – KEY INFORMANTS**

#### **General**

- Can you tell me about your organisations' experience with drug users?
- What do you think are the main health problems drug users present with?

#### **Capacity of existing Primary Health Care Services to work with drug users**

- Do you think drug users' uptake of primary health care services IS different from the general population?
- Why do you think drug users might be reluctant to attend primary health care services?
- What institutional barriers do they face?
- What difficulties do health care professionals encounter in providing primary health care to drug users?
- It is often said that there is a limited availability of health care professionals willing to work with drug users. Do you agree?
- How can this be addressed?
- What do you think could be done to improve uptake of primary care service for drug users?
- How can co-ordination between primary health care services and drug services be strengthened?

#### **Appropriateness of Specialised Services**

- What do you think of the idea of a specialised service as way of providing health care to drug users?
- What are the advantages of providing a 'special' service as opposed to integrating drug users into mainstream health services?
- What are the disadvantages?
- How do you think the wider community might feel about establishing a dedicated primary health care services for drug users?

#### **Content of Primary Health Care Service**

- If established, what services should the primary health care team in Clondalkin provide?
- Which professionals should be on the primary health care team?
- Have you any other comments to make on providing primary health care services to drug users in Clondalkin?