PURE MURDER...

A Book about Drug Use

Edited by

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and

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Foreword

Too often, what we hear about drugs comes to us sensationalised by the media or from academic sources, which many of us find impossible to understand. Statistics can hide very real human experiences.

As community publishers, we* feel it is very important that people can speak directly to each other. The way 'Pure Murder* has been put together reflects this. Noreen O' Donohue and Sue Richardson of Women's Community Press researched and edited this book. They began in November 1983 after the idea had been suggested to us by Gerry Callaghan and others involved at community level. Most of the writing was done by Noreen and Sue, with contributions from the various treatment centres, groups and individuals mentioned. Some of the experiences and quotes were received in written form, others were taken from taped interviews. All of these must remain anonymous.

Reading through the book, you will see it is a mixture of 'hard' information on medical facts and legal implications, together with how these affect real people in real situations. The names and addresses of the treatment centres and groups have been included in the hope that they will be of practical use. Valuable insights into the problems of drug addiction were given to the editors by many people, particularly those working with drug-users and most of these appear in the chapters about the treatment options and the community response to drugs.

Since many terms and expressions common to the world of drugs have been used in the book and if you are not familiar with them there is a list of them in the drugs slang section.

Everyone who has written for this book has their own way of naming those taking drugs — addicts, abusers, users, junkies, chemical-dependents, etc. Where the editors have written the pieces it was decided to employ the word user as being the simplest and least loaded of names.

We are very aware that although drug-use has spread throughout Ireland in varying degrees, this book relates mainly to the Dublin area; the reason for this is that we had neither the finances nor the contacts to research areas outside our own geographical base.

In contrast to the help we got from the majority of the treatment centres, community workers and others, assistance from the state was minimal: the department of health acknowledged our letters but did not answer our questions, the department of justice turned down our request to speak to probation officers, the health education bureau turned down our request for funding on the grounds that they had already produced their own literature on the subject: in fact the drugs squad was the only body who showed interest in what we were doing and co-operated.

Special thanks are due to the following people, whose help and support were invaluable in putting the book together - their names or the names of the places they work in are listed alphabetically:
Ana Liffey Project, Gerry Callaghan, Maureen Cronin, Concerned Parents Action Groups, Frank Deasy, Drugs Squad, Families Anonymous, Federation of Community Action on Drugs. Jems St. Drug Advisory and Treatment Centre, Paddy Malone, Mater Dei Institute, Mary Ellen McCann, Tomas McKeown, Catherine McMahon, Narcotics Anonymous. Rutland Centre, Staff members of St. Brendan's Hospital, Southern Health Board, Talbot Centre, Tranx Release, Youth Action Project (Ballymun), Youth Development Project (St. Teresa's Gardens) and some of the women prisoners in Mountjoy Jail and the users and ex-users in Dublin who contributed.

Drug Slang

Acid: LSD
Busted: arrested
Chasing the Dragon: Heroin put in silver paper, heated and inhaled.
Clean: Drug-free
Coming Down: Drug effect wearing off.
Cold Turkey: Stop using without substitute drug.
Cut: add to heroin pack to increase weight
Dike: Diconal
Detox: Detoxification
Dirty Fix: Harmful substance mixed with drug.
Dipping: steal from handbags
Fix: Injection
Fence: sell stolen goods
Gear: Drug
Goofing-out: nearly asleep
Habit: Addiction
Hep: Hepatitis
Hash: Cannabis
Hit: Effect of taking fix
High: Euphoria
Hooked: Addicted
In Bits: Sick
Joint: Cannabis cigarette
Kip: Sleep/bad place
Kick: Give up drug habit
Mainlining: Inject into vein
Nick: Arrest/prison
OD: Overdose of drug
Pusher: Seller of drugs
Palf: Palfium
Physeptone: trade name that Methadone is sold under
Phy: Physeptone
Pack: packet of heroin
Roach: end of cannabis cigarette
Smack: Heroin
Score: Buy
Strung Out: Craving/heavily addicted
Snorting: Sniffing
Skin Popping: Injecting just under surface of skin
Stash: Hide or Hoard
Shot: Fix
Turn On: Use drugs
Tout: Police informer
Tracks: Needle marks on skin
Tabs: Tablets/LSD dose
Withdrawals: unpleasant symptoms when stopping use
Works: Syringe & needle

What's Going On?

Heroin is only part of the drugs problem. Very few drug-users only use heroin. Though the other drugs they use may not be as strong, they are just as destructive, the withdrawal symptoms can be worse and the addiction itself may be even more difficult to cure.

Practically all heroin users also take Palfium and Diconal, which are "legal" drugs, until illegally obtained. There are far more people, particularly women, addicted to tranquillisers than heroin, 75,000 people regularly use them in Ireland. There are far more people, particularly men, addicted to alcohol than heroin, 100,000 semi or actual alcoholics in Ireland. There is an ever-growing number, particularly young people, addicted to glue and other forms of "sniffing" drugs, there are people addicted to cough bottles, slimming pills, cigarettes — the list is endless.

One of the difficulties of this situation is that neither the general public nor those addicted to these other drugs see them as being as dangerous as heroin. Because of this the problems that arise from their use are largely ignored by the State, the media, the church and others who make such a noise over heroin. It also means that the people addicted to them find theifaddiction harder to see as a problem: hospital spokespeople told us that this makes them harder to treat.

It's important to stress that these other drugs are all quite legal, unless illegally obtained, even though they are so

destructive. Many of them are wrongly called 'soft' drugs which also helps to conceal their danger.

For over 150 years, scientists and theorists have been putting forward ideas as to what makes someone turn to drugs and what can be done to cure them: they have not come up with an answer that fits all.drug-users.

Books have been published to 'prove' that there is or isn't such a thing as an 'addictive' personality, people who will inevitably turn to drugs. Surveys show that drug addicts come from large families, broken families, violent families, alcoholic families etc. — yes many of them do, but also many of them don't. Scientists have put forward theories that once someone has used heroin it brings about a chemical change in the body which cannot be reversed so there is no cure. Others disagree. Some said they'd found a way to 'block' the effects of heroin by using other drugs. Some say people use hard drugs because they are illegal and thus 'exciting', a way of rejecting the laws of society.

We are not dealing here with a problem that can be neatly categorised and dealt with. It would be just as accurate to say that people begin using drugs because they are there and so is the money to buy them, or because their friends use them.

Just as there is no one, universal reason why people begin to use drugs so there can be no one, universal cure for addiction. There are a variety of ways being tried out and some of them work for some people and some don't: for every person who wins the battle against their addiction there are hundreds who have so far not been able to. The only definite thing which can be said is that the drug-user him or herself is the only person who can stop the vicious circle they are caught in - the various treatments, centres, clinics, organisations etc. can only give them a helping hand.

The families and friends of users have to understand this too, because they are a vital part of the helping process which the user needs to support them when they are trying to come off drugs.

The state's response to the problem of drug addiction can best be described as woeful, though there have been marginal improvements over the past few months. There are plenty of promises on paper but we are going to have to wait to see how many, if any, of them are actually put into

practice. Even many of the state-funded drop-in centres which have opened up are only pilot projects with life-spans of 6 months to 3 years. From the 1982 statement by the then minister for health that there was no drug problem to the 1984 minister who says there is a massive problem but we haven't enougli money to deal with it does not seem much of an advance to us. Why has Jervis St. hospital only got nine beds for in-patient treatment? Why is the Drugs Advisory- Centre there stuck into a tiny porta-cabin with inadequate facilities for patients and staff and no creche or anything? Why is there such a small staff there that they are continually overworked? Like many other concerned people we have to ask the state 'What are your priorities?' Why have you not even ensured that your judges and justices know the differences between the various drugs?

In many cases the state's response to the problem has centered around regaining control: it could not stand by while groups of people acted independently of official bodies. The concerned parents groups and others like them arose because they and their children, friends and neighbours were at the heart of the problem. They were met with a wall of hysterical condemnations. The state had to open up treatment centres because otherwise local groups would eventually have opened up their own. The fact however remains that these local groups achieved results where the authorities had failed.

A garda told us.that this was because the local people 'got away' with things no member of the gardai could have. This, of course, is true, but the interesting question is Why? Why have the Gardai, as a group, got such a bad reputation in certain areas? Why do so many people believe the rumours of drug-users being taken into garda custody for questioning and having syringes dangled in front of them in exchange for information? And is the reason behind the call for comm-unity policing to put complete control over the communities back into the hands of the authorities?

However, it would[5] be neither fair nor accurate to put all the blame for the State's lack of action onto the politic-ians. It hasn't been only they who refused to heed the warnings that came from the few experts in the know, like hospital .and drugs squad people. Practically none of us

listened and we certainly did not understand the consequences that widespread drug abuse creates. The question is, are we listening and understanding now?

Whether we like it or not, drugs are one of the few job-producing sectors of our economy. The economic benefits go far beyond the pushers and smugglers even if it is they and their so-far unknown backers who make the most out of it. It must be recognised that a whole string of people make part, or all, of their living off the backs of users, and the misery of their families. We are not saying that all these people are only in it for the money, the votes or whatever - many of them are involved for the best of motives we know - but to show that drug-use involves more of us than the users and the pushers.

There are the judges, gardai, prison officers, probation officers, welfare officers and other state-employed people whose jobs bring them into contact with users. There are the drugs companies who make the 'legal' drugs that people get addicted to, and the advertising agencies who 'push' for them. The doctors who write prescriptions and the chemists who fill them. The newspaper and television journalists who write about them. The politicians who make the 'invisible' profit of votes for saying they have, or they will, do something about them. There are the churchpeople who do much the same. There are all the publishers, the sociologists, criminologists and all the other 'ists' who research and write about addicts or addiction. There are the people who staff the clinics, centres etc., where users go and try to get off drugs. All are benefited materially by the use of drugs. This needs to be recognised.

We believe that we live in a society that has been brainwashed into believing that just about anything can be cured by using drugs: not only physical sickness but psychological sickness. It has almost got to the point where people feel "cheated" if they leave a doctor's surgery without a prescription. Arguably there are conditions which are helped by taking drugs, but very often we use drugs quite unnecessarily. This over-use of drugs means we have been 'softened up' in our attitudes to using them and leads many people, particularly young people and people with problems of one sort or another, to start using drugs as a way of escaping

into the less real, and initially more pleasant world of drugs. By the time they realise they are addicted it is too late to stop without suffering withdrawal symptoms. Withdrawal symptoms are so painful that only those with a really strong motivation like severe collapse of health or family will stop using. Part of the problem is also that when they do stop they have to enter a whole new lifestyle and they come under enormous pressure from their previous 'friends' to go back using.

Over and over again those we interviewed told us that fighting against drugs is not just a question of giving information on what effects drugs have on the people that use them — it lies in changing our entire attitude to drugs, all drugs. In this book there is a certain amount of information for the simple reason that we believe that people do need it, if only in order to recognise when someone has started to use drugs, but we have also included sections by users, ex-users, people working in the various treatment and drop in centres and organisations that are there to offer help to those who want to try and get off drugs.

We hope we have managed to go some way in outlining the problems both of users and those who are affected by them, and those that work with them. We would have loved to have been able to say that we have discovered a 'cure' for addiction, but this is not, of course, the case. We do however believe that very little can be done to stop people taking drugs, let alone come off them, until the type of conditions which led them to use drugs in the first place are done away with.

It is no longer enough to say that people need decent housing, education, jobs etc. in order to live decent lives. It has got to the point where if we do not start to make sure that these are brought about, then the *majority* of the population will be addicted to one form of drug or another. People need to have a future they can believe in, and look forward to, and are prepared to fight for. If they can't have that, they will use anyimeans possible to opt out of what seems to be mapped out for them. And the way an increasing number of them are doing it is by taking drugs which seem to offer a ladder to scale the walls of the prisons that society put them into.

Pure Murder

This was told to us by a woman whose partner was a user.

It's really important to include how families and friends are affected by a drug user. Families go through hell, through pure murder — seeing someone you loved, cared about, wasting away in front of your eyes, changing into a different person. It affects everybody living in the house but I think it especially affects the partner. Its very hard to explain what I went through, to put words on the feelings I had, knowing R was using drugs.

He used to do a disappearing act. Every three weeks or so he'd disappear. He'd be gone from anything up to five days — you'd kind of know beforehand when this was going to happen. You think, well, he's due to go out now and have a turn on, and wonder how long will he be gone for this time. Will he take money, will he do it on dole day when you're waiting for a few bob and all the time seeing what he's doing to himself — killing himself, destroying himself. Well R was killing himself very slowly in comparison to some other addicts, but he was doing it just the same. I was always aware — well I did try to ignore it — well I did try to ignore it for a long time — no, it is not that you ignore it, you're trying to fight it and you keep believing the promises in the hope it will go away.

You get a feeling of helplessness. I felt that there wasn't anything I could do. I felt powerless at the time —

there was nothing I could do. You don't think of Jervis Street because according to junkies, the drug squad are across the road watching everyone going in, and once you're registered as a junkie you'd get raided every second night. This is what I was told and I didn't know any better. Now I don't believe this to be true and I'm going there for the past year. I definitely think that everything that goes on in there is confidential. People often have to go back three or four times to be detoxified. They're only going to get the physeptone treatment. Their regulations say you must give urine samples every time you go in.

In the end my fella went for detox to Jervis Street. There are all these fears of liver biopsies and that sort of thing which are terrifying for a user but fortunately R didn't have to worry about this because there was little damage done to his liver. They found out the extent of damage after a blood test.

I have three children which I had to look after as well. When he used to go off (you see you'd never know when he'd come back) he'd go down to the van for cigarettes — he's often gone missing just going down to the van — you couldn't trust him to do anything for you. Everything he said was a lie. You couldn't take his word for anything and when he'd go missing I used to literally tear my hair. I used to stand at the window. I used to spend most of my time standing at the window just watching — all the time watching.... and I....I actually ran at him with a knife one time. That's why I could even understand why the woman in Italy killed her addict son.

You're so helpless (and there's so little support for family and friends) that you just don't know where to turn, what to do. Other people, family and friends try to be understanding but they don't know what it's really like — they can't know.

I talked about the problem but there wasn't communication cos he used not talk about it. He just lay there — you know the way you have^our thoughts at night — I'd spend half the night sulking and he'd be goofed — it would just go in one ear and out the other. Then he'd start "I'm sorry, I didn't mean to hurt you — It'll never happen again" and in the end I'd say well all right, I believe you" because you have

to have something, some hope to hang on to — a belief. I was lucky I suppose because I was independent. He was always giving me his money, but if he disappeared I wasn't destitute. You'd think I can leave out this, do without that, put off paying for the telly, the electricity — you say I'll catch up again as long as there is food for the children. And so that was a great help.

You tend to deny everything to yourself and family although of course everybody knew he was using. You tend to say, 'Oh he came in stoned last night, but he was only smoking hash'. He'd tell me he was only smoking hash. We'd have an argument and in the end I'd take his word, and I'd wake up in the morning and check his arms. I was always looking, and this would annoy him and he'd be saying leave me alone, or he'd convince me that the bruise *was* a bruise, cos you want to believe — you don't want to face up to it.

R was using diconal most of the time, not heroin. Most of that was obtained througli doctors and from friends as well. Heroin has taken over now though because the diconal isn't so freely available.

R has now stopped using drugs. First of all, I'd reached the end. I just couldn't take any more. I had seen a poster in the shopping centre for a support group for concerned persons in Ballymun. It took a long time before I did anything about it. Eventually, just one day I decided I'd had it. I was walking through the shopping centre and I picked up a leaflet and got the phone number, picked up the phone and said I had to see someone. I didn't really want to be in a group cos there is the fear, that fear is always there — you don't like going into a group and talking in front of other people. So it was arranged that I talk to a girl. This was part of the Youth Action Project in Ballymun. That's what really started it off. The recovery started from there and I had to recover — this is very, very important — the other person has to get better too. This must come first. Before you can do anything to help the addict you have to be OK youself and vou're not at the time. You have to face up to the fact that you are living with an addict and you can only go down, things will never get any better.

In order to help, /ou need to be helped to sort this

out, to face up to it. The facilities to do this are very few and far between. There are the Coolmine groups, but I couldn't really identify with the people who go to the Coolmine groups because most of them have their relations in Coolmine and it's a different set-up really. Apart from the group in Ballymun I don't know of any other. The group was a great help to me and helped me realise I can live on my own — I don't need a junkie to help me to live — cos he's not helping me to live he's just helping me to die. I think there should be more support groups. You think you're alone until you go into a group like that and see that there are other people and they say — 'oh she/he does this or that' and you can identify with it.

I found pressure was the only way of dealing with it — you can't be soft. Before going into the group I thought this would be deadly - he blames you for everything 'I took gear last night because you made me — you drive me to take drugs.' You have to be firm to deal with this and its very tough — it's not easy at all.

Jervis Street referred him to Narcotics Anonymous (NA) and he went to a couple of meetings first — actually I went to the first one with him and he went back using again after the first couple of meetings. He went to go to a meeting one night but he didn't go. He went and had some diconal instead and he was gone for a couple of days, so that's when I realized that I'd have to throw him out. I'd have to 'evict' him. I convinced myself I wasn't going to lose anything - I was losing a man I loved — you have to get on with your life - he was going to die and he was going to make my life HELL and the childrens', so he had to go.

The way I did that was I wrote him a letter because I couldn't face him. I knew if I faced him I'd back down, so I wrote him a letter and enclosed a photograph of the children and me. And it was the hardest thing I've ever done. And I cried bitter tears then onto that notepaper. And I just prayed that he'd come back. I thought if he loves me, if he really loves me he'll do something about it — he has to and if he doesn't, well he wasn't worth having in the first place.

So he did it - it worked. He stayed out for two weeks. Now he came back which was harder again because it was very cold. I had warned everyone I could think of not to

allow him in: his family, sisters, brothers 'Please for his sake don't take him in, because you'll only damage him further' .

I did put in the letter that I expected him to stay off drugs while he was out of the house and that was a condition as well, which meant he couldn't go and stay with his junkie friends if he really wanted to do this. He did cadge a night here and there but only one night. On nights when he had nowhere to stay, he came home and I had to turn him away. I'm not rejecting you' I'd say, 'I'm rejecting your habit. You'll have to go until you succeed once and for all' . So he did and he said he'd attend the NA meetings regularly and if he lapsed again he said that he'd go to Coolmine and beg them for help because he wanted to come home, and he wanted to be with his family. So since then he has been going to the meetings regularly and has been marvellous. Now he's had his ups and downs but he's never been back using drugs. He did lapse just once and got stoned on drink and he had lapses in other ways but not drugs. These are things that are all part of his recovery. He just has to learn by his mistakes and be aware all the time of the dangers. This is why he doesn't drink — a lot of people don't understand this.

Now he goes to parties and is the life and soul of the party. At first he didn't think he could handle it. He thought he wouldn't be able to go anywhere to enjoy himself. He thought it would be miserable to sit in a pub and watch everybody drinking, but he took the plunge and we went into a rock music session and it was in a pub and he really enjoyed himself. We couldn't believe it. And parties - he was terrified of parties, which in a way is worse than a pub. The pressure is harder.

Another thing when you're coming off drugs —you must keep away from your 'friends' . It's very important, because it's very dangerous. When R came off drugs first and he'd walk through the shopping centre which is full of junkies, he used to actually shake and break into a run so they wouldn't stop him and try to talk to him. He couldn't handle that 'cos they were sure to say 'Oh there's great gear going so and so place' and that's all he'd have to hear and he'd be gone. You have to change your whole way of life, the way you

think and start to feel. Addicts don't feel. They don't feel real pain and they don't feel real love. They block out feeling, and it's not easy. It's very hard to change everything. Even just getting out of bed in the morning is hard for them, to make themselves do normal things. But getting over the physical side isn't as hard as changing the psychological effects.

Definitely there should be more support for families, 'cos as I said, an addict won't do anything unless he or she is put under pressure from someone, someone who loves them, be it a mother, or father or friends. They won't do it alone. You have to do it first. That's my belief. Therefore there should be more support for families — groups set up and. well there's no facilities for helping drug addicts at all. It's a joke, the way they deal with it. They don't deal with it at all. 9 beds in Jervis St. It doesn't make sense.

In my opinion, and from what I've heard, there's an addictive personality. R had an addictive personality. He didn't use drugs till he was 28. He always drank to excess. It was drink, drink, drink. Come home from work, go straight into the pub. fill himself up with drink and he was an alcoholic as well. He was cross-addicted. It's very hard to explain.

I think addiction is a key word here. The addiction can come in another form — say gambling. Just recently I came up against this gambling and it would oe so easy for this to take over from drugs. R has to keep working against it. It's good to be able to tell this story with a good ending. I hope it will be of encouragement to other people. I suppose R was lucky in a lot of ways. NA was great - his lifeline. He still needs the meetings.

In Bits'

PHYSICAL EFFECTS AND STATISTICS OF OPIATE USE

PHYSICAL EFFECTS

The majority of people who suffer bad physical side-effects from opiate use come from poor, working-class backgrounds. This is not to say that middle-class users don't suffer from hepatitis B, abscesses, collapsed veins etc. but far fewer of them do. In working class areas of Dublin where the houses, schools and flats are overcrowded, and the standard of basic education is low, proper health education is seriously lacking. A lot of doctors and teachers ignore the fact that health *education* is important and seldom bother to check on how much simple health information their patients or pupils have.

Malnutrition is one of the main causes of the bad physical condition that many users suffer. A heroin habit can cost over £100 a day, so there isn't much left over for food. This combined with the fact opiates tend to reduce the appetite means that users simply don't eat enough so the body does not have the usual reserves to fight sickness.

Many of the physical/medical side-effects of taking opiates come from ignorance as well as carelessness on the parts of the users. Some of the side-effects are also a direct result of the different things the pushers put in with the heroin to bulk up the amount in the 'packs' they sell, or that are added to crushed pills to 'clear' the mixture.

Needles are often shared between several users and this spreads infection. Sometimes a needle is used to draw the poisonous pus out of an abscess and then used to fix with.

The most common medical side-effects of using heroin or the other opiates are hepatitis, abscesses, collapsed veins, lowering of sexual drive and chronic constipation.

Hepatitis: The most common form is called Hepatitis B, People using opiates over a period of more than a few months are almost bound to.contact this ilhiess. Hepatitis is very contagious and can be caught by using anything from a needle to a cup or towel which has been used by someone already infected. It is also a sexually transmitted infection. One of the problems is that a user can have the infection for a considerable time before the symptoms, like yellowing of the skin and eyes appear, so it tends to be spread around without anyone being aware of it. Hepatitis cannot be cured, only controlled. If it is left untreated it leads to severe damage to the liver and eventually death.

> *One morning I woke up and noticed I was going yellow, my eyes were yellow. I got hepatitis. The doctor refused me another detox because I'd been in there too often. After 3 days when I got worse and worse and yellower and yellower they took me in as an in-patient. I was there for 5 weeks. They detoxed me again, gave me methadone, but I couldn't eat anything - there's no treatment for hepatitis. They put me on a fat-free diet. I was on a glucose drip because I couldn't eat anything. There vtere about ten people in for treatment at the time, the place was full. After a short time my liver collapsed. They didn 't tell me anything. They told my family they didn't think I'd make it. The doctor told my father that if my liver didn't start functioning within the next 3 days there would be brain damage because of the poison in the blood.*

Abscesses: Every time a user takes a fix the needle makes a break in the skin. Through this break impurities enter the body — either in the needle or immediately afterwards. These then fester under the skin and produce a yellowish/greenish pus like in a boil. The affected area swells and is extremely tender and painful. When the abscess has reached a certain size it must be lanced to extract the pus. If the abscess is large and has been left untreated or improperly dealt with, proper treatment can take a long time and is very painful,

and a scar will be left on the skin. Sometimes they become so large they must be packed (stuffed with something to keep them open to allow the pus to drain from them) and dressed every day.

Abscesses can be caused by the vinegar and lemon juice mixed in with the fix, by minute particles of crushed tablets, lack of personal hygiene and malnutrition. It is common for heavy users to end up with multiple abscesses and if the poison gets into the bloodstream then toxaemia (blood poisoning) can occur.

> *.....the pain is so bad I'd do anything to get rid of it. I'd saw my ami off if I thought it would work....*

Collapsed reins: These happen when a user is mainlining (putting the needle directly into a vein). Clots can form in a vein and cause the vein to contract or close and cease to function.

After a time heavy users find they have virtually no normally functioning surface veins left into which to put the needle. This is when they begin to use those under the nails, in the eyes, in the outer sexual organs etc. It can take up to eighteen months for these veins to begin functioning again.

> *.... My only vein left was in my groin. In order to stop this one from closing up on me I inserted the needle and having taken the fix I withdrew the rest of the works and left the needle in the vein, covering it with a sticky plaster so as to be able to go back to it. I didn 't think about what could happen walking around with a needle sticking into me.*

Lowering of Sexual Drive: Many people would argue that this should not be looked upon as a medical side effect but if we consider the sex drive to be an important and integral part of life then its lowering can have a negative effect on a person. Sexual appetite, like the appetite for food is lessened in users, but often they are not aware of it. Many users have a very intense, sensual relationship with the drug itself — their relationships with other people take second place. One worker in the field described it to us as a new form of the "eternal triangle" — the user, the lover and the drug. People living with users told us their partners' sexual drive fell and male users suffer occasional, but regular, impotency.

Pain & Illness: Many users say that when they come off opiates they experienced more pain and illness than when they were on them. They were not referring to the withdrawal symptoms but to things like colds, flu, arthritis etc. Some doctors say that users suffer these illnesses just like everyone else, but that a users's awareness of them is considerably less than non-users'. As far as pain is concerned, the opiates are morphine-based which means they kill a certain amount of pain. However, as the cause of the pain increases, the user's dosage has to increase to fight the pain. The body soon becomes tolerant of ever larger doses and the pain comes through anyway. It's all part of the vicious circle that users are caught up in, trying to kill one pain and creating another.

The effect of antibiotics, contraceptive pills and other medicine is not lessened if the user is also taking opiates. Some people believe that women need smaller doses of opiates than men to do the same amount of physical damage to themselves, but this has not been proved. The general physical, psychological, educational and financial state of the *pre-user,* how the user looks after her/himself once they start to use, and how long they have been using are the most important factors in assessing the possible physical damage that is likely to occur.

Although the medical/physical problems of opiate use affect both men and women, women users have added hardships and problems to cope with. These include pregnancy, childbirth etc. and are gone into in more detail in the chapter called Added Problems for Women.

Respiratory arrest: If the quantity of the drug injected is greater than the body can cope with, the user stops breathing. This is known as an O.D. or overdose and if they are not given treatment immediately, death results.

> *I woke up after three days being asleep from the overdose. There were a few doctors around me. I could not feel my hands or feet, they were numfc\ The doctor was asking all sorts of questions, I was just staring at him. "What is your name? What did you take? Tablets? Fixing? What vein? In the feet or hands? Why are they swollen? From what?"*
> *A priest came in and said, "Oh, you're alright my child." I just lay looking at the expression on everyone's face. I will have to get out of here, that was all I was saying to myself.*

Then I heard the doctors say I'd have to stay in for some test and was to be put in the casualty ward. So they did and I was trying to get out of the bed but I couldn't move. So the third day I started to feel sick. I mean terribly sick, like maggots crawling inside me. Then I started to freeze and sweat. Then the nurse came down. I remember asking for a doctor.

Oh. God, please take me, don't let me go through this. Oh. God, please. After a while I heard the nurse coming back, she and another one, but not with the doctor. She had a chest expander, a thing like a straitjacket. They tied me to the bed and got the porters to put the cot-sides up so I couldn V move. I screamed and roared like a mad woman. I thought I was in hell. I was in the horrors for seven days and seven nights. I saw the doctor and he said he could do nothing for me. I told him I thought I was in hell and he said, "Why didn't you think of that before you took drugs?"I cried all the time and prayed that God would take me.

Withdrawal symptoms: These begin 4 to 6 hours after the last fix. They include extreme anxiety, restlessness, fearfulness, fever, limb pains, vomiting, cramps, diarrhoea, nausea, dehydration, sweating, reduced appetite, insomnia, running nose and eyes, sneezing, convulsions and are very painful and frightening. They can last for up to a week.

STATISTICS

Statistics from Jervis St. Drugs Advisory Centre

The number of patients attending the Jervis St. Advisory Centre in 1979 was 415. It rose to 554 in 1980 and then to 800 in 1981. By 1982 the figure had risen to 1307 of whom 850 were new patients. In 1983, 1515 attended, of whom 841 were new patients. That's one thousand, six hundred and ninety one new patients over two years, and in 1983 *10%* of the new patients were heroin users. As Dr. Kelly, the Director of the unit has so often said, the Jervis Street figures only represent the tip of the iceberg. The 1983 breakdown of drugs used by patients shows that many of them were cross-addicted i.e. using several different drugs at the same time.

Drugs used and the figures for users were as follows in 1983:

Heroin	1,006	Amphetamines	27
Alcohol	245	Barbiturates	24
Cannabis	143	Morphine	12
Minor Tranquil.	113	Distalgesics	7
Diconal	101	Pethidine	5
Cough Mixtures	44	Yentolin Inhaler	2
Palfium	33	Parstelin	2
Solvents (glue, gas petrol etc)	32	Depixol	1
Physeptone	31	Solpadeine	1
Cocaine	30	Rivitrol	1
L.S.D.	28	Nicotine	1
DF118	28	Codeine Phos.	1
		Magic Mushrooms	1

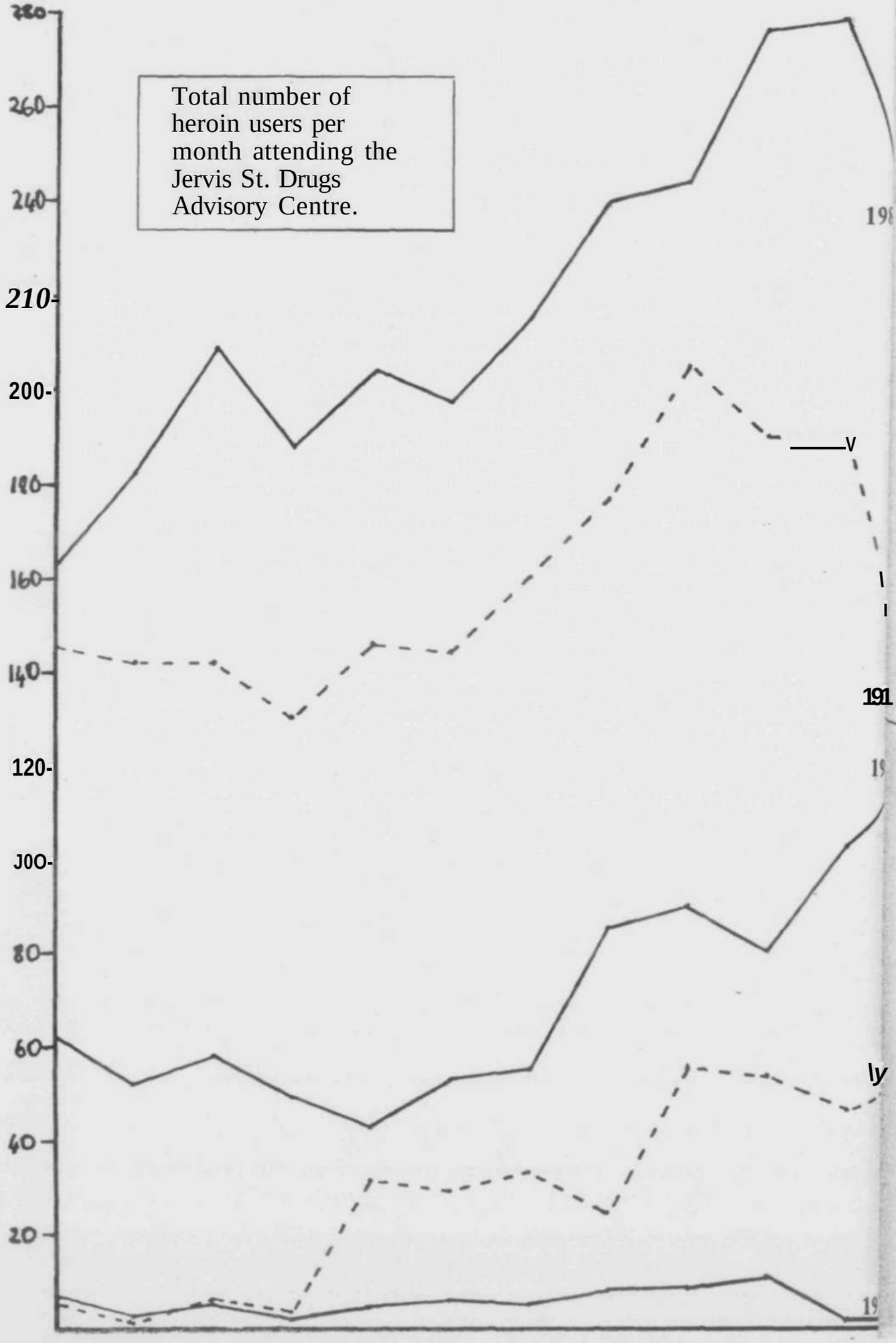
Approximately 50% of those attending Jervis St. are referred by the courts, probation service, or are people awaiting trial. The other 50% are self-referrals. According to Jervis St. there is little difference in the rehabilitation rate between voluntary and non-voluntary patients.

Several users we met criticized both the staff and the facilities there. Their criticisms ranged from what they saw as negative attitudes of staff-members, to the fact that rubber gloves and aprons are used to handle some patients: *'It makes you feel humiliated, dirty, like you're just a piece of shit.'* Some feel that middle-class users got better treatment than working-class users and are not as likely to be refused phy or detoxes. They complained of the long waits to see the doctors and of phy dosages that were too low.

It is difficult for us to assess these complaints. Some of the side-effects of drug use, like hepatitis, are very contagious and abscesses are messy. Staff would need to protect themselves. We met one middle-class user who had been refused a detox on the grounds that he had already had several and simply went back on heroin once his health improved. The small staff employed in the drugs unit have an outrageously heavy workload: not far short of 22,000 visits in 1983, or 400-odd a week.

Understandably the drop-in centres do not include medical treatment of users attending them. Apart from the fact that they have neither staff nor facilities to provide a medical service they believe that the psychological rehabilitation process should be kept separate from the medical care of users. Often those going for medical care have no

firm intention of giving up drugs; many want treatment, not cure, for their habit.



Added Problems For Women

TRANQUILLISERS & OPIATES

TRANQUILLISERS

It is estimated that women receive twice as many prescriptions for tranquillisers (tranx) as men do. The reasons for this are more cultural or social than physical.

The drug most commonly used by men is alcohol, and while women's consumption is rising it is still far less than men's. Male drinking is seldom seen as weak or pathetic - quite the opposite — the drinking man is almost seen as a hero. It is generally acceptable for men to 'let go' after drinking - to show themselves as emotional, angry, sad, bitter or resentful. If drink releases a woman's anger or bitterness she may be seen as dangerous or aggressive.

It is seen as acceptable though for women to use drugs if they do it under a doctor's control. It may be more usual for women to take tranx, but they are generally seen as inadequate women who can not cope without them.

Women are usually classified as dependent on men, physically and emotionally. But it is often *other people* who are physically and emotionally dependent on women: children, husbands, older or sick relatives. When a woman needs emotional support she may have no-one to turn to. In desperation she may turn to a doctor. Few doctors have

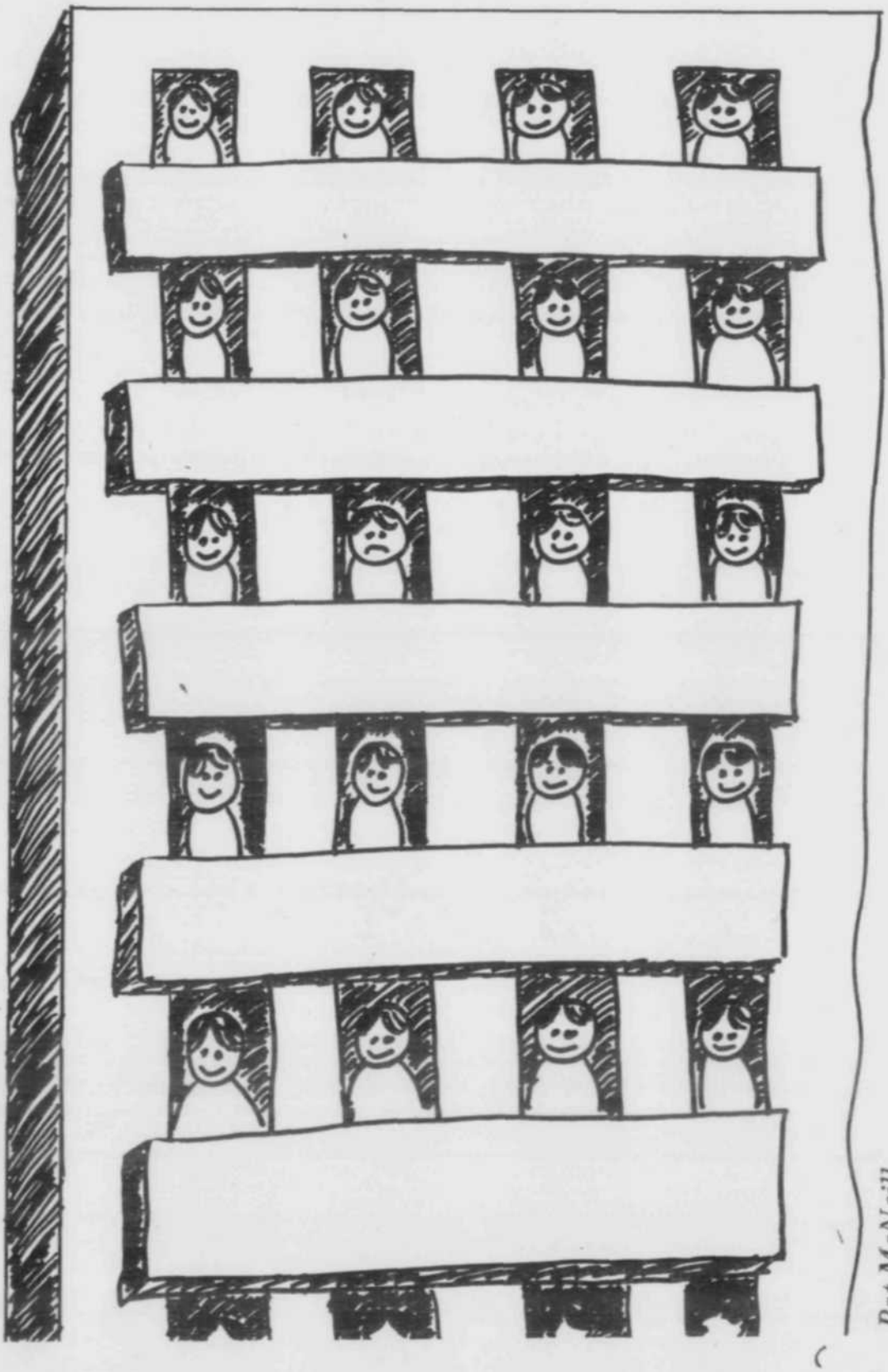
time or patience to listen to a woman talking about her problems. The woman herself may be embarrassed to take up a lot of a doctor's time when a surgery is full, so she turns her frustrations in on herself. The results are anxiety and depression. The doctor will prescribe for these 'symptoms' but the root-causes are left untouched.

Tranx do not solve any problems: they only supress feelings. Research has shown that after a period of a few months, tranx loose their effectiveness in lessening feelings of anxiety. All that is achieved is a physical dependency on the drugs. The body soon becomes accustomed to tolerating drugs and the dosage must be regularly increased if the original effect is to be sustained. Since few doctors will increase the prescription past a certain level the user is left in a permanent state of semi-withdrawal.

Common side-effects of tranx-use are dizziness, headaches, nausea, feelings of drowsiness, blurred vision, and reduced physical co-ordination like loss of balance. These side-effects are exaggerated by long-term use because of the build-up of the drug in the body. Women are more likely than men to be given a series of repeat prescriptions so there are thousands of dazed women in our midst.

*Throughout withdrawal from tranx I honestly thought I was going mad. I had never felt so ill. My head didn't just hurt, it felt explosive. Noise was unbearable; it wasn't just very loud, it actually hurt inside my head. Even eating (when I could) was painful. Much to the despair of my family, the radio and television would have to be very low. I thank my family for bearing with me, I know it was a difficult time for them too. My eyes would hurt, night was kinder on them than day. As my eyes gradually accepted light I became very confused at the world around me, I thought my eyes were deceiving me. I didn 't recognise all I was seeing. It wasn *t as I remembered it. It appeared unreal, colours were much brighter, outlines more defined, more vital, vibrant. I wasn 't ready for all this change, so I found it very frightenting. But you gradually adjust and enjoy what you see again.*

The biggest problem was learning to control the panic and tension: panic would wash over me. To fight it was futile. My heart would race, my stomach sink and rise again, but I learnt to give in to this feeling, and wait for it to pass.



The one without the smile is the one without the tranquilliser....

OPIATES

As well as the general physical effects of opiate use on the body, women suffer added complications that men don't experience. If a woman or girl is using opiates regularly, her menstrual cycle is usually interrupted. The most common early interruption is for the periods to become irregular with perhaps months between them, and then in many cases to stop altogether. The absence of a menstrual cycle does not mean infertility though, because some women we have heard about have become pregnant months after they stopped having periods. Due to the lack of the most usual sign of possible pregnancy - missed periods — many opiate users don't realise for ages that they are in fact pregnant.

According to medical opinion an opiate user who takes the contraceptive pill runs no greater risk than any other woman taking it. She is however more likely to be careless about taking it regularly, so it isn't effective.

The opiate user who has an intra-uterine device (I.U.D.) inserted is considered to be more at risk than the non drug-user. Opiate users tend to forget about their check-ups or be careless about having the device changed when it should be, leaving themselves open to dangerous infections. They are often careless about general hygiene and minor infections that develop are often ignored.

Various forms of sexually transmitted diseases are often allowed to go untreated for a long time, again due to general physical carelessness and indifference. This leaves women more vulnerable to serious results than if they sought treatment quickly.

I started staying everywhere and anywhere and I got mixed up with a bad crowd and it was all a mess. I didn't realise at the time though I thought it was great. I started taking drugs. Well, I had started smoking hash and popping pills at the age of twelve which was very young.

One night when I was only fourteen years of age I was after being taking drugs that night, but the next morning I had a terrible crash on a very big motorbike. I have an awful scar on my head and my knee, I also broke my knee cap. I nearly killed myself. My nanny was alive at the time, I caused awful honor and panic to my family. They all thought I was dead. I didn 't mean to put them through the worry but I suppose

I was just wild at the time. Maybe today I still am a bit wild but I'm a lot wiser. Well, I still do be going around taking drugs and robbing the money for them and coming in and out of prison over it.

When I was 17 years old I met a boy who used to hang around with the gang and I got pregnant. I was still living rough while I was pregnant and I still never realised the damage I was doing to myself and my baby which I was carrying. I never used to go to the hospital for check-ups or anything. I was even in prison when I was pregnant, but when I got out I stayed at home in my father's house till I had the baby.

Pregnancy

Up to 1980 the number of pregnant women attending the Jervis Street Drug Advisory Centre was one or two per year. In 1980 five-pregnant women attended, in 1981 there were ten, in 1982 there were 15, reaching a figure of twenty-five pregnant women for the first six months of 1983. The rate of increase is causing concern to those working in the treatment centres.

There is ar higher rate of miscarriage and stillbirths among users than non-users. General physical neglect, including poor nutrition is seen as the main cause. Research is being carried out to see if there is a more direct connection between these higher rates and the use of opiates. Opiates do cross the placenta but in far smaller amounts than either alcohol or nicotine.

Opiate users' babies are often born a few weeks premature. Approximately one third of babies born to heavy opiate users are believed to suffer from moderate withdrawal symptoms at birth. As an infant's body is not strong enough to bear the shock of sudden withdrawal from drugs, these babies are kept in hospital for some weeks to wean them off the drug. Opiates also enter breast milk and can be passed onto a baby by a breastfeeding mother.

Before I became pregnant I was on the gear. Then I found I was pregnant but it didn't bother me. Then I stopped taking gear, I went on a phy. programme, and they told me that nothing would be wrong with the baby. So she was born. But all through my pregnancy I never felt anything. Then when I had her I was delighted. I was very happy at first, and then she

became very sick. She was born a junkie. It was terrible. All the doctors and nurses were all talking about me and the baby. Then she was taken away from me and put in the intensive care unit. She had to be withdrawn, and she was getting gear fed to her through the head. When I would go up to see her all the nurses would talk about me, and I would just cry looking at her. ft was very sad then, I just hated myself for what I did to her.

Methadone Treatment

Methadone, a controlled substitute drug, is given to pregnant women attending Jervis Street during their pregnancy and for about six months after the birth. It is also given to them in the maternity hospital during their stay there. In the Jervis Street Centre pregnant women and new mothers have to attend a special group meeting once a week. The aim of these sessions is to discuss the special problems of pregnancy and motherhood and to help women cope with what is at the best of times a huge task.

Women and Treatment Centres

For the years between 1979 and 1982 the number of new patients attending Jervis Street was approximately one woman to every five men. The number of new women^ patients attending did not increase over these years. However, the actual number of women attending did increase and this is due to the fact that women went more regularly and returned more frequently to try once again to break the habit. It will not be known for a few years if the number of women now using opiates has increased because most users do not go to a treatment centre until their habit has resulted in illness or inability to cope with their lives. The Bradshaw Report (1982), which researched opiate use in Dublin's north inner city, found that more women than men in the 15-19 age group were using opiates. The treatment centres have not reflected any such increase.

Many opiate users have small children. Some children are taken into care because the authorities see their mothers as irresponsible and unable to cope. Workers in treatment centres also believe that women use their responsibilities towards their children as an excuse for avoiding treatment,

especially in-patient treatment.

Addiction to drugs can separate a woman emotionally from her children. Physical separation sometimes highlights the emotional separation and allows the mother to reflect on what her child means to her.

> *Last week I had a visit from my baby. When I heard it was her I was glad, but when I went out I had no feelings for her. I just held her in my arms and it was as if I had this pain. There was nothing there. Then when she was leaving I was so upset, not because she was crying but because I had no real feeling for her, my own baby. I thought I was going mad. I had no-one to turn to, to talk to, to say this to.*

Women often have to accept full blame for becoming pregnant. They are often the only parent caring for a child. They are sometimes forced into prostitution to support a drug habit, either their own or a male partner's. Women tend to be guilt-laden because of what their drug-influenced behaviour has inflicted on their children. Many treatment centres are now beginning to move away from the older approach of treating women in the same way as men and not acknowledging the more vulnerable position of girls and women in our society.

> *He* (husband) *started to get worse when I left him the first time, so I went back to him. In my misguided state I though I could help. This situation lasted for another couple of years. He would get arrested for breaking into chemists then when he would go to court I would go and ask the judge to give him another chance, usually pretending I was pregnant. Oh, we knew all the sad stories to give.*

To reflect this growing realisation many of the centres and groups have separate women-only sessions where women can learn to discuss these things on their own terms. There is however a long way to go.

> *I had been in Coolmine for eight months and then one day I just got very depressed. In Coolmine it is part of the programme that all day long you talk about how you feel. But I found it hard to talk to people - that was one of the many reasons for my taking drugs - so I just got it into my head to leave, so I did.*
>
> *Then when I went home and stayed in that night, some old friends started to come down. Then..... came down and I*

wanted to be with him, but I was afraid to say so in case he would laugh at me, and use me the way he did before. So I started to lay a lot of theory on him. "Listen man, I want to get my life together, so leave me alone. " So he did, and there I was, so lonely, because I did not know how to talk to people. I felt that I was a theory machine. I thought I was going mad.

I stayed away from gear for a while and the nights started to get more and more lonely, so I went out one day and met a few people. I went off and got stoned. It was weird at first. I felt so bad that I had taken a fix, I just said jack it in, and then I got back to all the old ways, all the self-hate I had. I thought I had forgotten it, but it all came back. I was projecting my feelings onto everyone. So one day I took an overdose of heroin and I was brought to the hospital. I will never forget as long as I live. It was terrible.

This was written by a woman in prison. Her children had been taken into care as a result of her drug-use.

I started on gear three years ago. I was pregnant at the time, it was a few weeks before I had a baby. I was in a girl's flat one night, and a few fellas came in to sell gear and when she bought her supply she asked me would I like to buy some palf to try them. I said no, I didn't want to, but she kept saying go on, try them, they're great. So then I said yes. I was afraid to say no because I thought the fellas were laughing at me. So I dropped some and I was really frightened in case something would happen to me and the baby, but I didn't let them see that. I kept saying it's great. That night I felt very sick and I said I wouldn't take them again, not until I had the baby.

When I came out of hospital I started to go dancing again. The dance I went to there was a lot of palf going around, and a lot of my friends were taking them. So I took them to fit in, and I felt real big when I was taking them, but I didn't like when I was stoned. I was always making myself sick. But I got used to taking them and I got to like

them. I was only buying palf in the night time, at weekends, and then it went to every night, and then it was an odd one in the day, and before I knew it I was depending on them.

I found out one Sunday night. I didn't go out I went to bed. I didn't know what was wrong with me. I just got up and cleaned all the house for my ma. When I told my sister she told me I had a habit on palf. I thought it was very funny, and it was great because I was a junkie now.

I hadn't taken a needle up to that time 'cause I was frightened of them. But things started to get terrible for me. 1 got that I couldn't do anything without taking a fix.

By this time I was getting into everything. I was using smack mostly. I couldn't get out of bed in the morning to dress the kids unless I had a turn-on. If I hadn't got one I wouldn't get up and the kids used to be going around the house all day while I was lying in bed. They would get up to terrible things, and they would be hungry and everything. But I never realised that because I was too wrapped up in gear and myself.

My mother found out that I was taking drugs. She was very upset about it, but no matter what she said or tried to do I just wouldn't listen. She even threatened to get the kids taken off me.

I got married then, but that didn't work because of the drugs, so we split up. I needed so much money to keep my habit going I had to go out robbing handbags. Shoplifting was no good, I couldn't get enough money out of it. I let myself go to bits. I didn't care what way I went around as long as I had my fix. I got really skinny and I looked terrible. Everybody used to say to me I was going to die, but that didn't bother me. I wouldn't even get up in the morning to bring the kids to play-school, so they put them out and that didn't bother me either. I was glad, because my mother, couldn't say anything to me for not bringing them. I remember my mother used to cry into my face for me to do something about myself, and stop taking them for the kid's sake. I got fed up listening to her, so I got the kids and moved out.

A fella gave me a flat so I moved in. There was always junkies in it, fixing in front of the kids. I didn't mind them coming up. I didn't realise what waygoing on in the house with the poor kids there. The kids were going wild, they didn't know right from wrong, looking at different people coming

using prepared opium' . The word *frequent* means 'return several times' to a place: in effect this means they cannot arrest someone unless they have already seen and logged them at the same place before. There is also the fact that opium has practically never been used in Ireland, and nobody has ever been charged with its unlawful possession.

The way cannabis is defined also creates anomalies. For example, take two people: one has a few leaves of the plant and the other has traces of the drug on their hands: the person with the leaves gets a £50 fine and the one with the traces can get a prison sentence.

The drugs squad would also like to see changes in the medical reports ruction of the Act. First they would like a distinction made between the 'hardened criminals' who push for gain and the users who push to support their own habits. They do not feel the former should get the benefit of medical reports. They admit though that there would be certain difficulties in defining the differences. They would also like the medical reports to be done before the court case, so there can be no temptation to manipulate the assessors who carry out the reports.

They would also like to see a closed remedial institution being used for convicted drug-users, instead of prison where the facilities for rehabilitation are far too limited. Users come out of prison just as addicted, at least psychologically, as they went in.

1983 was described as a good year in the fight against drugs. In co-operation with Interpol and other international policing agencies, the supply lines from India, Pakistan and the Lebanon were severely disrupted. Official figures for people charged with drug offences show only the tip of the iceberg of drugs-use, but the following figures certainly give food for thought. 2 people were charged in 1965,77 people in 1970 and 1,822 in 1983.

Though unhappy with the sensationalism with which the media has handled the drugs issue over the past year or so the Drugs Squad say: *'There is a marvellous sense of awareness now emerging and we know we hare solid backing for our work. Without community support we can achieve nothing. The concerned parents groups are a powerful force for good as long as their type of action is kept within the law.'*

THE MISUSE OF DRUGS ACT 1977

The following is a summary of the Act.

The Act includes things like the striking-off the register of doctors who over or wrongly prescribe controlled drugs (like palf and dike) and the proper labelling of drugs by the manufacturers. Then it goes on to give the law relating to the importing, growing, using, pushing, (or helping anyone else to do any of these) etc. of illegal drugs — cannabis, opium, heroin etc.

It is important to note that under this Act 'supply' of drugs includes giving without payment, so a person can be charged with supplying, even if they give the drug as a gift. All objects such as syringes etc. or utensils used for the taking of illegal drugs and any document like forged, altered or illegally obtained prescriptions are covered in the Act.

The Act has a three page list of controlled and illegal drugs at the end of it. The dail has the power to add any other drugs tp the list as it sees fit, by a government order. These orders can also prohibit the manufacture of a drug.

The rules forbidding the possession/use etc. of illegal drugs are in Sections 15/21 of the Act. These sections mention opium and cannabis by name, but heroin, palf. and dyke, are automatically covered in these sections.

It is illegal to possess (whether for selling or personal use), to use, to grow, to forge or alter prescriptions, to allow your land, vehicle, vessel, or house to be used to grow or store or use illegal drugs on. It is illegal to manufacture, import/export, sell, aid or incite anyone to do any of these things both here in Ireland and abroad. It is illegal or give false information or obstruct a garda investigation or conceal illegal drugs from the gardai.

Gardai may stop and search any person, vehicle, vessel or aircraft if they have reasonable suspicion of them. The definition of that word 'reasonable' is not given. During the search the gardai may seize and keep anything which might be used in evidence against you.

Gardai must obtain a search warrant to search a house or flat. They may not simply enter your home without a search warrant which they must get from a district court or

and going all day. I would get up some days and the kids would be playing with matches and all I would do was take them off them. I wouldn't slap them. I would be that sick I wouldn't be able to do so, so they didn't know they were doing wrong. They never went out to play because they were never dressed.

Then one day a social worker came up to me. There were loads of people in the flat fixing and the kids were there, and they weren't dressed and I was out of my head. He told me he was up to see about me and the kids: he was really shocked. He asked me would I let the kids go with him for the night. I said no, because I love the kids. He was talking to me about the kids, but I wasn't even minding him. He was always coming up to me from that day, and he always came when there was loads of people in the house. He wanted to help me get into hospital, but I wouldn't listen to him. I wanted to get off the gear, but I wouldn't do anything about it. I hated myself and I was always saying when is it going to end? I was always crying over the kids, I just wanted to die.

A terrible thing happened one morning. The kids set the flat on fire. We were nearly burnt to death. It was all my fault. I was asleep in bed and the kids were up playing around the house on their own. I don't know how we got out of the house alive, because it was a terrible fire. The kidr were taken to hospital, and while they were there the social worker was working on getting them taken away from me behind my back. He brought me to court and the kids were taken off me. If I'm off drugs I will be able to get them back. I have four years to get my life straightened out.

I have to choose now between drugs or my children. I I want my children so I hope I make it. If I don't make it, I \ won't get them back and I will die soon. Many more terrible things happened to me, but losing my kids was the worst, i I have drugs out of my system in here but they're still in my mind. They torment me: I lie awake at night thinking. I cant't stop thinking. Will I stay away from gear? Will I get the kids back? I don't want that life.

Busted

DRUGS AND THE LAW

After a while I came into a bit of money so I decided to have a go at selling. I bought it from one of the crowd. I cut it myself - more profit that way. The stuff I got was good quality. I was doing that for a month or so in pubs. You'd get known and people would ask you and you 'd tell them you 'd meet them at such a time. I did worry about getting caught, but I never was. During my addiction I'd deal for a month or two months and then stop and six months later start again and then stop. It wasn't because I felt bad about doing it, it was that I couldn't get it together. I'd always take more than I should take. Sometimes I'd get it on credit to supply others. Two grains at £250 would mean you'd need £300 back. I'd end up using the whole lot myself, wouldn't sell anything and end up owing the £300 which should have made me £550. So I ended up in debt with various people. I was threatened a few times, but I usually came up with the money. Tliey'd give me more to sell to pay them back. I wasn 't at this for a long period of time 'cos I could never keep it together.

DRUGS SQUAD

There are several anomalies in the Misuse of Drugs Act which the Drugs Squad people hope will be changed in future legislation.

In section 16 of the Act, it says 'a person shall not frequent a place for the purpose of smoking or otherwise

a peace commissioner. When a search warrant is issued it must be to a named garda and must be used within one month. The gardai may use such force as is necessary to enter the premises. They can then seize any substance, article or document that may be required as evidence.

The gardai may arrest you without a warrant if they suspect you of committing an offence under the Drugs Act.

Penalties

The penalties which may be given in court following conviction vary with the drugs concerned.

1: Cannabis

Possession for Personal Use:	First conviction, fine of £50. Second conviction/s up to a year in prison and/or a fine of up to £250.
Possession for Purpose of Supply:	In the District Court: Up to 1 year in prison and/or fine of up to £250. In Circuit Court: up to 3 years and/or fine up to £1,500.
Selling Cannabis:	In the District Court: up to 1 year and/or fine up to £250. In the Circuit Court: up to 14 years prison and/or fine up to £3,000.

A doctor or a pharmacist who has broken this law appearing before the District Court faces the same penalties, but before the Circuit Court, can get up to 14 years and/or fine up to £3,000.

2: Opium I Heroin

Possessing, Using, Growing, Having Pipes & Other Utensils:	In the District Court: 1 year in prison and/or fine up to £250. In the Circuit Court: up to 14 years imprisonment and/or fine of up to £3,000.
Forging, Altering Prescriptions:	In the District Court: 6 months in prison and/or fine of up to £100. In the Circuit Court: imprisonment of up to 3 years and/or fine of up to £750.

Allowing Use of Land, Vehicle etc.	In the District Court: up to 1 year imprisonment and/or fine of up to £250. In the Circuit Court: up to 14 years imprisonment and/or fine up to £3,000.
Aiding & Abetting:	In the District Court: up to 1 year imprisonment and/or fine up to £250. In the Circuit Court: up to 14 years imprisonment and/or fine up to £3,000.

When you have been convicted for any of these offences (except for the first and second convictions for cannabis for personal use) the court must remand you for not more than eight days for both medical reports and an educational/ social report. These must be made by the health board's personnel and social workers. The contents of these written reports and their recommendations will be shown to the judge and s/he must take them into consideration when deciding what sentence to give you. If you are convicted of your first or second cannabis possession offence then the court may order these reports, but it does not have to.

When the court has considered these reports instead of giving the usual sentences they may order any of the following:

That you enter into a recognisance (a contract), to be placed under the supervision of a social worker, or probation officer.

That you undergo medical treatment recommended in the reports at a named clinic or hospital. Or it may be that you will be ordered to attend a particular school, course or training.

Or you may have to enter Coolmine for a year or the amount of time you've been sentenced to, whichever is the shorter period.

The court can come to these decisions by what's known as 'in camera' procedures. This means not in the presence of the jury and/or public. The court has no obligation to tell the convicted person what is in her/his reports, but their solicitor or barrister may see them and may question them and comment on them.

The in-camera proceedings and not divulging the contents

of the reports mainly apply to juveniles.

If you break the conditions of your recognisance you may be brought back to the court and the fine/sentence appropriate to the conviction can be imposed.

If during your treatment period the doctor goes to the court and says that you need no further treatment, then the court may revoke (cancel) the recognisance. If this happens the court may then decide to send you to a different treatment centre, or it may decide that nothing further is required of you.

If the centre named by the court decides that you would not benefit from being there, or that you would be a disruptive influence upon the work of the centre, the court cannot force them to take you. If a centre refuses you. the court may send you to prison, but not for longer than the period of your original sentence *less* the time you have undergone in the treatment centre.

Section 29 of the Act lays down what grounds you may and may not use as your defence in court. Ignorance by itself is no defence: in other words you can't simply say i didn't know my flat/pipe or whatever was being used'. The grounds for defence are fairly complex and we feel that it would be misleading for us to interpret them as this will depend entirely on each individual case. It is a matter for you and your solicitor.

If you want to get a copy of the Drugs Act, just go to the Government Publications Office, Molesworth Street, Dublin 2, or you can write to them. The price is £2.02.

It should be borne in mind that the government is considering increasing the penalties, particularly the financial penalties of the Drugs Act. In the U.K. for example, one of the alterations made was that the assets of people convicted for pushing heroin could be taken from them.

'Hit A Doc'

When the gear we had was gone, it was suggested I should "hit a doe" - that is go to a doctor and give him a story[1] of being here on holiday and being a junkie. This was surprisingly easy. Lots of doctors were writing prescriptions for drug addicts. Word would go around which doctors to go to. I never had any trouble even though sometimes I would not have any money to pay them. Tliis went on for about two years, two years in which I had to put my son into care as my boy-friend started to beat me up when I said I would not go to any more doctors as I wanted to give up drugs. I had started to attend the drug clinic at Jervis St. Hospital. It was there 1 got to know all the addicts in town, lots of whom are dead now.

SOUTHERN HEALTH BOARD REPORT ON DRUG AND ALCOHOL ABUSE 1983.

This interesting report shows that although alcohol is still the most abused of all drugs in the southern health board area (which includes Cork city), there is a growing abuse of other drugs as well.

The major drug problems according to the area's gardai. pharmacists, psychiatrists and addicts undergoing rehabilitation, is the use of synthetic narcotics — diconal and palfium, which are prescribed by doctors. A survey of doctor's practices indicates there are a large number of people addicted to barbiturates and a number of others abusing hallucinogens and solvents (glue) etc.

The report says that some doctors were prescribing synthetic narcotics for known addicts in such quantities that they were able to sell them for profit on the streets of Cork city. Apart from these doctors, some other doctors are careless about who they prescribe for and the amounts they prescribe.

The gardai cited in the report believe that irresponsible prescribing by doctors was the single most important factor behind the growth of drug abuse in the Cork area. Gardai investigations have shown that over 17,000 palfium tablets and 1,300 diconal tablets were prescribed for one addict in a nineteen month period. Up to 1,400 palfium tablets were prescribed for another addict over a single month.

Glue sniffing — the abuse of domestic and industrial solvents — by children and teenagers is considered a serious problem in Cork. It is most commonly found among youngsters living in deprived inner city areas, but it can in fact be found in any area, even if the numbers are smaller.

The report committee believes that a demand for hard drugs has been created in Cork and that it would be foolish to imagine that what has already happened in Dublin could not happen in Cork. Already a number of professional dealers have appeared on the Cork scene.

Joe Lee

Behind Bars

This piece was written by a woman in prison.

The elements raged as I lay and shivered in my hot, stuffy cell. My God, would it never end, this torture, this assault on my poor sick body? How long has it been since I entered here? My mind wanders between fact and fantasy. Has someone really sponged my damp body, bringing me sweet moments of relief? Have I dreamed of cool hands on my brow, clean sheets beneath me?

Voices drift, people come and go in this nightmare. I hear my mother crying softly, but she has been long dead. Yet it brings me comfort not fear to know she is near. Day turns into night and I know it will have to end soon. God, give me the strength to make it.

Ten days have passed. I open my eyes. A watery sun struggles through the barred window. In the corner the officer nods in her chair. Proof to me that someone cared. I know it can't have been easy for her to six through this with me. I struggle to get out of bed, but my body is still weak. She stirs and smiles. 'Well, you've made it.' A pot of tea is shared. I had forgotten how good it could taste. But then I had forgotten many things in my drugged state. The staff are kind and they all help me in their own ways. We sometimes sit and have long talks. They are interested in what I have to say. Such a change from the people I had known before I came here.

My release date finally comes. I wake from a fitful sleep. I dress. Goodbyes are said and everyone wishes me luck. At last I am out the gates, and walking down familiar streets. The sun warms my back, making me feel good to be alive.

Such high hopes I had that morning.

Six weeks it lasted. Weeks of struggling with myself, of turning my back on old friends. Six lonely weeks till finally they got to me. All my good intentions flew out the window, all my dreams of drug-free life shattered when I again took the works in my hand.

I am back on the streets again. One of the many in this city who watch friends die. Thinking it can never happen to me. Rejected by society and hiding my hurt in a needle. Time stands still as I go about my lonely life of self-destruction. I know too well that's what it is. Now all my waking moments seem to be taken up in feeding my hungry veins. There is self-hate, a lot of it. I know it has to end soon, one way or another.

DRUG USERS IN DUBLIN PRISONS

In 1981 a survey on drugs and prisoners was carried out by the Department of Justice. It is the last official survey of its kind to date. The survey interviewed drug-users in Mountjoy Male Prison, Mountjoy Female Prison and St. Patrick's Institution for Young Offenders. Some of the facts and ideas from the survey are worth looking at, and are us follows: —

Although current thinking suggests that drug addiction extends across the whole socio-economic spectrum, it is not reflected in the drug addicts that come to prison. The vast majority of them come from deprived areas. All the addicts interviewed in St. Patrick's Institution were from working-class, inner city Dublin areas and most were from very large families. Their schooling was poor and often marked by a bad attendance record.

The criminal records of the boys imply that most of them were involved from a young age in a setting in which stealing and vandalism were commonplace. Although later

on much of the stealing was undertaken to finance a drug habit, it is assumed that many of them would have taken involved in such activity anyway. Not only was drug-taking fashionable in their neighbourhoods but most boys said that all their friends took drugs of one kind or another. Several felt pressure from peers to get involved in drugs. Awareness of the dangers of developing a drug habit and possible adverse physical effects appeared to be of little influence. Many of the young people around them were indulging in heavy drugs, enjoying the experience and apparently not suffering any obvious ill-effects.

Most of the ***heavy*** users surveyed had a good understanding of their drug problem. They were well informed about such facts as the body's increasing tolerance to a drug and the continuing need for higher doses. They were aware of the damage that drugs can cause to the body.

On the other hand many of the *light* users had a delusion of psychological control over their habit. They felt that if they really put their minds to it they could take or leave drugs. They took drugs because their friends did. because there was nothing else to do and most of all because they enjoyed it. They had little or no insight into the fact that in the circumstances of continued drug use the notion of will-power would become more meaningless and unrealistic.

Many of those interviewed were suffering from the initial stages of withdrawal when they arrived in prison, and received physeptone treatment for the first four or five days after arrival.

The closure of the drug unit in the Central Mental Hospital in Dundrum has created a void. No custodial unit currently exists for treatment under the Misuse of Drugs Act. Prison sentences as served at present by drug addicts do nothing for their problem except keep trie addict alive for a while longer.

Within the prisons there have been some developments in the treatment available to addicts. Methadone detoxification is available for addicts who enter prison while still physically addicted. The professional services of phychiatrists, psychologists and social workers are available to addicts who seek individual counselling for their addiction problem, but not many addicts have made use of these services.

A special unit of 30 places in the grounds of Mountjoy was originally intended as an experimental treatment unit for addicted offenders. However, since the closure of the detention centre in the Curragh camp this new unit is used to house prisoners transferee! from there. Consideration was given to the adaptation of some of the existing accommodation in Mountjoy as a self-contained unit for addicts, but as yet nothing has come of this.

As regards treatment, a common theme **with** most of the boys was their disregard for the Coolmine Centre. They showed no interest in going there, indeed they found the prospect unpleasant and threatening. One boy described a friend as *'...**twice** as much in the shits as before she went in there**.* Several stated that they knew many people who had gone there but none who came out and stayed off drugs permanently, though some had stayed off for six or eight months. Another boy said he had heard of some being cured in Coolmine but had not known any of them. In general the boys' negative feelings about Coolmine was based on the idea that freedom was greatly restricted there, and a strict and bizarre discipline was imposed which often involved personal humiliation for the addicts.

On the subject of treatment, the Survey picked out three points it thought worthy of discussion: —

1. It seemed essential to deal with the group phenomenon of drug-taking. The rapid growth of drug-taking in groups of people greatly lessens a young person's initial caution and fears about dangerous drugs.

2. The problem of the beginners and the light users strong delusion of control over their habit needs to be recognised. By the time they begin taking a more realistic approach they are usually already heavily addicted and psychologically dependent.

3. On the other hand the independent-mindness and self-reliance of the young is regarded in a positive light as an aid to treatment. Several of the boys made their only serious attempt to break the drug habit on their own when they were not under external pressure from any authority. This is precisely the type of motivation that needs to be tapped and supported.

*(Since that report was issued, **the** only change is that Nar-*

cotics Anonymous are now allowed into St. Patrick's Institution to hold meetings. A youth development centre, which will cater for 31 young offenders, some of whom will be drug-users, is being built in the grounds of Dundrum mental hospital. We are told it will be completed in 1985. Monies for staffing and equipping the centre have vet to be allocated. Eds.)

At the time of the survey in Mountjoy female prison in 1981, only three women were identified as drug users. The daily average number of women prisoners during that year was 16. Two of the women were 21 and the other 18. One 21-year old was married to a user and had two young children: the other two were single but each had a young child. The survey has the following observations to make: —

All three had poor school records. They had stopped attending at 12. 12 and 14 years and all had left school without any qualifications. However they could read and write well, and seemed capable of benefiting from a much higher level of education.

Theii\work records were also poor. One had never been in paid employment while the other two had experience of several periods of employment lasting only one to three days. All of the women were jailed for stealing or shoplifting.

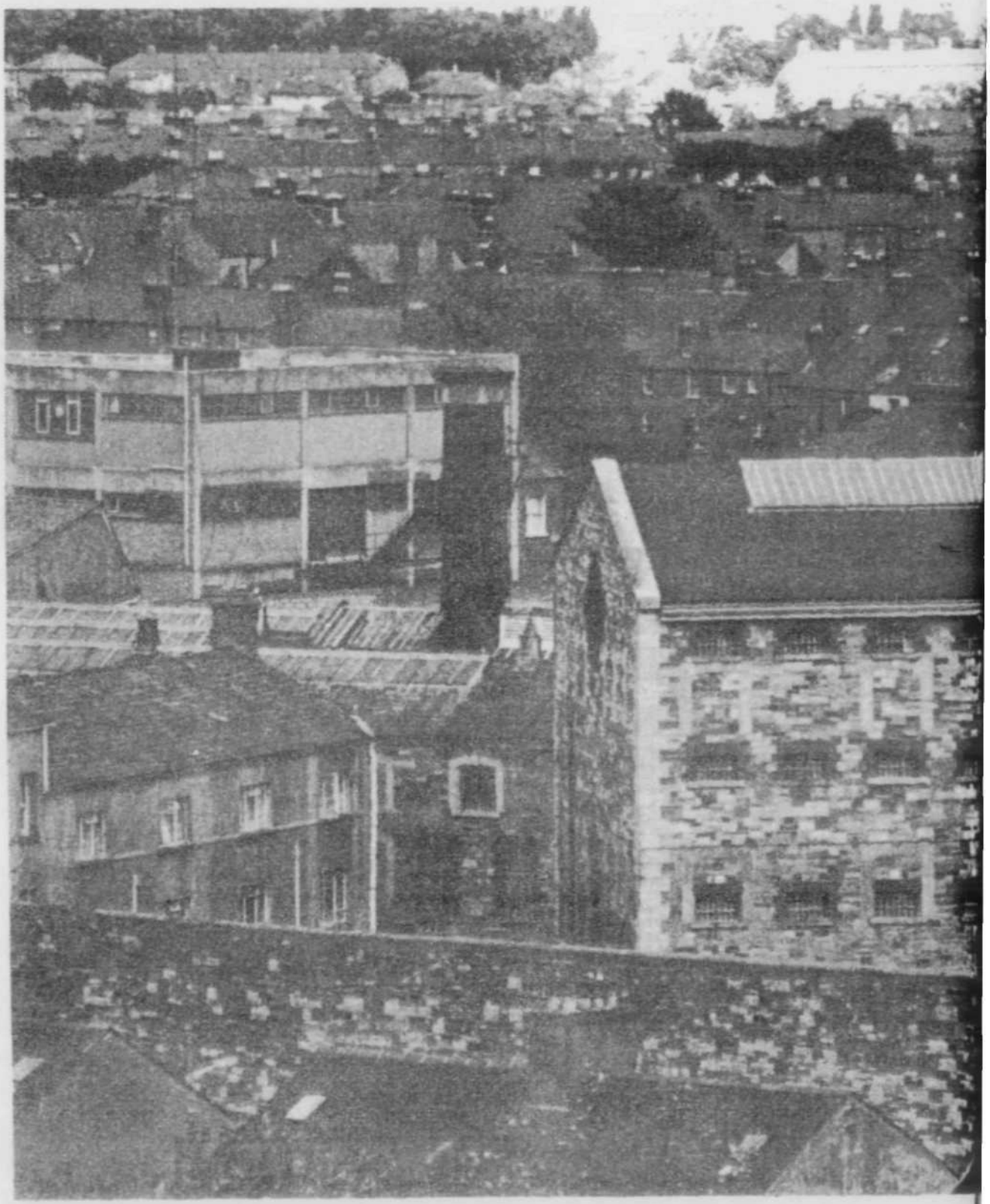
Serious drug-taking began for the women at 14, 15 and 17 years of age. Two of them who started on palfium both progressed first to diconal and then to heroin. The other woman's first serious experience with drugs was with heroin and cocaine used together. In addition to palfium, diconal and heroin all had used cocaine, two had used amphetamines and barbiturates and one had used LSD.

The most recent habit for two of the women was heroin. The third had a complex daily habit. She had been receiving physeptone from a clinic for long periods and tended to take both diconal and heroin as well. Her habit had been similar for almost three years. All three women bought heroin on the street or in pubs. One frequently obtained diconal on fraudulent medical prescriptions while the other bought diconal at £5 a tablet. One said she frequently bought up to £600 worth of heroin at a time. This woman stole mainly cash. A second woman financed her habit by shoplifting and fencing the stolen goods. All three women were

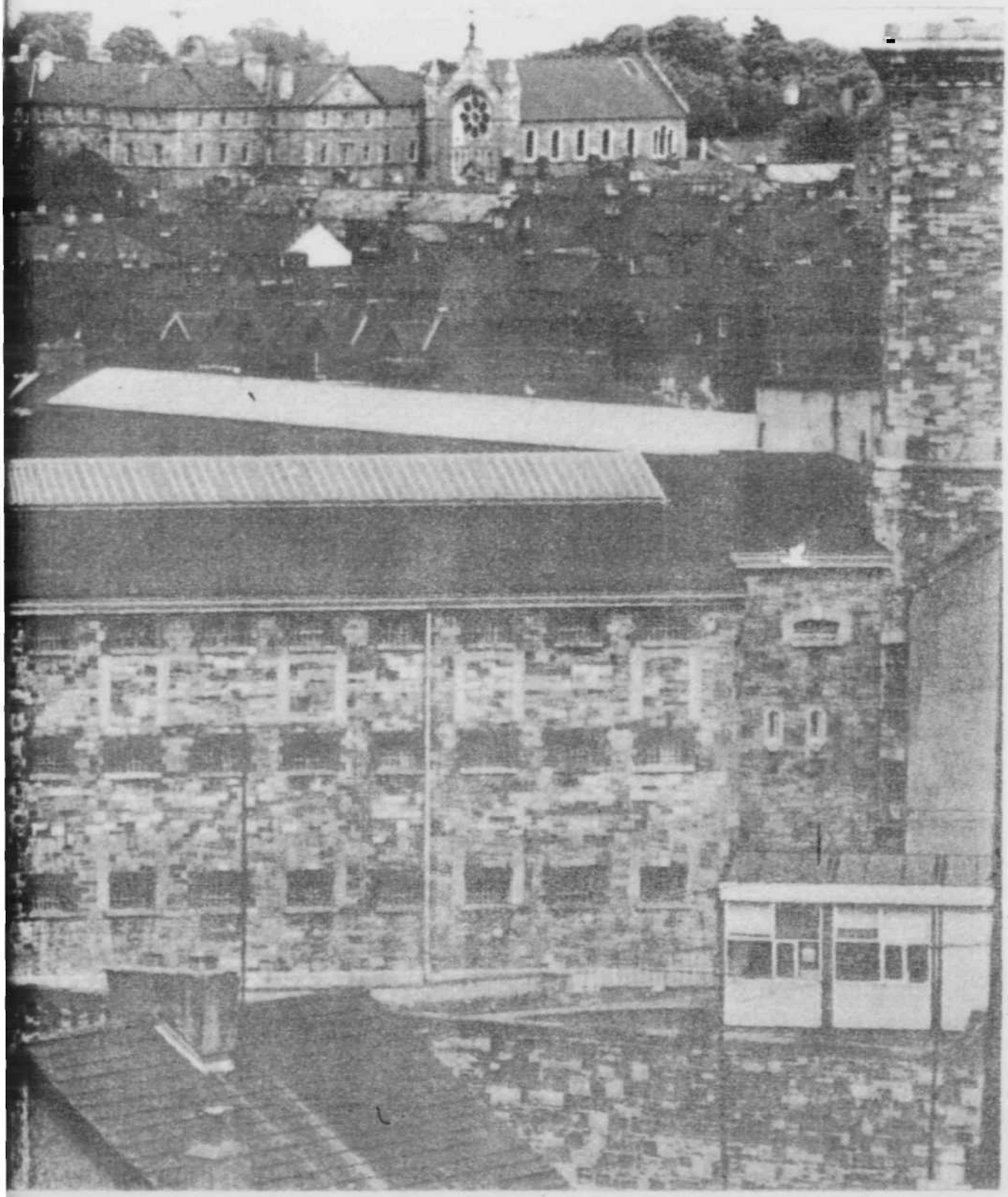
classified as heavy users. All three had sisters using drugs as well.

Two of them were on their regular drug habit on arrival in prison and received physeptone treatment. The third was already on physeptone and received none in prison.

The women had considerable experience of various treatments. One had been on a detoxification programme in Jervis Street Hospital on nine or ten occasions, lasting from 10 days to 8 weeks. However, it was noted that she was



abusing this, treatment because she was taking physeptone from the clinic and also fixing heroin and diconal. The same woman had spent seven months in a psychiatric hospital after an overdose and seven months in Coolmine. The second woman had been on physeptone detoxification in Jervis St. Hospital four times. She also continued to use heroin while on these programmes. This woman had also experienced daily psychotherapy over and eight week period with a psychiatrist in a remand centre in England. The third woman had not



Derek Spiers (Report)

experienced detoxification and this was because she had sought out-patient detoxification at Jervis St. but had only been offered in-patient treatment. This she refused, presumably because in-patient status makes abuse of treatment more difficult. This woman had also spent seven months in Coolmine.

The women had many comments to make about their experience with treatment. The two with in-patient experience in Jervis St. both stated that they used it only because of their state of imminent physical collapse. One said *It rebuilds your physical strength to enable you to take more drugs. You get your reins hack and your abscesses cleared up. I was using it as another source of drugs - phy. I never gave it a chance.'*

The two women with experience of Coolmine had strong negative feelings about it and appeared to have found the regime far too strict for them. One said she would rather spend *2* years in prison than 6 months in Coolmine. 7 *thought it was doing my brain in. I didn't see any point — only getting roared and screamed at all the tune. They try to turn you into a machine and turn you off your family.'.*

The second woman said it was too hard and too long and *'...a mad stupid different world. I felt like a machine. It was childish being told what to do, how to talk, what to talk about. The longer I stayed the harder it got. I was terrified of the groups, the shouting and the crying.'* However, on reflection she felt she had benefited from it although she had gone to Coolmine without a full commitment to giving up drugs. She said "*I went out because there was nothing else, hut I knew in my heart that I would not give up, because I love drugs.'*

The woman who had been an in-patient in a psychiatric hospital demonstrated the same lack of motivation, even to the extent of manipulation of the situation in the hospital. She reported that she would claim she was depressed when she wasn't in order to obtain more tablets and get 'stoned'.

All three women reported a feeling of emotional detachment from their children, husbands/lovers and people generally, and this gave rise to a great deal of guilt. One woman said *I think for a few moments about death and my kids, but I can't think for more than a minute — it's all too much*

for me. Even if I lost my children it would not make me think. I've never been a mother to them.' This woman when asked what might be a helpful treatment for her, answered: "/ ***know*** *that I can only help myself, no-one else can. If someone were to sort out my life for me then I could give up. but I just can 't sort it out and I can't think.'* This woman was sure that she would use drugs again.

The other two women had a reasonably strong intention of giving up drugs. One said: 7 *don't want to go out to lead the same life again.*' One of them thought a Narcotics Anonymous group should be introduced within the prison. However these two women were not at all sure they would never use drugs again.

The survey says that within the present structure of services the outlook for these women is not good. The women's desire to abandon drugs needed to be matured and strengthened by almost continuous support from outside themselves. A major problem is that for them any genuine commitment to breaking their habit is immediately followed by a confrontation with the actual disorganisation of their social and emotional lives. Long-neglected responsibilities and feelings of guilt immediately press in on them and they find themselves entirely unable to cope. It was apparent with at least two of them that this problem was worsened by the fact that their lives have centred around drugs from such an early age that they have never faced anything without them.

The survey's findings show that the facilities available in Dublin for drug abusers were not serving a very useful purpose for the type of user who ends up in prison. It also says that this is primarily because of the users lack of motivation and lack of commitment to breaking their habits.

It states that it would not be true to say that these women totally lacked the motivation to give up drugs. They did not have a delusion of control over their habits. On the contrary, they were dispirited and considered that their lives were in disarray and out of their control. In this situation drugs offered them one of the few direct pleasures of life and escape from disorder, disappointment and pressure. At the same time, in part at least, they were appalled at the situation they had got into and sincerely desired a return

to 'normality'.

(It is interesting to us that only the women ***were*** *asked about emotional attachment to their children. Eds.)*

> *But prison is no place for a junkie, they have too much time to think, too much* ***time to*** *feel sorry for themselves. And when I think of all the children that start off the same way as me I wish I could stop them and help them. Maybe they wouldn't listen to me, maybe they would. I know no one could talk to me, but not very many people tried to help, they only tried to force me which I didn't like. If you're being forced to do something you won't do it. Only if you feel that you want to do it yourself. Maybe that's why I didn't go to Coolmine cause I was being forced. But I know one thing for sure, please God will help me to do it, I am going to go straight when I get out of here because I don't want to be in hell. I don't want to kill myself, I want to live a normal decent life like some people do.*

Joe Lee

HELP!

TREATMENT CENTRES AND SELF-HELP GROUPS

A community worker reflects on working with users.

It is Accepted that the rehabilitation of drug users is a complex and lengthy process, involving high levels of staffing and demanding an extremely high level of commitment from the drug user and the worker.

As many workers have not been drug users/dependents themselves, users can often claim that its impossible for the worker to understand the situation. Naturally, full understanding is not possible, but this does not prevent the skilled worker from being effective. It can also be reassuring for the user to know that s/he shares many common hassles with people who have never been drug dependent — creating a more realistic environment within which a drug free life can be realised.

However, workers who have never been involved in a drug scene must learn to appreciate that this is a meaningful lifestyle to many users: the 'hustle' presenting an exciting challenge — the alternative often being boredom and unemployment. It is not enough for the worker to assume that the dependence is purely physical, otherwise s/he will not understand what heroin means to the user.

As workers go through the process of trying to enter into the drug users lifestyle they also run the risk of becom-

ing too emotionally involved with users. Apart from the practical aspect that this will drain the workers energies, it also means that the user may not gain responsibility/ control for his/her life. Users must learn to make their own choices in a drug free life. For some this could mean going back on drugs because they are not ready. This can be devastating to a worker who feels that s/he has placed so much energy into working with a particular drug user — but we need to allow users the freedom to make that decision. It is very painful to have to watch someone return to a life that one feels will eventually destroy the person, but the drug-user must make the decision, not the worker.

Many people who work with drug users probably end up feeling that their entire lives circulate around drugs — this can lead to difficulties in the workers personal/social life – yet obviously one can't expect to work a regular eight hour day. It means finding the thin line between care/ concern and that amount of detachment which allows you to see your work more clearly and will enable you to switch off when necessary. This possibly sounds extremely negative — its not meant to, but when one works in a situation which can often result in casualty the emotional strain is high.

Workers can often feel manipulated, cheated, worn-out and that their job is a thankless one. Its important that these feelings be recognised as they occur and be dealt with promptly otherwise it could be the drug-users who end up suffering. Workers need to be aware of the strain on their lives and cope with it, otherwise they might forget the privilege which is theirs, could stop seeing the bright/funny side of so many of the happenings each day and begin to forget that they are working with people.

.....the effect was uncanny. You would see him one time a fresh-faced kid. A week or so later he would turn up so thin, sallow and old-looking, you would have to look twice to recognise him.

Going for a detox seemed an easy way out - free drugs and all that. I wasn't really serious about it. The doctors said: "You know, you're an addict" and I said "No, no I'm not, I can give up drugs if I want". After two detoxes the doctor brought up going to a treatment centre. I'd heard about them, and I didn't want to go for treatment. After the third detox I said I'd think about it. When I came out I thought I'd try to give up the drugs, so I went drinking'instead. I was drinking for a week or so and one night I just said ah...forget it...I went back on the drugs and I felt I was finished. I went to town on every drug. I thought I was just going to burn myself out. I didn't see myself as a hero or anything like that. When I was younger I used to think it would be great to die young... like James Dean or Jim Morrison. But I wasn't like that. I resigned myself to the fact I was finished. My consumption doubled and I moved out of the house and just sank lower and lower.

I'm just really sick of the gear at the moment, but I like being stoned and all, I like the gear, I enjoy it, I can't give it up, you know I still have feelings every day for a £10 pack.

A while ago it was mostly diconal that was around at that time, so I started to use them, and then I used to be always taking overdoses, I wasn't trying to do myself in, I don't know what I was up to, my head was just fucked up. I left school when I was twelve, and all my mates would be going out with fellas and I wouldn 't. I was just really into myself, and then I just got into the gear. But the worst of that gear, the way it is with me, I want to get off it and I don't, if you know what I mean. I don't think I'd be able to live without it, like something would be missing. I was off it for 12 months, I was off it for 8 months, I was off it for 3 months: I'rri after getting loads of chances to get off it, and all my ma keeps saying is, you don't want to get off it, you really love your drugs. But she doesn't understand. I'm really, really into it. I know I can come of it, but I'd feel empty, there's something missing. When you're on smack it's great, you can talk to anybody, you could sit down and talk to the pope, you feel real secure and all.

.....thats the trouble, (he gear fucks your head up something terrible, you get really depressed, but still at the same time it's great.....

ANA LIFFEY PROJECT

Basement, 13 Lower Abbey St, Dublin 1.

This was written by Anna Liffey Project workers.

The Ana Liffey Project began in 1982 as a response to what was seen to be the needs of a growing number of heroin users. The aims of the project are quite clear; to accompany and facilitate users in their attempts to lead drug-free lives; to show that we are a drug using society, that it produces drug-users and therefore it has a responsibility to them.

The project has had to survive mainly on contributions from the private business sector, church bodies and concerned individuals. In the autumn of 1983 we acquired our premises in the basement of the Salvation Army building in Lr. Abbey St., and it is there that the day programme operates. This is available to people who are going through detoxification or who have already completed one. People are referred through Jervis St. hospital, the Probation Service, social workers, or self-referred. At the beginning there is an assessment period which usually lasts for a week, it can be longer if the person is going through detoxification. After this time the person then draws up a contract, mutual agreement between him/herself and a staff member. We recognise the freedom of the drug user to break the contract and return at a later stage to negotiate a new one. The staff are similarly free, responding to the drug user and supporting him/her throughout the course of the contract.

When an agreement has been reached, the person then joins the full programme. The core of this is group work, this is where a number of ex-users meet to share and talk about the difficulties in remaining drug-free. Often a major problem is lonliness because often ex-users find that in order to remain drug-free they have to stop hanging around with the friends who are still using. Thus, the ex-user is not only giving up a drug dependency, but may have to change his/her lifestyle also. This leads to pressures which need to be expressed with people who will understand.

The centre also offers creative and physical pastimes. The creative activities are used to enable people to develop methods of self-expression which may be new to them.

These include dance, art, craftwork and literacy. These help people to come to terms with their emotions in a positive way. Physical activities help people to be in touch with their own bodies and to achieve a degree of healthiness. They also replace, to some extent, the busy and challenging activities of a drug-users lifestyle. Both men and women are encouraged to take responsibility for the various needs of the centre, such as cooking and cleaning.

A major problem facing someone who goes through detoxification is the amount of spare time one has — we try to fill this with enjoyable, creative and challenging moments. People need intensive support for a long time after detoxification and this had not been available outside of a residential setting. Ex-users must recognise that undertaking responsibility for their own lives is crucial if they are going to remain drug-free. We encourage any motive a person may have to remain drug-free. We help them to understand their problem areas so they can devise their own solutions. Through this we hope that they will feel a growing sense of responsibility for themselves and others. Dnig users are often marginalised and the life they build after they come off drugs will not always be mainstream culture. It is not our aim to push ex-users into normal society or make them buy its values. The life they discover is their own achievement.

The initial period of fitting into the life of the centre is the most difficult time for many people, during this time pressures from the street are felt most strongly. There are internal pressures of wanting to go back to a life that was exciting, and pressure from friends and other users. To stay off drugs demands a supreme effort of will. This is the time that the ex-users need to examine themselves very closely because in this way they can begin to make positive decisions and organise priorities in their lives. Ex-users who have had to be deceptive will find this task of honest self-evaluation difficult at first. This is why a comfortable, trusting environment is necessary for this vital step to be taken. The most powerful force working for the ex-users is his/her own motivation to succeed. £n a residential setting the person is protected from the pressures of their home environment but in a day centre everyone must be aware of the difficult-

ies of changing their values in the face of criticism. As the men and women progress through the programme they can act as examples to those attending for the first time. This enables those who have been here for a while to guage their own progress and to develop, in a concrete way. responsibility for others.

The staff, like those who use the centre, come from all over the city, roughly half are women. Because of the nature of the work the staff go through a continual process of self-development, and develop skills in certain areas. The centre, combined with the work of two street-workers, offers a wide-ranging service. We would like to see more centres of this sort being set up to meet the growing needs of substance-dependent people.

COOLMINE THERAPEUTIC COMMUNITY

Coolmine, Clonsilla, Co. Dublin.

Coolmine is the longest established, most well known and best funded drug rehabilitation centre in Ireland. Their assessment and induction centre is in Lord Edward Street, Dublin. The community itself is based in Coolmine Lodge in Clonsilla and St. Martha's in Navan where they run an 18-month residential intensive rehabilitation course. Although we approached them on numerous occasions during the 6 months research period of this book we have not managed to obtain any detailed information on the form their programme takes. This is unfortunate as it leaves a gap in the treatment chapter on what help is available for drug abusers.

JERVIS STREET DRUG ADVISORY CENTRE (DUBLIN)

Jervis Street, Dublin I

The Jervis St. Drug Advisory Centre is the main medical centre in the country for treating drug use. It provides a detoxification service, a counselling service, a referral service and a liaison service with local community care and Health Board workers.

Any drug user who wishes to become drug-free can seek

a detoxification at the Hospital. Detoxification means the gradual withdrawal from the body of the drug used. The main drugs that detox is used for are heroin, synthetic opiates (like diconal, palfium) and opium-containing drugs. Users of valium and other tranquillisers also go through detox but unlike that for the opiates, valium detox uses no substitutes, simply the dosages are cut down bit by bit. For the opiate detox methadone, which is itself a synthetic opiate, is used.

The sudden withdrawal of an opium-based drug leads to severe "withdrawal" symptoms —cramps, convulsions, nausea etc. and to avoid these Methadone is given. Methadone was chosen because while preventing the body from suffering withdrawal symptoms it does not produce the euphoric (happy-making) feeling of their usual drug, and also the dose lasts up to 24 hours. Detoxification is a two-sided procedure. Its aim is to lessen and then end the *physical* need for drugs and to begin over-coming the *psychological* dependency on them. Learning to live without the 'high' is a necessary part of coping with psychological dependency.

Each patient who goes to Jervis St. is assessed. Assessment is used to measure the patients' desire and motivation to be drug-free. Some users see methadone as another drug which is free and easily available on a detox programme. Some see detox as a way of rebuilding broken health and getting them fit for further drug-use. Detoxification is refused if staff feel that a patient is likely to abuse the programme. Patients who have been detoxed previously but did not succeed in remaining drug-free will be given another chance, again depending on their wish to break the habit. Some patients go through 4 or 5 detoxes before they finally maii^ age to live without drugs. Some, no matter how many they have been through never succeed in breaking the habit.

A medical examination is carried out on each patient to determine any physical damage that has resulted from drug use. The psychologist will see the pre-teens of up to 16 or 17 years or anyone who has a history of mental illness.

The quantity of methadone given on a detox programme depends on the physical needs of the patient. Opiates have to be withdrawn very slowly. Methadone is given orally in order to break the user's habit of mainlining or skin-

popping or dropping tablets. The amount of methadone given is reduced every second day until the patient is drug-free. The length of the programme depends on the patient's previous drug habit.

A urine sample must be given on each visit. If the patient has used any other drug this will show up in the urine test and staff can then decide if the patient should be put off the programme or not.

During the detox programme patients are counselled to seek other help as well. Some go to the live-in Centres like Coolmine or the Rutland Centre when their detox is completed. Some attend day centres such as the Ana Liffey, Talbot or Donore Avenue, and some attend Narcotics Anonymous meetings.

The in-patient service in Jervis St. which consists of only 9 beds is used for those who have developed hepatitis or some other illness as a result of drug use. Patients who are not in a state of collapse rarely choose in-patient treatment. Many former users attend the out-patient centre regularly over a long period of time for the monitoring of physical weaknesses (usually to the liver) that has resulted from a drug habit.

MATER DEI

Clonliffe Road, Dublin 3.

In 1972 the Mater Dei Institute set up a Career Guidance training course and their involvement in counselling addicted young people came about directly as a result of the feedback they got from students off the course doing practical work in the schools. Mater Dei deals with children in the eleven to eighteen year old group.

It soon became clear that many children had family and social problems, as well as the problem of career choice and counsellors began to find children experimenting with drugs. Many of them were using cannabis and/or pills, taken from their parents medicine cabinets. They are not yet in contact with children using heroin. Most of the young people are only 'dabbling' , as yet, in other drugs.

Mater Dei chief psychologist is Dr. Kelly from Jems Street Drugs Advisory Centre, and children are referred by

the counsellors to Jervis Street and vice versa. The service offered by Mater Dei is counselling in both individual and group sessions. Unless the young person concerned particularly objects, Mater Dei also contact and counsel the parents and try to link them into the progress of the child. They have found that often there is only very limited communication between the parents and the child. Many of the parents were not aware their daughters or sons were using drugs. Interestingly they find nowadays that there is a higher level of help and support from the fathers of users than there was in the past.

Separate programmes are worked out for each of the young people to suit their needs. Usually they begin with individual sessions and work towards joining the group sessions. The group sessions are used as much to learn social skills (how to communicate, share ideas etc.) as to reaching an understanding of their own personal problems.

Sometimes they find that very shy or withdrawn youngsters experience great difficulties in speaking out at the group sessions. *It's almost as if they don't believe they can speak at all* — to quote a counseller from the institute. To overcome this they improvise projects which involve speaking into a tape recorder or video camera to 'prove' to them that they can speak or sing or whatever.

The young persons' progress is monitored through Mater Dei's network of career guidance officers in the schools. Their teachers are asked to take notice of and comment favourably on any improvement they show. This is an important part of the programme, as very often if recognition is not given to the extra effort being made by the young^ person, s/he feels all the work is a waste of time and lose heart.

Like many of the other groups involved in trying to help people stop using drugs, the Mater Dei workers believe that simply giving information on drugs is not enough. Indeed they question whether there is much point in doing this at all. Often this information is either ignored or disbelieved, particularly by teenagers and schoolchildren.

Teenagers and schoolchildren watch their parents use their own drugs like alcohol or valium or cigarettes and are very aware of the double standards the parents try to

impose: "Its alright for me, but not for you". Like others, Mater Dei believe that living in a society where adults use (and abuse) "legal" drugs so freely sets the stage for youngsters to experiment with legal and illegal drugs. What is needed is a whole change of attitude towards *all* drug use.

NARCOTICS ANONYMOUS

P O Box 1368, Sheriff Street, Dublin 1

N.A. stands for Narcotics Anonymous. Part of their charter is that they cannot advertise themselves in any way. For this reason we found an N.A. member who told us how N.A. operates. There is no doubt that this organisation has helped keep drug-users what they call "clean" i.e. drug free. Below is his account of how the organisation works, together with parts of his own story of addiction.

"NA originated in America, its very big there. Two years ago there were 2 meetings in Dublin, now there's 18. NA exists in Drogheda, Belfast, Limerick, Wexford and Dublin, its spreading all the time. I don't know who started off the first meeting, but it was an addict. The people who organise the meetings are all recovering addicts. NA is completely self-supporting. We have to pay rent. There's a hat passed around at the end of every meeting. If you have something fine....if you don't it doesn't matter. We usually get the rent. Its in the tradition of NA that we decline outside help.

At NA meetings there are people addicted to all sorts of drugs, tranquillisers, mood-altering drugs, valium, dike etc. We have people who are cross-addicted, very heavily into drink and drugs. We've glue sniffers too, or it could be a psychological addiction like smoking hash. The youngest we have is 16, but if anyone younger wants to come they can. I found there's great support, great help and love. People just rally round when you come in. You can say what you want to say — nobody's going to put you down, and nobody would reject you. Its very open and honest.

A typical meeting would be people gathered together in a room, we start with coffee and a chat. When the meeting starts there is someone to do the chair — they talk for say 20 minutes about whatever they want — their life, recovery today,

experiences. A secretary runs every meeting and they arrange for someone to speak. There are meetings in Dublin nightly.

Its all about change. Change of behaviour, attitudes and thinking. Trying to become positive and to like yourself as well. I still don't like myself really. My self-esteem went very low when I was using because of the things I was doing. I was completely closed off and isolated for years. I'd become really devious and narrow-minded. If anyone came near me or got close to me, I sort of backed off. Now I'm opening up. I'm just trying to live my life today without doing things, like robbing or hurting people, whether physically assaulting them or having resentments against them. I wouldn't like to think where I'd be today without support from NA. If I miss 3 or 4 meetings in a row I find my thinking goes a bit off the wall: my addiction comes back up. I start thinking I'd be able to do this or that, have a drink, pull a stroke.... Some days now I feel content tho I do have bad patches like everyone else. I'm coping with those now without drugs. I don't drink, it would lead me back. At the start I was getting a compulsion to use heroin, now I find the odd craving I get is for drink, but if I went back drinking I know I'd end up using heroin again. There are situations that come up where before I would have just escaped into drugs. I can't do it today. I have to face up to these situations. I talk to people about things as they come up. If I'm feeling low or a situation arises there are always people there, NA people to talk to. During the day I used to keep in touch with NA people, they had given me their phone numbers and they said don't hesitate to ring. They recommend you goto as many meetings as you can for the first few months to help you through, 'cos it's a rough time that first few months.

When I first started going to NA meetings I didn't notice anything at the start. I didn't think I was getting anything out of them but it did something for me — I was keeping off drugs one day at a time. If I experience a problem most of the other people have already gone through it and know how I'm feeling.

I had been taking drugs for 6 or 7 years. I started with drink when I was around 14 to 15. From the start I drank to get drunk, not just to be sociable. We used to take drink from the house, spirits. My parents didn't notice or say anything.

I was going on 16 and one of my friends was smoking hash so I started smoking with him. There was another friend at school whose father was a doctor. His father had baskets full of sample drugs from various drug companies. There's a directory which tells you what each drug contains, so anything that looked good we'd take it. Some of the time we got nothing out of it, other times we got sick and other times we got out of our heads. I didn't see anything wrong with it.

I was going to the university bar every night as well and there was every drug you could want there. You had to pay for it though. I was robbing the money from home, from anywhere, or borrowing. I was mitching school. I was under a lot of pressure to do well at school. Things started to go wrong at home and I started rowing a lot with my family. My father was very strict in my upbringing. I didn't normally go home When I was out of my head.

Then I found I couldn't enjoy myself any more without drugs. It was a bit of a shock to me. I was bored, and it seemed life without drugs wasn't fun any more. I went on using them and before my 18th birthday it was heroin. I tried it, I snorted it and I fell in love with it. It became the drug I took. The effect, the hit, I got off it seemed to be what I'd been looking for. I channelled all my energies after that into getting heroin. I was taking it about 2 months when I left school. I failed my leaving and it didn't bother me. It bothered them a lot at home. I got a series of jobs and all my wages went on buying heroin. I lived at home and my family fed me. They never threw me out or asked me to leave. They're religious, devout catholics the pair of them, and had this idea that it wouldn't be a very Christian thing to do to throw me out on the street. They had a very rough time too. They should have thrown me out, maybe I'd have faced up to things sooner, I don't know.

When I was 19 I was in a job and started fiddling from the job to support my habit. I had enough money from the job and the fiddle to keep myself going - £30 a day. If I'd had £100 I'd have spent it.

There were people around the area selling from their own houses, most of them were unemployed and most of them were using themselves. They didn't make any money, just supported their own habits. They dealt in small amounts,

£10 packs, a few grams at a time. When I was using if anyone made an effort to give up we used to hate it because it would be leaving you there. I'd feel relieved if they came back and started using again. So there is group pressure.

All my friends were users as well. A group of 6 to 8 of us, we all went along at the same pace. It's funny a lot of us ended up looking for help at the same time too. Today I'm living without drugs. Now I'm in NA and I'm a lot happier now and I don't want to lose what I have today. What I've gained is too precious to throw away. I'm learning more about addiction. If I was to go back using I'd know exactly what I was letting myself in for.

RUTLAND CENTRE LTD.

Knocklyon House, Knocklyon Rd, Templeogue, Dublin.

The Rutland Centre is a drug-free community specializing in the treatment of alcohol and drug dependency. The Centre was officially opened in May 1978 and has the support of the Dept. of Health and the Eastern Health Board. It has facilities for 27 in-patients and takes people from any area of the country. 20% of the beds are allocated to drug users. The Centre treats both women and men over the age of 18 years and the majority of -irug patients so far have been in their early twenties. Over the past number of years the ratio of men to women has been approx. 4 to 1. The treatment programme is residential and the average patient-stay is about 6 weeks.

Referral: The Centre takes referrals from many sources, including psychiatrists, G.Ps, social workers, psychologists, clergy, Alcoholics Anonymous, employers and family members. A prospective client is asked to be drug and alcohol-free under medical supervision for 24 hours before the first assessment. In some cases, local medical or psychiatric services will have carried out detoxification on the client before this first interview.

An immediate family member or other 'concerned person' is asked to come with the client and assist in the first interview by providing extra information. If a decision to offer treatment is made, the client is referred to the

National Drug Advisory Centre in Jervis St. hospital where detoxification is undertaken when a bed becomes available. After completion of detox no psychoactive (mood-changing) drugs are used during treatment because of their potentially addictive properties.

On return from Jems St. hospital, the client goes through psychological assessment. On completion they are assigned to a staff team and therapy group and begin in-patient treatment.

Treatment: Treatment at the Rutland Centre looks at the nature of addiction and its harmful consequences for the user and his/her family. Treatment is designed to help clients to learn to cope with their lives free of alcohol and mood-altering chemicals.

The programme consists of daily lectures and films on alcoholism and other dependencies, intensive group-therapy, individual counselling, family treatment and routine medical examination. The Centre's team consists of a consultant psychiatrist, addiction counsellors, doctors, nurses, psychologists and social workers. The Centre actively promotes client involvement in Alcoholics Anonymous, Al-Anon. Al-Ateen, Narcotics Anonymous and Gamblers' Anonymous. Narcotics Anonymous hold meetings at the Centre once a week and residents attend them.

Family Counselling: Participation of the client's family and other people special to them in the treatment process is encouraged. 'Concerned persons' are seen as being personally affected by living close to the user and as sources of vital information on alcohol/drug-use and linked behaviour. This involvement by others during therapy helps to weaken the client's defence mechanisms which have developed to protect their addiction. In addition there is emphasis on improvement in communication among family members.

There is a 'Family Day' at the Centre once a week and treatment, consisting of lectures and joint therapy involving the patient and concerned persons, goes on all day. There is also group therapy for close relatives and friends one evening a week. During the post-treatment recovery period Family Therapy is available for those with difficulties.

Aftercare: Aftercare is available for up to two years after-

wards and involves weekly group therapy, individual counselling, and family therapy when needed. Continual involvement with the fellowships of Alcoholics Anonymous, Narcotics Anonymous and other self-help programmes is also recommended as a basis for the establishment of a sober or clean way of life.

Research: The Rutland Centre is committed to ongoing research to monitor the efficiency of its treament programmes and to contribute to the understanding of the effects of dependency on both the client and concerned persons.

THE TALBOT CENTRE

The Talbot Day Centre, at 26 Upper Sherrard Street, Dublin 1, was set up by the Eastern Health Board in response to requests made by a local committee. They were concerned by the rapid increase in the number of young people in their area abusing drugs, and the lack of follow-up treatment facilities for them in the community.

Perhaps because of this, the Talbot Centre is very much 'member-based'. This means that members (those attending the Centre) themselves play an important part in deciding how it is run. Members don't just help in the cleaning, cooking etc. (which the staff also do), but they also help work out how the weekly budget will be spent and met, disciplinary procedures etc.

The centre opened on the 24th May, 1983, and currently has a staff which includes a project leader, two project workers, a secretary/receptionist and an attendant. It has developed links with other agencies working in the field of addiction, and has people from these attending the centre on an occasional basis, as and when necessary. These include a teacher, a social science student, a counsellor specialising in chemical dependency, a clinical psychologist, a representative from Narcotics Anonymous and probation officers.

The age of the members of the Centre covers the 13 to 18 age group.

Group work is a very important feature of the way the Talbot Centre is run. There are brief daily morning meetings to divide up tasks, arrange activities etc. Then

there are two formal group meetings. The weekends are always testing times for the members, temptation to use drugs etc. have to be met out of their own resources and these formal meetings gear them up to cope and then see how they did. During the week there are also formal and informal one-to-one meetings, each member has a particular staff-member they are responsible to and any problems they meet which aren't thrashed out at the group meetings can be gone into on this more private and personal one to one fashion. All these meetings are to build up the users ability to cope and take responsibility for their own lives. Each member and staff can also call emergency group meetings at any time if they feel its necessary. All these meetings help build up the close relationship between staff and members. All progress is mentioned and evaluated continually by both staff and members as each person has a very exact and thorough knowledge of whats going on. The outreach worker has 2 meetings a week in the prisons with past and prospective members so that contact and interest is either kept up or begun.

The general aim of the programme is to provide a balanced mixture of learning experiences. These include life and social skills to help the members learn about themselves and their potential, one to one relationships, relationships with groups of people, and skills to use in the community. Examples of skills would be to cope with stress, set and achieve goals, manage their own sexuality, how to seek out information and resources, how to make, keep and end relationships, how to give and get help, develop and use political awareness, their legal, social and educational rights and learning the history, economics, resources and possibilities of their own community.

Learning technical skills has been somewhat hampered by the size of the building they operate from, though the scope of these will increase when they move into the bigger building which is now being prepared for them. So far they do reading and writing, history, woodwork, maths, photography and developing film, art, block making, macrame etc. It is entirely up to the members to decide what they want to study. The teacher involves them directly in planning the programme. Outings are arranged for basketball.

bowling, swimming, the cinema, the zoo (they keep rabbits in the back-yard) museums etc. One member is now sitting for his inter exam.

The Talbot Centre runs twice weekly counselling sessions with pregnant girls who have been using illicit drugs. This is a new departure for them and girls who are not members of the centre can attend as well. These sessions give the girls straight factual information on pregnancy, childbirth, child rearing etc. as well as helping them to help themselves to cope with their situation and its implications for their lives.

Because it is a day-time centre the staff actively seek to involve either the parents or another caring person close to each member in that member's programme and progress. The parents or caring person have a vital part to play in the recovery of the members. Frequent home visits are made by staff members to help the parents continue the work of the Centre. A pre-condition of acceptance of any new member is that each of them has a person who will play this part in his or her programme. Regular fortnightly meetings are held to discuss any problems that arise.

The group counselling sessions held for the members twice a week are divided into younger and older groups partly because the younger members are less involved in drugs than the older ones and partly because each age group has its own needs and difficulties.

Users and their families can approach the Centre themselves and others are referred there by Jervis Street Drugs Advisory Centre, the probation or other government agencies.

The Talbot Centre will be moving to 29 Upper Buckingham Street, Dublin 1 in the near future where they will have considerably more space to enlarge their facilities and the number of people they can take on to the programme.

TRANX RELEASE

P.O. Box No. 1378, Sherriff St, Dublin 1.

Tranx Release is a support group for tranquilliser-users who wish to give them up. Tranquillisers (tranx), though 'legal' drugs are just as addictive for many people as heroin and the other opiate drugs. And because they are

seen as an easy option they are prescribed more often and for a greater number of people than the hard drugs.

Tranx Release was started in May 1983. The founder member was a tranx-user for 20 yeaes. She was said to be suffering from endogenous (inherited) depression and spent weeks and months in psychiatric hospitals during those 20 years. Her addiction to tranx and sleeping pills was total until she became part of a recovery programme. The programme was run by an ex-user who knew and understood what she was experiencing during her recovery.

There are up to 100,000 Irish women and men using tranquillisers. Up to 50 million pills are consumed annually at a cost of approximately £12 million. In 1977 tranx supplanted antibiotics as the most commonly prescribed drugs in Ireland.

Only a small percentage of users are in their teens for the simple reason that they are less likely than older people to go to doctors when they have problems.

Many tranx-users do not see themselves as drug users. To them the drug user is the criminal teenager on the streets who is 'into' heroin and other opiates. Because they refuse to recognise the fact that, along with heavy alcohol users, they make up the majority of addicts in the country, it is more difficult for them to come to terms with their addiction.

Not everyone using tranx becomes physically dependent on them, but many people do. Steady use over as little as 14 days can cause physical dependency. If they are used constantly over a few months and the supply is then stopped or one decides to give them up, withdrawal symptoms can set in within 48 hours of last taking them. The user can experience sweating, nausea, panic attacks, restlessness, feelings of unreality, loss of balance, poor appetite — in other words something akin to withdrawal symptoms from opiates. It can take anything from 3 months to 2 years to be fully detoxed from tranx.

Psychological dependency is always present if a person continues to use tranx over any length of time. Those on low daily doses are just as dependent as those on higher doses. The dependency is not determined by the amount that is used but rather by the felt need to use them.

Panic and stress are the prime factors behind the use of

tranx. If someone tries to break the habit they soon realise that the conditions that drove them to tranx in the first place have not changed. Tranx don't help anyone solve problems or make it possible to face them; using them just suppresses potential for coping with the situation.

YOUTH ACTION PROJECT

la Balcurris Road. Bally mun, Dublin.

The Youth Action Project was formed in March 1981. in response to three successive young deaths in Ballymun late in 1980. It is a community based, voluntary group, believing that drug abuse needs a response from within the community. The base of that response was laid during the last three years, providing an advice and information centre for drug abusers and/or family members and friends: also developing a community education programme, which has taken shape by: —

a) a parent-effectiveness training course, for parents and teenagers;

b) a course for youth leaders and guidance counsellors, on the nature of addiction and responding to it;

c) lately, four public awareness meetings, to encourage thought on how families and communities respond to members with a drug problem, and look at how those responses could change;

d) planning is in progress to provide a course for workers in the area, to help them develop more effective responses to drug related problems.

Links have been formed with other groups in the area, and with Jervis Street Drugs Advisory Clinic, Coolmine Lodge, and contact is maintained with other community drugs responses. Representation has repeatedly been made for funding for full time staff, particularly a coordinator, but to date this has not been definitely responded to. From scarce resources, a counsellor has been retained on occasions, to assist in the planning and implementation of developments.

Without full time staff, the project cannot develop into a daily service for those coming off drugs, and their families, and strengthen the links already made. Through

recovery of addicts and their families, it is hoped that alternatives will emerge, for them and for the community, thus sustaining a drug-free life.

The Project has also applied for larger premises to be made available in Ballymun, to operate a programme which would include group meetings, developing workshops, assessing individual needs, etc. Hope is high that convenient premises will be made available to the Project, to build on the work already done in Ballymun.

Services presently available are: Advice and Information Centre. Volunteers Group (a meeting for new volunteers from the community).

The following self help, autonomous, groups meet in the premises in 1A Balcurris Road, and it is with pleasure they have been welcomed to Ballymun:

Narcotics Anonymous (a self help meeting for those with drug problems)

Families Anonymous (a self help meeting for families of drug abusers).

The Youth Action Project has now become the recognised service for drug related problems in the area, and future developments are keenly anticipated.

YOUTH DEVELOPMENT PROJECT

Donore Avenue, Dublin 8.

At present the Teresas Gardens Youth Development Project caters for young people from the Gardens or immediately surrounding areas. Initially it was intended that a larger centre would be opened to cater for the whole of Dublin 8 area. These plans have been very slow in materialising due to the lack of funding and official commitment so it was decided to go ahead and begin in the buildings which belong to the Teresas Gardens Committee. At the moment they haven't got facilities to expand at all, but the Centre is very much part of the Community. In the long term it is envisaged that the Youth Development Project will move to Weaver Square, where its programme of education and youth development will be more intensive and will cover a wider geographical area. Staff at the youth

development project consist of a project leader and two other project workers, one of whom is a counsellor. There are provisions for a fourth worker. The project is being run for a minimum of 3 years and a maximum of 5 by the Eastern Health Board. They see their present programme as having four distinct phases:

1. To make contact with local users, arrange a detox programme for them, monitor their progress and assess it, done with intense family and parental involvement.

2. Post-detox plan which will continue to monitor progress and work out an individualised rehabilitation programme. Some will go to the Coolmine Therapeutic Community or the Rutland Centre. For those who do not wish to go into an institution they will arrange counselling, encourage parental involvement and put the user in touch with Narcotics Anonymous.

3. Rehabilitation plans are designed for individuals on their motives, commitment and level of addiction. For some well motivated persons, rehabilitation may continue through regular attendance of Centre for counselling and/or participation in other youth programmes.

4. The fourth stage in the Centre's Youth Development Programme. This is where young people with problems of addiction, or who live in families with such problems are given the opportunity to become fully involved in the life of the community througli organising and developing local activities.

The Centre is in contact with a video group — City Vision — and made a video on work in the area. This is a pilot project and is intended for use as information on the area. City Vision taught the young people working on the film how to use the video equipment. The script of the 20 minute video was written by locals. They also worked with an art teacher who does mural paintings and painted the sets for the video. City Vision filmed the recent opening of the Centre and they will be making an edited video of this soon. The young people are involved in running clubs, discos and holiday activities for the kids of the area. They also look after fund-raising ventures. In many ways they

became the working force **for** the local development committee. This is where the co-operation between the EHB Project and local development committee is crucially important. It is where EHB staff and development committee work jointly in local development. In many ways community action and development becomes a form of therapy.

The development committee put a lot of effort into developing its own resources, seeing this as being vital for long term development. It employs a full-time community worker and it has the services of a part-time teacher and a part-time community artist. It also employs five young people as youth workers on **a** Temporary Youth Employment scheme, under the supervision of a groups leader.

A local man is attending a dnigs course in Trinity college in Dublin and is funded by a youth employment agency grant for 6 months. The YEA grant was made to the Teresas Gardens committee and they decided to invest it in this way. The course includes counselling and group-work skills, family intervention etc. and is the first of its kind in Ireland.

There is a local newspaper called The Gardens, written and produced locally and working on this would also be part of stage 4 in the rehabilitation process.

The local probation officer sits in the Centre every Thursday and efforts are made to support probationers on minor infringements.

Those in the Centre say there are now no under-18 years old users in the Gardens any more. This is due to work done over the past 3 years in getting young users involved in the community and away from drugs. They say there are only about 11 users altogether left in the Gardens.

They are now preparing to do a study of drug use in the area and a profile of local users. They have not yet decided who to approach for funding. They did not take part in the 1982-3 Medical-Social Research Board report on drug use because they felt the area had already suffered from a lot of bad publicity and they didn't want to add to this. When they saw the bad publicity the North Inner City suffered as a result of the Report they were glad they had nothing to do with it. They also say the money which was available 2 years ago to start **a** Centre was turned down by them because they felt they were not readv to operate it

effectively. They say that due to the local work that has been done by the voluntary committee over the last 3 years a huge psychological change has come about in the area and families are now beginning to move back in again. They help those who want to come back by contacting the Housing Dept. of the Corporation for them. They believe that the anti-pusher campaign did so well because, though it began spontaneously, there were local organisations to back it up.

On the 9th of April Barry Desmond. Minister of Health, officially opened the Centre. He also promised the Committee that they could have the bigger premises which had previously been planned.

However, local people are still very sceptical of Health Board and Departmental Officials and they will not accept that the Minister is sincere about his commitment until work actually commences on renovating the new centre. This has not, as of yet, happened.

WOMEN TOWARDS RECOVERY

A new counselling service, offered by women, for women. They are trained and experienced alcoholism counsellors: they offer alcoholic women individual counselling, group work, and education about their alcoholism and recovery. They will help women put their recovery in the whole context of being a woman, assisting in the difficulties which many alcoholic women have in seeing themselves as, separate, autonomous individuals, rather than developing identities based entirely upon their relationships with others.

Further information: Liz Roche 551639

Derek Spiers (Report)

'We've Had It Up To Here'

COMMUNITY RESPONSE

CONCERNED PARENTS AGAINST DRUGS ACTION GROUP

Written by Willie Martin, a voluntary community worker in St. Teresa 's Gardens, Dublin 8.

'Pushers Out', 'Pushers Out '. Most people in Dublin know the battle cry of The Concerned Parents Against Drugs Action Group. It is not a cry of vigilantes on the warpath as the media would have everyone believe. It is a cry of mothers and fathers who have lost sons and daughters to heroin. It is also a cry of humanity and a plea to the leaders of that humanity to intercede on their behalf. A cry that time and time again has fallen on deaf ears - that is until one summer's day in 1983 that cry from the hearts of the people was heard by the people, and justice was seen to be done. By that summer of 1983, the use of heroin had reached epidemic proportion in the city of Dublin. St. Teresas Gardens was one of the worst affected areas. It was estimated that over 200 junkies a week were getting their supply of heroin in St. Teresas Gardens. The flats were in a constant upheaval of vomit, urine, blood and overdoses. Many of the junkies were so badly in need of a vein to fix into that they pulled down their pants and searched through their lower parts, not giving a damn about the children who would be passing up

and down the stairs. In short, the situation was totally out of control.

As a community worker at the time. I and my colleagues on the Teresas Gardens Development Committee were long aware of the problems. For years we had been struggling to alleviate the problem but **with** little success. It was not our fault. We had approached all the right people — Ministers for Health, T.D.'s, Corporation officials and the police. Nobody took us seriously. They implied that it there was a drug problem wouldn't they be the first to know about it.

In 1980 one far-seeing social worker wrote to the then minister for health, T.D/s, corporation officials and the drug abuse centre. She was flatly refused. Undeterred, my colleagues and I carried on. We ran dances, summer projects, formed boys and girls clubs in an effort to defeat the problem. With the under 14-year old age group, this worked very well. But once they passed the 14-years age group there was very little in the way of community activities. Some turned to drugs then, out of complete boredom. Others played follow-the-leader, not realising just what they were getting themselves into. For a few pounds they could have a whole new make-believe world of their own.

Although we had only a small percentage of addicts in the flats, when added to the hundred or more from outside the area, our problems tripled. Muggings and break-ins were the order of the day. It was a most frustrating time for myself and my colleagues. Here we were, putting in hour after hour for months on end trying to get a grip on the problems, and each day we were seeing the problems worsen.

What we needed was a good youth development scheme and a Drug Centre. But as no-one would believe we had a problem, there was no place to get money to implement such a scheme. It was like banging one's head off a brick wall. I personally believed that a good majority of the youth population would die drug-related deaths. I'm sure a few did. Back in the summer project of 1978 I had seen children of 12 and 13 years of age being adventurous, fun-loving and mischievously full of life. Now here I was in the summer of 1983 seeing some of those very same youngsters dejected and broken. Totally lost to a bit of powder that one had to look hard to see in one's hand. Like a lot of community

workers in Dublin. I was mad, so mad I could smell blood. My community was stagnating in a pool of heroin. Addicts were getting younger. There seemed to be no light at the end of the tunnel.

Then one evening while distributing leaflets advertising a forthcoming meeting on maintenance and police harassment around the flats, three young, married women approached me and asked me to get a meeting, together on drugs in the flats. I listened to what they had to say and then asked them if there were any more who felt as they did. They told me that there were women in each block who were trying to keep the junkies off the stairs but that they were intimidate4 by the sheer numbers of junkies, who told them in no uncertain terms what to do with themselves. They also said that some children were told to 'fuck off the stairs by junkies. Listening to the women talk, I thought 'Great, here at last was a reaction.' If more women felt as strongly as they did, then we were on our way.

The first meeting had a disappointing crowd. 20 or so women tunned up but they were nothing if not enthusiastic. Each one promised to bring a friend or neighbour to the next meeting. Meanwhile if any one of them had trouble getting junkies off the stairs, they could call on their nearest neighbours who were at the meeting to give them a helping hand. In this way the Concerned Parents Against Drugs was formed. Our next meeting was attended by over 50 parents. We set out chairs and planned our next action. It was decided to keep all the junkies off the stairs, and all outsiders who were involved with drugs out of the flats. The feeling was that we had enough junkies of our own without having to contend with outsiders from all over the city. This plan worked out very well. Parents stood on the corner of the flats and politely refused admission to the outside junkies.

At this point many of us knew that we could never solve the problem successfully unless we could get to the source of the heroin. This was the main discussion at our next meeting. The women were all for marching to the doors of the known pushers and shouting them out. The men thought it might be better to send a small delegation to each of the pushers* doors and ask them to give up selling heroin in the flats or get out. The mens' arrangement won

out and so six men set out to talk to the pushers. The meeting meanwhile carried on while we waited for the delegation to return. On their return they told the meeting that all of the pushers they had approached had promised to stop selling heroin in the flats.

This was accepted as a victory. Although we did accept the word of the pushers, we did so with a pinch of salt. We kept a close watch on their activities, realising that with the amount of money involved some would be reluctant to stop selling. This proved to be the case. Heroin continued to be sold underhandedly. We warned the pushers again and again until at our biggest meeting to date, it was decided to give them an ultimatum. They were told that they had one week to get out of the flats. This decision was not taken lightly. We realised that such a decision could have serious repercussions. Nevertheless we strengthened our resolve and carried on.

When the pushers were approached this time, the crowd stood in the background shouting 'Pushers Out', 'Pushers Out'. That was on a Monday night. That Tuesday we got word that the pushers had no intention of getting out. An emergency meeting was called with the result that the pushers were helped on their way. The media had a field-day. 'Vigilantes evict young families', was one of their nicer comments. The people who deserved praise were accused of all sorts of crimes. Even the pushers got in on the act by getting some of the parents summonsed. I felt fucking sick.

If the media wished to think that we were vigilantes, taking the law into our own hands, then let them think so. We knew better. We had lived with the problem for 4 years, day after day. What could the media know of broken fathers and mothers constantly on the verge of tears, not knowing who or where to turn to?

Those early weeks after the evictions were hard on the whole community. The men were out on patrol all night, every night. The women looked after the days, keeping the junkies out of the flats, explaining to them that there were no longer drugs in St. Teresas Gardens, eventually proclaiming a drug free zone.

When other flats saw how successful we were they soon followed our example. We gave advice and support when

needed. Dolphin House was the second area to proclaim a drug free zone. From there it escalated to its present state. The battle is yet far from over. The media still continues to try and undermine the concerned parents groups. The police still haven't gone all out against the pushers (the poor things want more power). The government and T.D.'s still haven't implemented the full and necessary drugs programme.

All of that doesn't matter. What really matters is that the communities are uniting. People are once more controlling their own lives. My community. St. Teresas Gardens, now has a drug centre, where addicts can go for the advice and counselling they so desperately needed. Many of them are now ex-addicts and are fully involved in a youth development programme. One of them is a member of my family, who at one time I didn't think would live very long. It doesn't take much to see again the way things were early last summer. I just have to close my eyes and I am transported back. Looking out of my window I can now see children playing in the gardens, adults talking and joking and I realise: yes, we have won. This is the way a community should be. Happy, carefree and, above all, united.

COMMUNITY ACTION IN THE NORTH INNER CITY OF DUBLIN

This was taken from an interview with Paddy Malone, a community worker in that area.

Heroin was introduced very cunningly and deliberately into the inner city of Dublin. First the area was 'flooded' with hash. In the pubs, pool-halls etc. there was open and massive selling, but no-one really minded because hash wasn't seen as particularly criminal or dangerous. When the pushers had introduced a sufficiently large number of youngsters to hash and to the *idea* of using drugs, a block was put on the hash and heroin, palf and dike were brought in. The local teenagers didn't know about the dangers of using heroin. Those in the 17/18 age group had reached the age when joy-riding etc. had lost its glamour and become bor-

ing. Veiy few pubs would serve them — in the pubs they would at least have been under some minimal supervision of older people. Hard drugs however could be taken just about anywhere — they saw it simply as a good turn-on, a new trend....cool....and were easily led into using it.

A couple of genuinely concerned local people became aware of the situation and approached the local V & S Group (voluntary and statutory workers). They were met with disbelief, but afterwards a local cleric from the **V** & S did a survey of his own. He then got a group together and with the help of people from Coolmine a one day seminar was held. This seminar however was intended to concentrate on hash as the problem drug. Only one of the V & S Group was aware that hash wasn't the dangerous part of the problem which all of them should have known. Only professional people were invited to the Seminar — no parents, potential users or users. Two local people, who were aware that heroin, palf and dike were the main problems tried to steer the Seminar onto these.

Another group who had become aware of the problem was the Prisoners' Rights Organisation. It had become **clear** that an ever-increasing number of men and women were going to prison for drug-related offences i.e. for robberies done to earn money to support drug habits. Though the prison authorities had introduced giving physeptone to users in 1981 for withdrawal symptoms, the Drug Treatment Unit in Dundrum Mental Hospital had been closed down: prisoners were leaving prison with their psychological habits as strong as ever. The P.R.O. held two public meetings in the north inner city to alert local people to this problem and call for the re-opening of the Drug Unit so that prisoners could have the chance of rehabilitation from drugs. About 200 people came to the meetings: they backed the P.R.O.'s recommendation and tried to arrange a meeting with the Department of Justice to discuss the matter. They were continually fobbed off however and the meeting never took place.

Six people from the seminar arranged by the local cleric then approached the Health Board and the Health Education Bureau for further information and help. The official bodies didn't believe what the local people told them and fobbed them off. The Medico-Social Research

Board was then commissioned to do an 'official" survey. However, when it came to finding users to supply the information the experts had to contact the local people again as they were the only ones who knew who was using and who wasn't. Local people agreed to co-operate on working on the survey on two conditions: 1) that the names of the users were not given because dmg-taking is a criminal offence and information on their families was very personal and 2) that they be shown the results and recommendations of the survey *before* publication. This was agreed and the only conditions made by the Health Education Board who were funding the survey was that Dr. Bradshaw, the leader of the team, personally interview 12 users picked at random, to ensure that the answers given were true. Why they imagined that the information would be falsified was never clarified. A large percentage of the users were in prison in Mountjoy (male and female). St. Patricks, Loughan House and Limerick. No locals were allowed into the prisons to carry out the survey. Dr. Bradshaw also went all the way down to Mullingar to do interviews.

After a lot of delays local people managed to get a meeting with the then Minister for Health, Michael Woods, to ask for funding for a drop-in centre in the north inner city. This was agreed and £20,000 was signed over to open the Talbot Centre in Sherrard Street. Paddy Malone believes the local people would somehow have set up a centre on their own anyway because of the problems that drug-use was causing in the area. He believes it would have been run along different lines though.

The survey took three months to complete. At no time were the local helpers shown the results or the recommendations: in fact the recommendations have never been published. The next thing they knew the results had appeared in the newspapers.

The survey, which became known as the Bradshaw Report, was a bombshell for many people. It proved that there was a very serious problem. It showed that in the north central Dublin area 10% of those aged 15-24 were using heroin. Among those in the 15-19 age-group it was 12%. Among girls aged 15-19 it was 13%. The statistics for female users were worse than the figures for the New York ghettos.

It also pointed out that the vast majority of heroin users, most of whom were mainliners, also abused other drugs. They actually prefered dike to heroin because even though the 'rush' didn't last as long it came on quicker.

The Bradshaw Report received massive publicity, most of which went to giving what was already called a 'bad' area, an even worse name.

The north inner city Concerned Parents Group was set up as a result of a meeting called by a group of women from one of the blocks of flats, and they singled out three particular problems: 1) drugs 2) car theft 3) break-ins to old people's flats. The last two were seen as anti-social crimes, closely associated with drugs. Two meetings were held but the women were unhappy with the non-attendance of the male tenants and made their feelings known. At the third meeting 30 men turned up. Paddy was invited because they felt he would have ideas on how to structure the group. A leaflet was drawn up giving the three objectives and distributed round the flats. 50 people came to the next meeting. It was emphasised that if work was done on the pushers the other two objectives would fall into place: the drugs problem was the most urgent because addicts were injecting outside people's doors and on the balconies, vomitting on the stairs etc. A decision was made to broaden the group to include people from all the flats in the Dublin 1 area.

During the week before the next meeting a group of people took it on themselves to patrol a block of flats after pub-closing hours in a vigilante-type group. They were approached and told their actions were harming the group and they immediately ceased operations.

The next meeting was held in Rutland St. School and 250 people came. A lot of accusations had been made about pushers in the flats, pubs, pool-halls etc. and there was a debate on how to tackle the open sale of heroin. Because most of the people at the meetings were unused to mass meetings they were afraid to publicly denounce pushers. It was therefore decided that a leaflet would be sent round each week with space to write pushers' names, places and times of sale and this could be handed in to the organisers.

At the next meeting, three names were on the list. They were all from one particular block of flats, and the people decided to march on the block and confront them.

This was a testing time for the group. When the march went to the flats there was great unwillingness to give the flat numbers: it took fifteen minutes to establish where the three people lived. When this had been done seven people were chosen to go to the actual flats while the rest stayed downstairs. At the first flat the people in it were agressive and abused the delegates and the crowd. At the second flat the named person wasn't in and word was left on how the people felt about pushing. People were hesitant about approaching a third flat. At the same time they were pleased with the march but decided that in future they would march on the places where the selling was done instead.

By the next meeting a flood of actual and suspected pushers' names had come in, and the number of people at the meeting had increased to 400. It was then discovered that some names had been submitted through mis-information, petty jealousies, grudges etc. The people were assured by the organisers that the meetings would go on anyway without the necessity to give in false names and pointed out the harm that could be done to people wrongly named. The meetings had become an important event in peoples' lives because they felt that for the first time they were able to control something in their community. At that same meeting two of the people whose flats had been marched on the previous week attended and admitted they'd been pushing and said they had since stopped. They said that they had been doing it to support their own habits. Most of the group accepted this, but they were given a firm warning that if they began again they would be marched on again. Paddy's impression is that they came because of the public humiliation to themselves and their relatives and their objective was to clear their names and become part of the community again.

The idea of investigating the pushers named worked, and false accusations ceased. The meetings and marches continued and were very successful in stopping the pushing in the area, though a sharp watch is still kept to ensure that it doesn't begin again or to nip it in the bud if it does. By the early summer of 1984 these meetings have dwindled to once a fortnight, but as a direct result of the meetings a whole host of tenants associations and other organisations

have sprung up.

Nearly every block of flats now has its own tenants association. These are involved in community activities and development. They have made representations to the corporation for better facilities and feel that if they had these it would go a long way to ensuring that the same situation could never arise again. There are summer projects for the children and young teenagers being arranged and demands have been made for each flats block to have its own sports/recreation area. The concerned parents group has brought forward individuals who were always concerned about their area but might never have found a way of getting involved in the community if they had not acted together in the way they did, feeling their strength in fighting a common enemy which affected everyone. There is a difference between the new tenants associations that have sprung up from these activities and the old ones. The old ones had got to the point where they consisted of just a few people, no-one else knew or even wanted to know what they were doing.

Paddy says: 'Even though we might have got rid of most of the pushers, and we may have no new addicts, we still have the same amount of addicts as when we started. Even though we have two drop-in centres in our area, the amount of people from the area attending them is practically **nil.** Basically then, we still have a serious problem on our hands.

Nobody in this country, or anywhere else, knows how to deal with drug addicts, so therefore I think we have built one more wall between ourselves and the people we set out to help — the addicts. As one who has worked directly with young teenagers before and whilst they were becoming addicted I haven't got the first idea of how to deal with, or even talk to an addict to help them come off drugs. So I pose a big question mark over what we and other concerned parents groups are doing and have actually achieved.

None of the people working on the drugs scene has been able to come to grips with the problem. Even ex-addicts who would now be working with young addicted teenagers, have come from totally different drug backgrounds to those they are now trying to help. It's a different era now: earlier the problem wasn't on the same scale. They have been three years off the streets, and a new culture has taken over. The

drugs scene has become more of a 'business' thing, than the 'pleasure' thing (if that's the right word) it was in their time. Today's young teenagers have stronger demands, particularly taking into account their background and social standard of living. The treatment the ex-addicts got then doesn't really fit them to work with inner city youth today.

I have been involved in both of the two centres set up in our area and I believe they have not achieved what they set out to do. For example from August 1983 to May 1984 the Talbot Centre had an input of *58* teenagers, and have only been able to hold onto six of them on a regular basis. Some of the teenagers are now using a wider variety of drugs than they used to througli information they have obtained from other youngsters attending there. Unlike the residential centres, the people going there are only spending eight hours a day in there, and for those hours they are able to put on a false image of themselves to the staff. They tell they staff they're 'clean' when they're not. Most of the staff are now aware of this problem. Also the present premises are so small you can't segregate one group from another.

We have 30 full-time workers and approximately 2O voluntary workers in this small community, yet in spite of this we are precisely the area that if there's any problem around we are the first to experience it. I question whether the people employed by the many agencies in the area are there just to hold down a job or there to pass their experience and skills on to the local people and then move on. Only 6 of the full-time workers are actually from the area. All the voluntary workers are locals. A vast amount of money has been put into the north inner city through the various agencies, and yet we still have the problems that the experts were employed to cope with. My view is that they're sent in to deal with, rather than solve, the problems.'

NATIONAL FEDERATION OF COMMUNITY ACTION ON DRUGS

Coalmine Family & Friends Association, c/o Coolmine Therapeutic Community, Coolmine, Clonsilla, Co Dublin.

AIMS

1. To provide a national framework for Community and Parent Groups engaged in eliminating drug abuse from our society.
2. To support these groups in Action and Prevention Programmes aimed at eliminating drug abuse.
3. To co-ordinate the activity of these groups.
4. To provide a unified voice on drug abuse and in making representations to Government and other Agencies.
5. To seek guidance from other such national community bodies in other countries.
6. To disseminate up-to-date information about the prevention of drug abuse among the groups.
7. To ensure that the news media are supplied with accurate information relating to drugs and the community.
8. To find ways to help parents to cope more effectively with their children's exposure to the temptations of drugs.
9. To help educate the general public and in particular parents and young adults in an appreciation of the drug problem and what steps may be taken to minimise it.
10. To help form further local groups and develop an overall community interest and awareness in combating drug abuse.
11. To support the activities of those bodies involved in combating drug abuse and in particular those involved in the rehabilitation of adicts.
12. To co-operate with other voluntary groups who are involved in local community activities.
13. To research new ways for young people to constructively occupy their free time.

A Parents Action Programme was launched in January 1982 by the Coolmine Therapeutic Community. Its objective is to motivate people in different communities to form community groups which will undertake an action and prevention programme which covers three main areas: community education on drugs, an information and referral service, and a focus for preventive action on issues like under-age drinking etc. Sr. Maeve from Coolmine co-ordinates the programme. It does not function as a group. The idea is that parents must be involved first in the fight against drugs before any longterm solutions can be found.

The Way the Programme Works:

An interested parent or person may wish to organise a group in their area. They contact Coolmine for information and advice. An organiser is sent out to explain the programme and give support. From this a local group can be set up with continued support from Coolmine. Already groups exist — Raheny. Donamede, Donnycarney. Darndale, Coolock, Finglas, Clondalkin, Tallaght, in many areas in the southside suburbs, in Wicklow as far south as Arklow and in Leixlip, Co. Kildare. The programme organisers have had queries from many places and foresee many new local groups being established in other parts of Ireland.

Some of the Points the Federation wants to Emphasise:

Much of the drug use begins with under-age drinking. There are still pubs who feel no responsibility to refuse drinks to very young people. Drugs are often available in these pubs and young people get access to them. According to the Drug Squad (and confirmed by the experience of people affected by drug abuse in their families) approx. 60% of drugs on the streets come, not from organised criminals, but from students, business people etc. The amounts they carry may not be very large, but that only makes it all the harder to catch them. Most of them would get their supply from trips outside the country or by getting others travelling out to pick it up for them.

The Federation sees the progression of drug abuse from drinking, to hash, to harder drugs and often finally to heroin. Some of the young people they know or have met are addicted to cough mixtures.

The Federation emphasises the physical and personality-damaging side-effects of cannabis addiction, which it says are often not recognised or taken seriously. They say hash is more carcinogenic than nicotine and tar; it is fat soluble — that is it goes to the fatty parts of the body and as a result it takes a longer time to wash out of the body. The fatty parts of the body are the brain, kidneys, liver and the reproductive organs. Learning ability is impaired, ovulation and semen production is reduced and there are added risks during pregnancy. •

The Federation feels that those calling for the legal-

isation of cannabis etc. - the so-called soft drugs as being irresponsible in not considering the dangers that free availability would pose, especially to young people.

The Federation does not involve itself directly in rehabilitation, but while its primary objective is prevention of the spread of drug abuse, another of its aims would be to make rehabilitation easier by ensuring a drug-free society for those who have had treatment, or those wishing to become healthy again. They believe it is very difficult to break the drug habit if the environment that fostered it in the first place is not changed. The Federation is modelled to some extent on the U.S. Federation of Parents for Drug-Free Youth.

The Federation is against the introduction of a medically controlled supply for drug users. This is a system whereby methadone treatment is prescribed by a doctor on a long-term basis for a user. The thinking behind it was to control the intake of drugs i.e. to keep the user happy and prevent serious withdrawal symptoms while at the same time controlling the amounts used. It was found to be impossible to control the intake of drugs because the amount needed by the user was continually increasing and the doctors couldn't prescribe what the user felt they needed to keep going. This practice has now ceased in the U.S. It still exists in England, but many feel that it does not work. It has never existed in Ireland.

The Federation feels that laws relating to combating drug use and availability should place more emphasis on proprietors of public places being held responsible for what goes on in their premises.

When The Economy Improves'

THE STATE RESPONSE

In 1971 a report of a government-sponsored working party on drug abuse was published. The working party was comprised of people working in the areas of health, justice and education. The main findings of the report were that although a variety of drugs (amphetamines, barbiturates, tranquillisers, cannabis and LSD) were available during the late sixties, the main drugs used when the report was issued were cannabis and LSD. The report was satisfied that at that time drug pushing was not commercially operated on a large scale. The report does admit that the problem of drug-use generally had steadily increased in size in the Dublin area.

There was no evidence of any significant use of heroin in the country. It does make the point however that it was very difficult to get illegal supplies of heroin here. It also said that the position should not be viewed with complacency in case supplies did become readily available. The authors were awaiting a* detailed analysis to determine the background and conditions of the drug users, but at the time of publication this study was not finished. As a result the report carries no conclusive evidence of who was using drugs.

Apart from the report on drugs in Mountjoy prison carried out in 1982 this was the last official report undertaken until the ministerial task force report of 1983. The task

force was asked to look at the question of drug use with particular reference to the inner-city area of Dublin. The task force was a response to a report of the Medico-Social Research Board (the Bradshaw report) which indicated that *10%* of those in the 15-24 year old group in the north inner-city of Dublin were using opiates. The Bradshaw report was a response to a group of concerned and determined locals who recognised the serious extent of the drug problem long before any official body believed it.

Although the report from the task force was completed in 1983 it has not been published. All that was published was a governmental statement on the findings, indicating the recommendations they were prepared to implement. The statement said that the necessary funding would have to come out of the existing budget. In other words, the money needed to fight the drug problem would have to come from *cutbacks* in some other area.

It was a ministerial task force. This meant that different government departments undertook to implement the recomendations relevant to them.

Department of Justice: amending the 1977 Misuse of Drugs Act in the areas of redefining cannabis, irresponsible prescribing by doctors, differentiating between the pusher and the user, updating the fines under the act. possible strengthening of the drugs squad, possible implementation of a proposal that one judge of the circuit court and one of the district court have special responsibility for all drug cases in the Dublin area.

Department of Health: the provision of a unit in St. James' hospital, Dublin, to provide detoxification and treatment facilities for drug users on the south side of the city, the transfer of the Jervis St. hospital in-patient drug unit to Beaumont hospital *(this hospital is in the process of being built for ages and ages. It is believed that the present government may delay the opening of the hospital because it is situated right in the heart of opposition territory. Eds),* the out-patient walk-in centre at Jervis St. would remain in Jervis St. with a new expanded building provided when the rest of the hospital moves to Beaumont, the department of health in consultation with the Coolmine therapeutic community will explore the possibility of setting-up a programme

that might be more relevant to those users who come from socially and educationally deprived backgrounds, *(as the greater number of users over the past few years come from socially and educationally deprived backgrounds it is a bit slow now to be thinking of providing a more relevant programme for them. Eds)* and the department of health will consult the Coolmine community to identify the funding they need to expand their services.

Departments of Health & Education: will together investigate the possible provision of treatment accommodation for Dublin inner-city users in the 12—16 age group.

It remains to be seen how many of these recommendations will eventually be implemented and how effective they will be.

The state also funds, through the Eastern Health Board part of the costs of the Don ore Avenue centre, the Talbot centre and the Ana Liffey centre. This funding, such as it is. is all short-term.

Crime statistics are an indication of the extent of the growth of drug use. In 1965, 2 people were charged with drug offences. In 1970, 71 people were charged, and by 1983 the figure had risen to 1,822.

Methadone — An Expensive Failure

In the mid sixties in America a new treatment for heroin addiction was investigated, and following what appeared to be startling research results, a long term methadone maintenance programme went into action. At the time it was seen as a solution to the problem *o\'* heroin addiction — in fact it worsened the situation considerably. The story behind it though is extremely interesting and should be considered in some detail lest anyone here in Ireland be contemplating the introduction of anything along broadly similar lines. Our information comes from a report called 'Methadone: the forlorn hope* by Edward Jay Epstein published in *Public Interest* magazine.

Methadone was developed during World War 1 1 by German scientists as a substitute for heroin and morphine. In the late 1940's Eli Lily (a large US drug company) began manufacturing it for experimental use. Though not as powerful as heroin, methadone had the same painkilling and sedative effects. Initially it was used in hospitals for detoxing heroin users. It was less expensive than heroin or morphine and could be given orally. The dosage lasted up to 24 hours.

In 1964 Dr. V.P. Dole, a Rockefeller Institute researcher, and Dr. M.E. Nyswander, a psychiatrist, began **a** series of experiments to assess the results of **a** long term methadone maintenance system. They took 22 heroin users, hospitalised them and established a 'stabilising' dosage (i.e. where the patient no longer craved heroin nor suffered the withdrawal symptoms). They then discharged the patient from hospital and got them to report back daily for their dosage. One year later they published a report in which they said that 'Hopelessly addicted people are no longer addicted to heroin and are now in useful occupations*. The two doctors suggested that the effect of using methadone was to produce a sort of chemical 'blockade' against the hit of heroin, and therefore protected the users against going back on heroin.

Encouraged by their findings, the doctors enlarged the number of people enrolled on the programme to 1 20 and in 1966 reported an 89% success rate — i.e. people who responded well to the programme. They also said that *71%* of their successfully treated users were now working or studying or both. They further claimed that their blocade had virtually eliminated the users criminal activities and estimated that the programme had saved the citizens of New York about 3 million dollars.

In 1968 Dole and Nyswander produced another report called 'Successful Treatment of 750 Criminal Addicts' in which they said that over the four years of their research *94%* of their former heroin addicts had stopped committing crime. The sponsors of the Dole/Nyswander team then set up a body called the Methadone Evaluation Unit (MEU) to produce an independent evaluation of the experiment. In 1969 the MEU reported that the anti-social behaviour of former heroin addicts on the methadone treatment had been 'substantially reduced'.

These two claims, the elimination of heroin addiction and the lowering of crime rates received massive publicity. Although some people pointed out that one addiction was being replaced by another, the press earned stories like, ' A teaspoon of methadone a day is changing former dope addicts into decent law-abiding citizens'.

Methadone was seen as the 'magic bullet' that killed heroin addiction. The idea of any easy, chemical, solution to the heroin/crime problem had enormous appeal to the

public. By 1970 there were 64 official and quasi-official methadone programmes round the country.

In the early 60's addiction had been seen by the State as an individual's problem, for which the treatment was detox and rehabilitation. By the '70's though addiction had come to be seen as society's problem because of the volume of crime it gave birth to. State policy changed from relieving the individual of his/her suffering to relieving the rest of society of the criminal results of addiction. Nixon came to power and by 1973 there were 394 state-funded methadone programmes, with 73.000 men and women attending them.

Analysis of police data however, showed that the figures of crime, unemployment and addiction were still rising significantly. There was little evidence of the overall numbers of drug abusers dropping. The Centre for Criminal Justice then did research on 416 patients in the Addiction Research and Treatment Corporation (ARTC). They found an overall reduction of 20% in the crime rate of methadone patients. This was a lot lower than Dole/Nyswander's figures. The ARTC then went on to break that 20% figure down further. They found that in the under-31 year old group the only crimes reduced were drug offences, forgery and prostitution. In all categories the charge-rate increased. Robbery went up four times, assault by 50%, burglary and theft also increased. Compared to charge-rates when the patients were still on heroin the level of criminal charges actually went higher *after* a year on methadone.

Epstein asks 'Why should two methaaone programmes in New York City, both dealing with criminal addicts, yield such different results?". He points out that the Dole/Nyswander patients were given somewhat higher dosages, but this was obviously not sufficient reason. He then analyses the statistics given by Dole /Nyswander and ends up calling them 'artifacts' . Dole/Nyswander never looked at the actual police records of their patients, they just asked the patients themselves. He found they selected very carefully which addicts to take in and that if any were convicted during the programme they were dropped immediately. Dole/Nyswander also based their figures on actual imprisonment and it was well known that New York judges were four times less likely to sentence anyone to prison for an offence

if they were on niethadone as opposed to heroin. The famous 94% of non-arrests during the first year of treatment at the Dole/Nyswander programme did not point out that 80% of all the people on the programme had not been arrested at all for a full year before they joined the programme. All in all Dole/Nyswander had done some very fancy foot-work on their statistics.

The important question is why didn't anyone take a careful look at the statistics right at the start? We feel part of the answer to this is that the Dole/Nyswander reports appeared to produce the 'goods' that everyone was looking for. An easy-way-out-solution to a complex and very expensive problem.

We feel this is the danger point that Ireland stands at right now. The public attitude to addiction is changing here much as it changed in the US between the 60s and 70s. Drug users are seen by a lot of people as a problem to society instead of seeing that the type of society they live in must bear a heavy responsibility for their addiction. The methadone maintenance programmes of the US and UK did not work. It produced niethadone addicts as well as heroin addicts. The fact that in the US 73,000 of them were "legal' users is irrelevant. The only relevant point is that they were all addicted. In the UK much the same thing happened and over the past three years the number of people using heroin has risen nearly as rapidly as it has here in Ireland.

Epstein gives figures to show how people on the programme continued to use heroin and other drugs whilst they were on the programme. Patients who had been on a programme for six months were given daily urine-analysis for a month and it was found that 77% were still using heroin, 30% were using barbituates, 25% were using amphetemines. Nine months later using the same group of people who had then been on the programme for a year and four months it was found that 92% were using heroin, 43% barbiturates, 69% amphetemines, 43.6% cocaine. Their consumption of illegal drugs actually went up plus they became poly-drug users. This effectively cancels out the theory of methadone creating a blocade against heroin use.

By 1971 many of the clinics had brought in the urine-analysis tests and if patients were found to have "dirty"

urine they were put off the programme. This of course did not stop them using drugs. Methadone from the clinics had also "leaked out" onto the streets, creating an additional drug available for use and by 1974 the Drug Enforcement Administration in the U.S. said that deaths from illicit methadone surpassed deaths from illicit heroin and that methadone constituted a substantial share of the illegal traffic in drugs.

Even when it became obvious to anyone with eyes in their heads that the programme was not working, a highly respected director of the Addiction & Research Laboratory in Stanford said '....putting people on the maintenance treatment had the big advantage of breaking the conditioned behaviour of addicts, bringing them into the clinic daily, ensuring regular contact with staff and introducing a degree of regularity into their disordered lives". So methadone was being used as a form of social control, keeping tabs on the users. Epstein calls this "chemical parole". Doctors and researchers who knew the programme didn't work as it was supposed to, continued to defend it because they felt it was the only way that "hardened" addicts would be brought in off the streets and into the clinics where they might be persuaded to try rehabilitation.

How To Tell If Someone Is Using Drugs

It is very important to remember two things:

1) Ivjany of the symptoms, such as nervousness, weight-loss etc. could well have nothing to do with using drugs.

2) Not all drug-users allow their appearance to deteriorate: it obviously depends a lot on where and how they live, who is looking after them and what stage their addiction has reached.

The signs of drug use can be divided into physical, mental and general.

PHYSICAL SIGNS

Initially many users don't use a needle. They may start out by inhaling the drug or, in the case of palfium, diconal etc. simply swallowing the tablets, so there won't be any needle marks.

Xeedle Tracks: These can be on any part of the body, not necessarily on the veins as many users begin with skin-popping i.e. just inserting the needle under the skin. In the beginning the tracks will usually be on the arms or legs where they can be hidden from general view. Later they'll be on the backs of the hands, feet. etc. Tracks look like small dark red/brownish marks/scratches/scabs and there is often bruising around them.

***Nose** nibbing <£ Scratching:* One of the side-effects of the opiates is extreme **itchiness** all over the body, particularly the nose.

Pupil Change: With cannabis they become very large and the irises go pinkish. With the opiates the pupil will go down to pinhead size, and the eyes take on a watery and unfocused look.

Swellings: On the arms, legs etc. they may be the first sign of an abscess forming.

Vomiting: Often a user will vomit shortly after taking a fix.

Bloody Clothes: Small blood stains may be found on clothes, particularly those worn next to the skin, including knickers and underpants.

Goofingout: Users' slang to describe the condition where someone looks as if they're almost falling asleep. Similar in appearance to severe drunkeness.

Sniffles: Continual running nose.

Weight loss: This can be considerable because the drugs cut down the appetite for food.

Sleep: Users have a tendency to sleep very long hours at a time, often till 3 or 4 in the afternoon.

Sweating: Because of the unusually heavy sweating produced by drug use, sheets may be wringing wet when the user gets up and the hair also gets very greasy very quickly.

Red Lips and Nose: Glue and other solvent sniffers' lips and noses get a bright, burning red.

Nose Sores: Again this applies to people sniffing, and sores appear round the nostrils.

PSYCHOLOGICAL SIGNS

The psychological effects of drug use vary with the type of drug used and the length of time someone has been using. Though all drugs at times produce a 'euphoric" or 'happy-making' effect, this is often short-lived and tends to be of a very passive, 'dopey' or giggly type.

The more usual mental side effects are a lot less pleasant. They include extreme nervousness, restlessness, anxiety and bad temper, often leading to bad rows and fights in a family situation. The user will be very overbearing in arguments.

Perhaps the most distressing symptoms, particularly in families, are the gradual growth of slyness, cunningness.

continual lying, deviousness and furtive behaviour. Often the lies are quite unrealistic but the user will always find an 'explanation' for them and expect to be believed.

Drugs are very expensive and money *has* to be found for them. Sooner or later the user will become a user in another sense: they will use any and everybody round them. They begin by borrowing money, graduate to selling their possessions and finish up robbing cash or any object of value.

Even though there has been rows, fights and walk-outs in the home, the user practically always goes back or keeps in touch by phone or friends etc. Family bonds are very strong.

There is often a feeling of profound guilt by the user for the things they do, but this is often expressed as hostility: *'....you don't know what it's like, I HAD to...'*

GENERAL SIGNS

It is highly unlikely that a user will tell anyone e^e in the home that they are on drugs until they can't hide it any longer. Most continue to live at home after they begin using and will use *in* the home, in the toilet or anywhere else private. They tend to be careless though and may leave the following lying around:—

Burned pieces of silver paper: These will have been lit to soften or heat a drug.

Burnt tea spoons: These are used to heat the drug in.

Small mirror and blade or rolled notes: The blade is for cutting the drug, the mirror to place it on so every grain can be seen and the rolled paper to sniff it from the mirror up the nose.

Pipes: These are used for smoking cannabis in.

Torn cigarettes and papers: These are used for making 'joints' (cigarettes with cannabis in) and usually contain a home-made filter of thin cardboard.

If the user is on glue they may leave plastic bags or plastic milk bottles with glue in them around. Glue also leaves stains on the clothes and hair. If they are sniffing Kosangas they may forget to put the top back on the cylinder, and leave matches in the cap. If they use Tippex this also leaves white or pale pink stains on clothing and hair. If they use Ventolin (the inhalers made for severe asthma cases) they

may leave the cases lying around.

Or you may find a syringe and needle.

There are other miscellaneous things to watch for. Vinegar and lemon juice are widely used to add to the injection to clear its discoloured appearance. Butter and vaseline are used to soften the skin before injecting. Shoelaces and belts are needed to use as tourniquets to pump the veins up before injecting. Air fresheners are used to clear the smell of drugs. Firelighters to inhale. Drug use often brings on cravings for sweets and junk foods. As many as £2 worth of lp jellies can be eaten at a sitting!

Lately some parents have been driven to distraction watching over their children, particularly the teenagers, because of the increase in drug use. Don't let your anxiety *get* out of hand. If you are suspicious SEEK HELP from people working with users. Any of the hospitals, treatment centres or organisations we have listed in this book will be glad to talk to you.