

**The Characteristics and Motivations
of Attenders at a Dublin Drug Centre.**

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Dissertation

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Declaration.

This dissertation is submitted in partial fulfilment of the requirements for a degree of Master of Science in Community Health , at the University of Dublin, Trinity College.

It has not hitherto been submitted to any other university.

I wish to confirm that it is entirely my own work.

Signed



Simone Carton.

Date

16/11/1989.

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I would like to extend my warmest thanks and appreciation to the sample described in this study. They were eager to participate and told their stories with candour.

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Abstract.

Since 1979, the use of illicit drugs, has been a serious problem in Dublin. It has been estimated that there are between 3,000 and 15,000 illicit drug-users in Dublin but only 1,400, approximately, attend the drug-related agencies per year. Injecting heroin is the preferred drug and method of use among drug-users in Dublin, consequently the prevalence of HIV in Ireland is highest among this group. The objective of this study was to identify the reasons for first and continued contact at one drug-related agency in Dublin, the Ana Liffey Project. The respondents were also asked their ideas that would improve the service provided by the agency studied. A total of 50 attenders with a history of illicit drug-use were interviewed. Data collection was by means of a semi-structured questionnaire administered by the researcher.

The major findings of the study were that the drug users in the sample studied were aged between 20 and 25 years, unemployed and living in local authority accommodation. They had been or were multiple drug-users and 88% of those sampled had or were currently intravenously injecting heroin. For most, the first agency they contacted for their drug-use was the Drug Advisory and Treatment Centre. 52% were 7 or more years using drugs before they made contact with the Ana Liffey Project. There were a variety of reasons why the sample first made and continued contact with the Ana Liffey Project. Reasons for first contact were usually because respondents had reached a critically low point in their drug habit. Reasons for continuing to attend this agency were because of satisfaction with the counselling service and because the agency was somewhere to go and 'drop-in'. Ideas for improvement of the agency studied included expanding the service especially with more activities. It is recommended that in the evaluation and development of existing drug-related agencies there should be greater cognisance of the variety of needs of attenders. Further research should focus on studying the characteristics and motivations of those illicit drug users who do not attend the drug-related agencies.

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Chapter I

Introduction

There has been an increase in the consumption of illicit drugs* in many countries since the 1960s, resulting in a rise in the prevalence of drug addiction in the Western World. This trend has continued into the 1970s and 80s. The use of illicit drugs, especially heroin, is a serious health problem in Ireland. Drug-use reached epidemic proportions in Dublin in the early 1980s and even now at the latter end of the decade, remains a serious health problem in the community. The seriousness of the problem has been compounded by the association between the use of intravenous drugs and seropositivity for the Human Immunodeficiency Virus (HIV) and the development of the Acquired Immunodeficiency Syndrome (AIDS). In this introduction, one aspect of this complex problem, the characteristics and motivations for attendance of a group of past and current illicit drug users at one drug centre in Dublin, with particular reference to;

1. The Prevalence of Drug Use in Ireland and Dublin.
2. Profile of the Illicit Drug Users.
3. Health Status of Illicit Drug Users.
4. Routes into Addiction.
5. Routes out of Addiction.
6. Deciding to Abstain from Drug Use.
7. Intravenous Drug Use, HIV+ and AIDS
8. Intervention Strategies.
9. Changing High-Risk Behaviour.

*Illicit drugs in this study includes the non-medical use of prescribed drugs, illegal drugs and the use of substances not commonly used as drugs e.g. solvents. To avoid repetition 'illicit' drugs and 'drugs' shall be used interchangeably.

10. Does High-Risk Behaviour Change?

11. Reasons for Agency Attendance

12. Help-seeking Behaviour.

1. The Prevalence of Illicit Drug Use in Ireland and Dublin.

Prevalence data are useful in mapping out the extent of a particular problem in the community. However, in relation to mapping out the prevalence of illicit drug use it is widely accepted that the 'official' number of drug users will be an underestimation. This underestimation is contributed to by a number of factors:

1. The use of certain drugs is an offence under the Misuse of Drugs Act 1977 (Implemented in 1979). Therefore, people who use these drugs will be cautious to admit and describe their drug-use.

2. The use of illicit drugs is predominantly among deprived inner-city areas, where the drug-using population tends to be transient, often homeless, and therefore not easily accessible for research purposes.

3. Most illicit drug-users are not registered with a general practitioner or attend a drug treatment centre, therefore accessibility to this cohort is difficult.

In the 1960s there was little empirical evidence of a serious drug abuse problem in Dublin. The only study carried out at the time investigated the prevalence of amphetamine dependence in a number of psychiatric hospitals in Dublin(1). (Though a crude indicator since not all people addicted to amphetamines are admitted to psychiatric hospitals.) Unlike European and American cities where amphetamine dependence had reached serious proportions, the findings from this study in 1966 showed that only 0.9% of admissions to Dublin Psychiatric hospitals were with a diagnosis of amphetamine dependence.

However in 1970, the picture in Ireland was beginning to change, where there were 940 persons reported to be using using illicit drugs(2). The most common drugs being used during this time were cannabis and LSD (d-lysergic acid diethylamide)(3). There was also an increase in the non-medical use of the synthetic opiates, such as, Diconal (dipipanone) and Palfium (dextramoramide)(3), and following the increased availability of heroin in the United Kingdom (4) and Europe, the drug scene changed dramatically.

Studies attempting to measure the scale of the problem at the time in Ireland (3,5,6,7,) concentrated on the prevalence of drug-use in specific areas, usually poor inner-city areas, surveys of drug use among random samples of primary and secondary schools, and records of drugs seized and offences involving heroin from Police sources. Prior to 1979 serious drug abuse was little known in Ireland. It was confined to a small group of drug users whose supply of drugs was unorganised and constantly changing (8). Since then, there has been a serious heroin problem in the capital city. There are no accurate figures for the number of drug users at present but it is estimated that the figure is between 3000 and 15000. This 'official figure is calculated from the number of illicit drug users attending the drug treatment centres. To get a more accurate figure of the number of illicit drug users the 'official figure' should be multiplied by 10 (35)

A study undertaken in 1971 (5) by the Medico Social Research Board (Renamed the Health Research Board) of post primary students in Dublin showed that 2.3% claimed to have experimented with drugs. Unpublished data from the National Drug Advisory and Treatment Centre, Jervis Street Hospital, Dublin revealed that prior to 1979, morphine alternatives such as diconal (dipipanone) and palfium (dextremoramide) were the most widely abused drugs obtained from pharmacy break-ins and prescriptions from a small number of doctors. During this time there was no evidence of any significant use of heroin in Dublin.

In June 1982, the Eastern Health Boards report (9) on the non-medical use of drugs, concluded that there has been a dramatic increase in the use of illicit drugs, especially heroin, in the Dublin area. Their conclusions were supported by evidence from local residents, police, clergy and politicians. In response to this, the Minister for Health requested the Medico Social Research Board to investigate further these reports of a dramatic increase in illicit drug-use in Ireland during the previous 12 months. This study(10) concentrated specifically on measuring the prevalence of heroin use in Ireland in the 12 months between 1982-1983.

This study (7) was carried out in a North Central Dublin area and in counties Galway, Sligo and Cork, to assess the prevalence of illicit drug-use in the community, and overcome some of the difficulties in measuring prevalence as previously mentioned, the research team used an unique method of investigation. From lists devised by local resident committees, police and various community workers. Selecting these individuals was based on the assumption that they would be most knowledgeable about the the use of drugs in the locality. They asked those suspected of using heroin to admit if they had ever used or were currently using heroin (both use and possession being illegal) and to co-operate in answering a lengthy questionnaire that included questions about the extent of their drug use and other personal information.

Their results showed a dramatic increase in the use of heroin by injection in Dublin, especially in Central Dublin. They revealed that 10% of young people aged 15-24 had used heroin in the 12 months prior to the interview. What was unexpected in their results was that while the prevalence of heroin-use among the men was greater than women in the 20-24 age group, the rate was higher among women in the 15-19 age group.

These figures are similar to a study (3) undertaken at the National Drug Advisory and Treatment Centre Jervis Street Hospital, Dublin. Between 1979 and 1983, 70% (N =1440 out of total sample 2057) of those who attended, were using opiates mostly, heroin and other synthetic opiates such as Diconal. During these 4 years the number of attenders increased [this is defined as the number of new patients plus those who returned a second or more times] from 294 in 1979 to 1314 in 1983. Most of this increase was due to the increase in the attendance by opiate users, as their attendance increased from 182 in 1979 to 1028 in 1983, a five to six fold increase. In contrast, the increase in attenders for non-opiate use was less than three-fold. Similar to the 1982-83 study, there was an increase in the younger age groups attending the hospital, particularly in the 12-19 and 20-24 age groups.

Their conclusions in this report (7) were that until the Spring of 1981, there had apparently been very little use of heroin in the Republic, but at that time an epidemic of heroin use had begun in Dublin. The estimated prevalence of 9%, predominantly among the 15- 24 age-group, living in inner-city areas was deemed to be a high prevalence by any criteria and it was recommended that a more rigorous study be carried out to provide more precise data, of heroin-use not only in Dublin but also in other selected counties in Ireland.

An investigation (10) also carried out by the Medico Social Research Board in the Dun Laoghaire Borough, using similar methodology showed a lower proportion 2.2% of young persons aged 15-24 years who regularly used heroin in 1983-84. Following the Drug Misuse in Ireland study 1982-83 (7), the government of the day commissioned a special task force to carry out further research. The main reasons for conducting the research in the Dun Laoghaire area were firstly, the

members of the investigating panel had some knowledge of the abuse of drugs in the districts under investigation. (They used the same methodology as the 1982-83 study (7)). Secondly, in the opinion of the members of the panel these wards had neither the highest nor the lowest incidence of drug abuse in the Dun Laoghaire Borough, thereby giving a more accurate prevalence of drug abuse in the areas. Finally, a sizable part of the wards were comprised of local authority flats- this facilitated a comparison between heroin and cocaine use in the apartment blocks and in the nearby housing estates, which were a mixture of homes privately owned and homes purchased or rented from the local authority.

The results of this study showed a lower proportion of regular heroin users 2.2% in the 15 - 24 age group in Dun Laoghaire than the 10% in the same age group in North Inner City Dublin (7). While the number in the Dun Laoghaire area is lower, 2.2% is still considered to represent a serious heroin problem. It was expected that the numbers using heroin would be greater in the local authority-flats than in the nearby housing estates, however, the result was more dramatic than expected. 26% in the 15 - 24 age group (N=42) who lived in the flats used heroin compared with the 1.4% (N=1285) who resided in the other housing. It should be noted though, that one variable, the mobility factor, heightens the contrast in heroin use between young people in the local-authority flats and those in the other types of housing.

Illicit Drug Use Outside Dublin.

There is **no evidence of a serious problem** with illicit drugs outside of Dublin. In the study carried out by the Medico Social Research Board (7), counties Galway, Sligo and Cork were included to assess the scale of the drug problem beyond the Capital City. Using the same methodology i.e. contact with persons who would be expected to be knowledgeable about the local drug scene e.g.

specialist police, psychiatrists and pharmacists the researchers tried to measure the extent of the problem in the rest of the country.

Galway.

Only one person was known to be using heroin and only three other people were known to have used heroin in Galway over the years. Barbiturates, amphetamines and cocaine were not reported to be used in Galway. The major drug problem in Galway was instead identified as the use of psychedelic mushrooms, benzodiazepine tranquillizers leading to dependence predominantly in the middle aged.

Sligo.

In Sligo, the picture was similar. There was no evidence of any serious drug-use but vague reports of two people who had moved from England who were using heroin. There was no reported abuse of barbiturates, amphetamines, LSD or cocaine, although cannabis was widely available and used. Like Galway, the most serious drug-dependency problem was considered to be the **abuse of benzodiazepine tranquillizers** prescribed by General Practitioners and psychiatrists.

Cork.

In Cork there were 314 persons reported who were known to use heroin. It was also reported that approximately 34 persons were using synthetic opiates; diconal, palfium and pethidine. There was some abuse of benzodiazepine tranquillizers, mostly by middle-aged people for whom they are prescribed in excess by General Practitioners and psychiatrists. There was some solvent sniffing, particularly among children from the Travelling Community. Cannabis was widely used, some LSD, but there was little or no reported use of barbiturates, amphetamines or cocaine.

Reports from the provincial cities, Drogheda, Limerick, Waterford and Wexford were unconfirmed and anecdotal.

Clearly then there is not a comparable drug misuse problem between Dublin and the rest of the country. However, it is felt that there is **no room for complacency**. Firstly, there is abuse of tranquillizers, solvents and cough medicines which is often a precursor for the more serious and widespread abuse of illicit drugs. Secondly, the use of drugs by intravenous injection, so preferred by the drug-users in Dublin, now carries the extra risk of HIV infection which has serious consequences not only for the drug user but also for the rest of the community.

In conclusion, since the 1970s there have been considerable changes in the patterns of illegal drug-use in Ireland and in the type and availability of drugs. Worldwide, political changes from the Golden Triangle in South East Asia and the Middle East have contributed to the increased availability of illicit drugs. There is general agreement among the police, voluntary agencies workers, doctors and Department of Health officials that in the last ten years the extent of opiate addiction has increased. Since it is not a statutory obligation to notify the Department of Health of any person who is using illicit drugs, the main sources of data have been the number of attendances at the National Drug Treatment and Advisory Centre and prevalence studies carried out by the Department of Health. The results from these studies have consistently shown an increase in the use of illicit drugs especially heroin in the last 10 years, an increase that reached epidemic proportions in the early 1980s.

2. Profile of Illicit Drug-Users.

The drug scene in Ireland and Europe has changed in many ways in the past 20 years. In the early 1960s, drugs were relatively easy to obtain, comparatively cheap and used by a small number of people characterised by their diversity rather than their similarities. Gerry Stimson and Edna Oppenheimer in their book on Heroin Addiction (11) described the profile of the addict, ranging from the "junkie" living in poverty, suffering from infections and occasionally being arrested and imprisoned to the more "stable addict" who led a reasonably normal life, inconspicuous in dress and manner, who kept apart from the other addicts and suffered few problems. Others lay somewhere between these two extremes.

The profile of the heroin user in Dublin in as described by the 1982-83 Medico Social Research study (7) fell mostly into the category of 'junkie'. This study noted the concentration of drug use among teenagers and young adults 11% (N=13 out of 88) stated that they were first introduced to heroin when they were less than 15 years of age. While a further 53 were introduced to heroin between 15-19 years of age. Other personal characteristics included their early school-leaving age, only 6 of the 88 entered secondary school and 8.8% (N=10) of the sample were illiterate. Not surprisingly these features perpetuated into their employment record, only 4 of the 88 were employed at the time of the research and 64% (N=56) had been in prison at some time. Similarly in the Dun Laoghaire study (10) where the social conditions would be considered to be better than the Inner City, 44 of those using heroin were in the 15-19 age group and only 6% had remained at school until they were 17 years old.

In conclusion, the profile of the illicit-drug user in Dublin in the 1980s is a consistent one. Throughout the studies (7,10,8,12). The 'typical addict' is young,

under 25, single and unemployed. They are usually living with their parents or partner in local-authority housing complexes. Educational achievement is low, few ever completing secondary education. Most have been arrested and served prison sentences for an average of 3.4 years. Their use of drugs begins between 15 and 19 years of age, intravenously injecting heroin being the preferred drug and method of drug-use. Most drug-users are multiple drug users. This is partially explained by the fluctuating availability and cost of the opiates. For example it costs approximately £160 for one days supply of heroin (13). Consequently few addicts use only opiates. The other drugs used mostly include, Palfium (dextramoramide), Diconal (dipipanone), DF118, cannabis, morphine, benzodiazepines and methadone.

3. Health Status of the Illicit Drug User.

There is very little evidence to show that pure opiates themselves cause any direct physical damage when used over long periods. Most of the physical damage is caused by the manner in which the drugs are administered and the life style that accompanies illicit drug-use. These would include; unsterile injection practices, the sharing of syringes, the injection of drugs such as barbiturates which were not designed to be injected and also infection caused by contaminants found in illicitly manufactured heroin. Drug users in Dublin prefer to inject heroin, as a result of this the physical complications frequently found among the Dublin addicts are septicemia, abscesses and hepatitis seropositivity for HIV infection and AIDS.(13,14). The growing level of tolerance that accompanies increased use necessitates more heroin to produce the euphoric effects which sooner or later is required to alleviate discomfort. This therefore increases the risks of infection and other drug-related diseases.

4. Routes into Addiction.

As previously mentioned illicit drug use in Dublin is predominantly in vulnerable communities where there are large families, educational achievement is low and high unemployment is high. There are many social and psychological theories that try to explain the intricate influences of family and the social environment on behaviour. However, it is beyond the scope of this study to unravel that puzzle. Peer pressure, feelings of futility in a depressed environment, no alternative role models to emulate are but a few of the factors that could contribute to someone deciding to take drugs. Only one study carried out in Dublin asked respondents why they started to use heroin (8). Peer pressure was referred to by 63% of respondents as the main reason for starting to use heroin, it is not recorded what the remaining 37% respondents answered. It is worth noting that the opiates, (from which heroin is derived) preferred by the Dublin addicts, are used in medicine mainly for the relief of pain, sedation and the reduction of anxiety. Of all the opiates, heroin probably has the greatest analgesic action, usually used for the control of pain in terminal illnesses.

One of the difficulties in establishing the reasons why drug users first use drugs, is that the thoughts and feelings expressed by the user may not be fully understood by the observer. Many users are ready to admit that effects of drugs are hard to explain and often their description does not go much beyond saying that when you inject heroin 'you just feel it' (11). Stimson and Oppenheimers' 10 year study (11) of 128 heroin addicts describes the initial reasons for use ranging from, 'getting a buzz' to 'keeping straight'.

5. Routes out of Addiction

There is now considerable evidence to show that many drug-users stop using after a period of time. This is often referred to as the '**maturing out**' process(14). Studies in the United States and Great Britain have suggested that after 5 years approximately 25% of addicts become abstinent, and 40% after 10 years.(11) However, these studies can provide **few prognostic indicators** between those who stop and those who continue to use drugs. The general trend for those who remained abstinent was one of overall improvement in their social economic and personal life when compared with their drug-using peers. Those who stopped using led a generally more socially stable life, were less likely to have problems with the law, were more likely to be employed , lived in stable accommodation, had little contact with drug users and were in good or excellent health.

All the evidence suggests that those who said that they abstained from using drugs in fact did so and did not replace their dependence on one drug to dependence onto other drugs. Similarly, Oppenheimer et al (15) mention several major differences between those who abstain from using drugs and those who continue to use drugs [Oppenheimer's study concentrated on heroin users.]. Those who stopped using heroin tended to be younger, had a shorter history of addiction and used smaller amounts of drugs when they first started. Those who stayed on heroin and methadone hardly changed at all over the years for better or worse, (The only aspect of their behaviour that did change was that they improved their sterile injection techniques.) Clearly, these two groups are very different in relation not only to their history of drug use but also in other social and psychological factors. Therefore comparisons are not helpful and one can only conclude that the routes into and out of addiction are varied and complex.

6. Deciding to Abstain From Drug-Use.

At any time for the drug user there are advantages in continuing and ceasing to use drugs. The conflict between the advantages and the disadvantages is a continuous source of tension swayed by external and internal factors that are not always apparent to the addict or the observer. Stimson and Oppenheimer (11), concluded from their study that the addict's decision to stop using drugs was the result of perceiving a shift in the balance between the advantages and disadvantages, in favour of the former.

How this shift is perceived and articulated to the clinic doctor and to an drug-using friend will more than often be very different. It is reasonable to assume that the drug-user talking to a researcher, probation officer or social worker will be full of good intentions about coming off drugs or going for treatment. The same person may never have talked in such a way with their drug-using friends. The drug-user plays a dual role, surrounded by his/her peers there is a shared vocabulary, and a daily routine that is full of uncertainties and excitement. Each day, the drug-user, with his/her peers, takes the risks associated with securing their drugs, meeting 'pushers', and finding 'safe' places to 'shoot up'. When this routine becomes chaotic or reaches a crisis point, the drug-user may voluntarily seek help or the social services may intervene. Here the drug-user meets a whole range of people whose task it is to facilitate and treat the addict to become drug-free. Often the addict before, during, and after deciding to quit drugs, experiences much professional, social and family pressure, persuading him to stop using drugs. The ambivalent, position of the drug-user to reform or continue to use, results for most drug-users, in many failed attempts to stop using, repeating crisis and patterns that can continue for many years. Stimson and Oppenheimer (11) quote one ex-addict describing earlier unsuccessful attempts at 'cures' in hospital and what it feels like to be in such a situation of conflicting demands.

"You say this and that, and you're talking about cures, but for a junkie, at the back of his mind he's not talking about a cure at all really. It crosses his mind because he thinks that's the right thing to think about, and the fact that he's made the effort. He goes in for a cure, but if he's got half the chance of getting a bit (of heroin) while he's inside there, that's all well and good."

P157 (11).

7. Intravenous Drug Use HIV and AIDS

A special consideration for the intravenous drug user, in more recent times is the **risk of becoming seropositive for HIV and developing AIDS**. the prevalence of HIV is higher in areas where intravenous drug-use involves the sharing of syringes for example at "shooting galleries" [where anonymous, multiple-partner needle sharing takes place.]. It is believed that the geographical variation in the prevalence of the disease is due to the different equipment sharing practices, method of use (smoke or inject) and differing times of arrival of the virus in the population of drug users (16).

In the United States the majority of cases, 73%, of AIDS have occurred in homosexual men, and intravenous drug users account for the second largest group of cases (17%). Together these two groups account for 90% of reported cases of AIDS in the USA, half of which have been reported from New York city (17). In the Friedland study (17), 74% of subjects (drug users and homosexuals) had attended "shooting galleries".

In the United Kingdom, 88% of the notified cases of AIDS have implicated homosexuals and bisexuals, only 1% of notifications have implicated intravenous drug-use alone as a high risk activity (18). In England and Wales drug-use alone

has been implicated in only 232 (5.7%) of 4001 reports of human immunodeficiency virus (HIV antibody positivity). However the picture in Scotland is the reverse, particularly in Edinburgh, where intravenous drug-use has implicated 618 (61.3%) of 1008 reports of HIV antibody positivity (19), 607 (60%) have come from Edinburgh (16) and this is second only to the North-West Thames region in England (16,20). HIV was introduced to Edinburgh in 1983, it spread rapidly because intravenous drug use with opiates predominates in Edinburgh, far more than either Glasgow or South London (21,22).

In Ireland, by October 1989, 865 people were tested as seropositive for antibodies to HIV. **54% (N=465) of this group were classified as intravenous drug users** (23). This high percentage of seropositive individuals who have been exposed to HIV through the use of intravenous drugs is a characteristic that distinguishes Ireland from the experience of the United States and the United Kingdom while resembling Dublin to Edinburgh. This high percentage of seropositive individuals is expected to increase even though the numbers of new intravenous drug users has begun to decline since the early 1980s. As the interval from infection to the development of clinical features of AIDS is five or more years (24) there is a very real fear that very many of those who injected drugs during the early and middle 1980s, even if only for a brief period, may now be infected (28). This indicates that the scale of the epidemic of HIV and AIDS where intravenous drug use is the main source of transmission, as is the situation in Dublin, will present the community with a **major health problem**. If the disease becomes disseminated into the general population it will do so from the heterosexual parenteral drug users (18).

8. Intervention Strategies

The absence of both a treatment and an effective vaccine for AIDS means that the primary prevention of the disease remains the only useful strategy for populations. As well as pre and post-test counselling, the developments of STD services (especially in the semi-rural areas), the main part of the AIDS strategy for Ireland is a major information/education programme aimed at informing the general public of the facts relevant to the disease and of the need to modify high-risk behaviour to prevent the spread of the disease (25). Dr. James Walsh the Deputy Chief Medical Officer for Ireland and the Director of the AIDS campaign, sees the most pertinent question to be, how can human behaviour be motivated away from casual sex and drug abuse until research provides a vaccine or an effective means of treatment?

9. Changing High Risk Behaviour.

All health education incorporates cognitive and behavioural components. At the cognitive level the message is given in order to increase knowledge and change beliefs about the risks associated with the disease. The behavioural component of health education persuades people to modify their behaviour so as to reduce their chances of getting the disease. In evaluating the effectiveness to the AIDS campaign it is important to ask the question who hears these messages and what is the difference between **what is heard and what is actually done?**

10. Does High Risk Behaviour Change?

Since there have been no studies carried out in Ireland investigating whether high-risk behaviour among drug users has changed since the media campaigns, it is necessary to look at how similar groups elsewhere have or have not changed in their high-risk behaviour as a response to the AIDS epidemic. The possibility of a change in high-risk behaviour among intravenous drug users is dependent upon

many variables; HIV status, beliefs about HIV transmission, attendance at drug dependency clinics or with a General Practitioner and ones own perception of the risks of becoming HIV+. Each one of these variables plays a different and unique role in motivating each individual to modify their behaviour. The current prevention strategy in Ireland provides information, directed both at the general public and the high-risk groups, about behaviours that need to be changed. To a limited degree, the campaign provides the means to change these behaviours, for example, the needle exchange programme and providing condoms at certain centres.

This approach however, fails to take account of the factors that make it difficult for clients to change and to sustain change over a variety of situations and circumstances. In a study carried out to evaluate the effectiveness of the first year of the syringe-exchange scheme in England and Scotland (26) many of the subjects reported that they had shared because "there was a group using drugs together". Some commentators suggest that there are **"rituals of injecting"** that encourage sharing. Others see 'sharing' as the pooling of resources and skills, such as money, shelter, 'street-knowledge' that enables the financing and purchasing of drugs and also encourages the sharing of syringes. But sharing can also be seen as a normal human response to be with ones' friends, sharing not only needles but also sharing a common vocabulary , environment and experiences.

In order to facilitate the transition of the health education message into practice, the provision of needles, condoms, counselling and support if requested is essential. While these services will make an important contribution in reducing high-risk behaviour, they are fallible. There is no perfect response to the complex problem of motivating people to change their high-risk behaviour - deciding to change is a very personal decision.

In many ways the strategies to date could be seen as clumsy attempts to change behaviour and beliefs that are firmly held by a vulnerable group in society. For example, there is evidence that intravenous drug users are aware of the dangers of equipment sharing in the spread of HIV and there has been a change in behaviour by a majority of drug users in their sharing practices (27,28). But when a drug user needs a 'fix' urgently they will often proceed to share equipment despite their knowledge of the risks involved. There may not always be a correspondence between the need to inject and the availability of a clean needle. This is supported by a study carried out in Melbourne in 1987 (29) where 84% of intravenous drug users said that they shared because they could not buy a needle or syringe at the time and place of abuse, 11% said that they 'could not be bothered' and **only 5% wanted to share.**

Among the intravenous drug-users in Edinburgh it was demonstrated that there were significant changes on needle sharing practices and sexual behaviour over a one year period, which spanned from pre AIDS awareness to post-Governmental interventions (30). Debunking the commonly held belief that drug-users are apparently incapable of, or unwilling to change their behaviour, the investigators showed striking behavioural change among the intravenous drug-users. This was the first U.K. follow up study which attempted to measure change in behaviour directly related to sharing of equipment and whether ones HIV status influences the degree of change in high-risk behaviours. Their results revealed a large decrease in the number of intravenous injections per week, from 23.4 to 7.64 Also the number of individuals with whom they shared in a month fell from 13.7 to 2.69. Comparing those seropositive and seronegative for HIV, the former group demonstrated marked falls on the average number of intravenous injections per week, 20.3 v's 7.57, $p < 0.005$ and the average number of sharing episodes per month fell from 48.2 to 10.9, $p < 0.0005$. The conclusions of this study were

that behaviour change is not only likely but occurred rapidly among this at-risk group. The change in behaviour was reinforced by information from multiple sources; the media, doctors and community workers, and by the provision of needles and syringes.

A similar study, but at a drug dependency clinic carried out in London (31) questioned intravenous drug-users about their sexual and equipment-sharing behaviour. They confirmed their hypothesis that there was a significant tendency for **high-risk sexual behaviour to be related to high-risk equipment-sharing behaviour**. This concentration of high-risk behaviour, though only represented in 14% (N=23 of a total sample of 162). The study identified a large variation in both sexual and equipment sharing behaviour between individuals, to the extent that 'an average number' of sexual or equipment sharing contacts would be meaningless. However, those 14% are at a very high risk of becoming seropositive for HIV and of passing the infection into the rest of the community. **Intervention, therefore, should concentrate on the groups at highest risk for becoming seropositive for HIV, rather than spending *limited resources* uniformly in the community, where there is relatively little contribution to the overall impact of HIV on the community.**

A study carried out in London (32) examined the extent to which intravenous drug users were likely to reduce their high risk behaviour in response to concern about AIDS. Acknowledging that there are cultural and regional variation in injecting and sharing, the authors felt that it was imperative that there was a deeper understanding of the general circumstances in which such behaviours occur, and an appreciation of the extent to which concern about AIDS is altering habits. Their results show that 54% (N=62) of 127 regular illicit drug users altered their injecting and sharing patterns because of a number of

considerations. These included, having hepatitis, easy access to a supply of clean injecting equipment, being tested for antibodies for HIV (all those tested with a seropositive result reduced their risk behaviour and 60% (N=20) of those with a seronegative result substantially reduced their risky behaviour.) 32% (N=37) had to some extent changed high risk behaviour, such as reducing the frequency of sharing and or the numbers of people with whom they shared.

Similar to the London study, another study in 1988, (31) found that 14% (N=16) of the sample continued to share and that those who were in contact with agencies were more likely to have reduced their risk behaviour than those not in contact with the agencies. 65% (N=40 out of a total sample of 115) of the 'agency group' had substantially reduced their drug related risk behaviour compared with 39% (N=19) of the 'non agency' group. Some of the reasons behind this may be explained by the likelihood that the 'agency group' by definition comes into contact with professionals who will encourage behavioural change, or it may be that a greater concern about AIDS leads to agency contact.

11. Reasons for Agency Attendance.

December 1st 1988 was 'World AIDS Day', a day set aside to remind everyone that 300,000 people throughout the world had the disease, and that its spread could be contained by effective preventative measures, notably the use of condoms and programmes to help intravenous drug-users (33). This article in the Irish Times commented that some television advertisements advising people of the AIDS Helpline phone number amounted to the total effort of the Department of Health to mark the day, while free material about AIDS sent from the WHO's headquarters in Geneva lay undistributed in the Department of Health. Such inadequate and evasive education and prevention programmes are a poor response in a country that has the highest incidence of HIV positive babies per capita in Europe (34)

and where the number of people seropositive for HIV is doubling every nine months. While many have criticised the absence of any public educational campaign the health-campaign strategists could be excused since much of the research concludes with recommendations advocating messages that are targetted towards high-risk groups rather than national campaigns. However, currently in Dublin only a small proportion of intravenous drug users are at any one time in contact with drug treatment and related agencies. It can be roughly calculated that of the 3,000 to 10,000 intravenous drug-users in Dublin only 1,400 approximately are receiving treatment per year. This figure would be close to the findings of Hartnoll et al (35) who in trying to estimate the prevalence of opioid dependence in the United Kingdom, concluded that for every regular opioid user who had received treatment at a drug clinic, 6 to 10 had not. In addition to this over half of those (55%) who do not make contact with the drug treatment centres are between 3 and 7 years using opiates before they first make contact with the drug related agencies (36).

From the AIDS strategists perspective, it could be argued that even to target the high risk groups in the place where they are most accessible, the drug treatment centre, is futile since the small number of drug-users who avail of the service have been engaging in high-risk behaviour from an early age and a long time before they seek help. Therefore further research, it could be argued, should focus on studying those drug-users who have not yet made contact with the drug-treatment services and why they so often only make contact after many years of using drugs. By definition this group are difficult to gain access to. One suggestion would be to survey General Practitioners to establish the number and profile of this large group.

Alternatively, it has been argued that in order to gain a clearer perspective of the techniques needed for attracting clients to the services it is helpful to ask those

who have made contact to give their account of the **precipitating events and motivations prior to their first contact**. Though this group are by **definition are self-selected and represent a small number of drug users**, as consumers of the drug-related services, their opinions and reasons for agency contact are valuable. In light of this, the main objective of this study is to identify the important reasons why illicit drug-users sought help at one drug-related agency in Dublin and having made contact how they perceive the contact to have contributed to their recovery (if applicable).

12. Help-seeking Behaviour.

There is considerable sociological work on general help seeking (37,38). Zola in his classic article Pathways to the Doctor- from Person to Patient (37), argues that rather than people making contact with the medical services because they "could not stand it any longer", Zola hypothesises that there is an accommodation, both physical, personal and social to the symptoms and it is when this accommodation breaks down (not necessarily at the physically sickest point) that the person seeks or is forced to seek medical aid. Zola has described several distinct, non-physiological triggers that occur prior to the decision to seek help.

1. The occurrence of an interpersonal crisis
2. The perceived interference with social or personal relations.
3. Sanctioning. (This is where one individual takes the primary responsibility for the decision to seek aid for someone else-Zola comments that this was the overwhelming favourite of the Irish!)
4. The perceived interference with vocational or physical activity.
5. Temporalising of symptomatology.

According to Zola, a more appropriate question to ask in relation to agency and professional contact is not the traditional one of "why the delay?" but rather "why have you come now?".

Thom (38) in a theoretical paper on the use patients make of services (especially the alcoholic services), has suggested a 'stages' approach to help-seeking. These stages would involve attending one agency at a time and if this is unsuccessful the patient then discontinues contact and attends another agency which may fulfil his/her needs. Thom comments that this process is unlikely to be a rational progression for most people.

Many of the studies of the late 1960s and early 70s ignored the drug users motivations and reasons for seeking help, reasons for the delay before first contact and their expectations of treatment. on the help-seeking behaviour of intravenous drug users were descriptive and focused on drug users attending clinics for the first time. Stimson and Oppenheimer (11) carried out one of the first longitudinal studies of opiate users from first agency contact to follow-up after many years of abstinence. In their endeavours to describe the drug-users demographic features and drug-use profile, the researchers have to a large extent ignored the drug-users' motivations and reasons for seeking help; the reasons for the delay in first contact and their expectations of treatment.

There is no reason to hypothesize that the illicit drug-user, like the general medical patient in Zola's study, mostly seeks contact when their previously adequate accommodation and coping skills break down. Or it may be, using Thom's hypothesis, that the drug user has not perceived any of the drug related agencies as capable of fulfilling their needs and often it is only after multi-agency contact and finding the best place for them that some drug users can seriously contemplate undertaking treatment for their use of drugs. Indeed a recent study (39) found similar characteristics and help seeking patterns between drug users irrespective of the type of service or agency attended. Their help seeking patterns

were discontinuous and uncoordinated and featured multiple contacts and simultaneous use of different services.

Beliefs and motivations have been ignored for facts and figures and without this information we do not know enough about how to devise effective treatment services or campaigns to meet the particular needs of this group nor about how to make existing services attractive and relevant (40). **Each addict brings with him / her a variety of reasons for coming and numerous anxieties about the treatment.** The extent to which these factors influence treatment uptake and outcome is unclear. The answers to these questions are as much an **integral part of any AIDS strategy** as a any television advertisement or WHO booklet.

Some of the studies that have been carried out have highlighted that the similarities between addicts who seek treatment and addicts who do not, are greater than the differences. Rounsaville and Kleber (41) in their study of opiate addicts who do and do not seek treatment found that the two groups were comparable in their frequency of opiate use, occupational functioning and psychiatric morbidity (other than depression). Sheehan and Oppenheimer (40) attempted to identify the main reasons why drug users sought help. They grouped the answers of 50 drug-users who were attending one London Drug Dependency Clinic into three categories. They concluded that the most likely reasons for coming for treatment were emotional ones or related to the actual experience of being addicted to drugs, or referred primarily to their children or partners. They referred to these as 'high impact items' which irrespective of how frequently they occurred were always influential reasons for making contact with the drug related agencies.

Clearly, there is a dearth of research on help-seeking behaviour of drug-users to the drug-related agencies. In the absence of a comprehensive, prospective study, this study should be regarded as offering a small glimpse onto one part of the career of the drug-user while it also highlights the many gaps.

CONCLUSIONS

1. All the indicators point to a substantial rise in the numbers of young people using illicit drugs, notably heroin. This increase reached epidemic proportions in Dublin in the early 1980s.
2. It is estimated that there are between 3000 and 15,000 illicit drug-users in Dublin. Illicit drug-use is concentrated in very deprived inner-city areas and some suburbs. Prevalence studies in one inner-city area revealed that 10% of those between 15 -24 years had used heroin in the previous 12 months.
3. Beyond the capital there is no comparable illicit drug-use problem. There, the most serious drug related problems are alcoholism and benzodiazepine dependence.
4. The 'typical' addict is introduced to heroin between 15-19 years of age. Intravenously injecting heroin is the preferred drug and method of use, but because of fluctuating availability of heroin, all intravenous drug-users are multiple-drug users, the other main drugs of use are Diconal, Palfium, cannabis, amphetamines, cocaine and morphine.
5. Peer pressure is the main reason given by heroin users to explain why they first used illicit drugs.

6. It is estimated that 40% of addicts will become abstinent after 10 years. Reasons given for coming off drugs include; health, financial, personal decision and prison.

7. In Ireland the majority of people who are seropositive for HIV are those who have and /or continue to intravenously use drugs.

8. The main focus of the AIDS strategy in Ireland has been to inform the general public of high risk activities, research has shown that prevention campaigns need to be targetted at those at greatest risk - intravenous drug users.

9. Behaviour change in response to concerns about becoming seropositive for HIV and AIDS has been significant among the majority of drug users from studies done in the United Kingdom. Those who change their behaviour tend to have been tested for HIV, attend a drug related agency, have hepatitis and have easy access to clean injecting equipment.

10. There is a small group of intravenous drug users who do not change their high risk behaviour and it is considered that this group may be the 'bridge' for the spread of HIV in the community.

11. Reasons for making contact with the drug-related agencies has been a neglected part of the research. It has been argued that gaining a clearer picture of this process may be useful in developing relevant and attractive services for the drug-user.

A Profile of the Drug Treatment and Rehabilitation Agencies in Dublin.

Drug Advisory and Treatment Centre (Trinity Court).

The Drug Advisory and Treatment Centre, commonly referred to as Trinity Court or Pearse Street consists of an advisory service, in-patient and out-patient units. In 1988 (January to December) a total of 1,052 patients attended the centre and the total number of attendances were 26,884.

The advisory service is provided for all those who are concerned about the problems of drug abuse or addiction, for example parents, teachers community workers. Information and public lectures are provided by the staff, especially the health education sister, to schools, community and professional groups.

The in-patient unit is located at Beaumont General Hospital. This unit has a capacity of 10 beds and provides the following service;

1. To detoxify those who have found the out-patient programme impossible,
2. To stabilise patients who are going through a critical phase in their treatment,
3. To carry out investigations on those who are debilitated or acutely ill due to their drug use. The average length of in-patient treatment is 2-3 weeks, during which time patients also receive individual counselling and participate in group therapy.

Emphasis is placed on the need to follow detoxification with a drug-free rehabilitation programme such as Coolemine Therapeutic Community or the Rutland Centre. Some patients go directly to such programmes on completing their detoxification programme [Personal Communication with the Health Education Sister at Trinity Court.]

The out-patient unit provides a methadone detoxification programme, methadone maintenance programme and occupational therapy. The aim of the methadone detoxification programme is to assist patients to become drug-free. An oral form of the drug methadone (physeptone) is administered daily, under supervision, in gradually decreasing doses, over a period of 2-3 weeks. When commencing this programme, the patient undertakes not to use drugs (there is random urinalysis to ascertain if drugs other than methadone are being used) and to co-operate with other commitments and requirements of the programme. Usually these include that the patient will attend group therapy and or occupational therapy at the centre. However, this is negotiable and some patients opt to attend another drug-related agency, for example the Ana Liffey Project or Narcotics Anonymous.

Eligibility onto the methadone maintenance programme is decided by one of the doctors at Trinity Court. Certain patients are maintained on methadone for an indefinite period. These are patients who have either repeatedly failed to cope with detoxification or who are experiencing the additional difficulty of coping with the knowledge that they are seropositive for HIV or have been diagnosed as having AIDS. Such patients are carefully monitored by the clinical team (doctor, nurse and social worker) and are requested to participate on regular counselling either at the centre or at some other outside agency.

Coolmine Therapeutic Community

Coolmine Therapeutic Community was founded in 1973 as a response to the frustration felt in Dublin at the time - after detoxification there was nothing to assist the ex-drug user to remain drug-free and as a result of this many inevitably relapsed back to using drugs. Coolmine as it is referred to, was developed from the Daytop Village Therapeutic Community Model established in

New York in 1963. Their belief is that drug addiction is a disorder resulting from 'faulty growth and learning' and in their residential and day programme their approach is to 're-instruct residents and teach them better ways of apprehending and responding to life' (Personal Communication with the Director of Coolemine.). To achieve this re-instruction, Coolemine offer 3 services a residential treatment programme, an induction centre and a day centre.

The residential treatment programme is designed to encourage the drug user to live a totally drug-free life. There are approximately 89 residents participating on this programme at two centres located in County Dublin. The residential programmes last for 9 to 12 months.

The induction centre is where drug users make initial contact with Coolemine. Here they receive counselling and preparation for those who wish to participate on the residential programme. Approximately 251 drug users attend the induction centre at any given time.

The day centre caters for approximately 28 people who are 'not too deeply addicted to drugs', or who have completed the residential programme and want to continue with the counselling. Altogether, Coolemine provides these different services for approximately 368 drug users per year. Over half (52%) of those who attend Coolemine have been using drugs, mostly opiates between 6-10 years and are mostly between 21-25 years of age (Personal communication with the Director of Coolemine.)

The Rutland Drug Treatment Centre.

The Rutland Drug Treatment Centre offers an assessment, residential and aftercare service for individuals who present with all types of addiction problems, including, alcoholism, gambling, benzodiazepine, illicit drugs. Of the 250 people who attend the centre each year the majority are alcoholics, only

about 12% of attenders per year are illicit drug users (mostly heroin). Each year 1000 people avail of the assessment service where they are usually referred by a doctor (or sometimes their employer) to formally assess the extent of their addiction and make recommendations. The residential programme lasts for 5 weeks and includes a variety of psychotherapies which often include the participation of the clients' family (usually 3 family members per client) and often a representative from where the client is employed. The aftercare service provides those who have completed the residential programme group therapy once per week.

The Ana Liffey Project.(ALP)

The Ana Liffey Project was established in 1982. It was a voluntary initiative in response to the serious heroin problem in Dublin which was at its height during this time. Initially, it concentrated on providing outreach street-contact and counselling services for drug-users. However since that time, the project now concentrates on providing a drop-in and appointment day centre service for drug-users. They provide individual and group counselling, and support for the families of drug-users. They also provide group therapy and counselling for drug-users in Mountjoy Prison including the Separation Unit (A special Unit in the prison where prisoners who are seropositive for HIV or have been diagnosed with AIDS are separated from the other prisoners.)

In each of the years 1987 and 1988, the ALP saw almost 400 drug users and had over 4,500 counselling sessions. Most of those who attend ALP are using drugs, trying to stop using or are on the methadone maintenance programme at Trinity Court. A small number who are no longer using drugs, continue to visit the centre for ongoing counselling.

As mentioned in the description of Trinity Court, there are a number of people on the methadone maintenance programme who decide not to avail of the counselling or therapy services provided at Trinity Court but are required by Trinity Court to participate in some counselling/therapy as a condition for participation on the methadone maintenance programme. Some choose to attend ALP to fulfil this requirement. More recently this arrangement has been less frequent. It is not encouraged by ALP and less so by Trinity Court. The general feeling is that voluntary participation for any counseling to be effective is essential.(Personal communication with ALP.) A similar arrangement has operated with the probation service and ALP. Pending release from prison, an agreement is made between the prisoner and his/her probation officer to attend ALP as part of their temporary release contract.

Chapter II.

OBJECTIVES AND METHODOLOGY

This is a descriptive study, the aim of which was to investigate the reasons why a sample of past and current drug users attended one agency for drug users in Dublin.

The objectives of the study were:

1. To describe the characteristics of the attenders.
2. To investigate the reasons why the attenders first made contact with the agency.
3. To investigate the reasons why the attenders continued to visit the agency.
4. To explore the scope for improvement of the services of the agency based on attenders' suggestions.

Methodology.

Originally this research was to be carried out at the Drug Advisory and Treatment Centre (Trinity Court). After the objective and the questionnaire had been discussed and agreed upon, the author received an unexpected directive that the study could not commence. The reason given was that there was a doctor carrying out a similar piece of research and that there 'would be too much overlap between the two studies'. The Ana Liffey Project was recommended as an agency that would also be suitable to investigate the objectives of the study. Initially the study was greeted with enthusiasm as ALP saw this study as an opportunity to carry out a pilot project for research they had proposed to do in the future. When the questionnaire was being adapted for ALP there was a conflict of interests between the needs required for the purposes of this dissertation and the needs of ALP for their pilot project.

This conflict centred around the inclusion of certain questions, whether the interviews should be tape recorded, if they were who would have access to the tapes, ownership of the data and publishing rights. The author was advised at this stage to look into the possibility of carrying out the study at either the Rutland Centre or the Coolemine Therapeutic Community.

The Rutland Centre said that they could not accommodate the research for two reasons. Firstly, they did not have sufficient numbers of illicit drug users that were required for the study and secondly they emphasised the confidentiality of each client and felt that that an independent researcher would pose a breach to this confidentiality.

The Director of Coolemine was very enthusiastic at the first meeting and gave provisional approval that the research could be carried out at their centre pending clearance from an associate. After two weeks of reassurance that there would be no

difficulty to get sanctioning, the study was not permitted to take place at Coolemine. No reason for this decision was given.

At this stage there were only two options available, to disband the study or renegotiate with ALP. The second option was chosen because so much preparation and planning time had been invested and it was impossible not to give ALP 'one last shot'.

After much discussion (and using many skills of diplomacy!) ALP finally agreed that the study could be carried out under the following conditions;

1. The interviews would not be tape-recorded.
2. That certain questions be included in the questionnaire for the purposes of further research. (These questions were not included in the analysis of this study.) to be carried out by ALP. These included the following;

- Were you encouraged or supported to come to the Ana Liffey Project? If yes who supported you ?

- Did you get what you were looking for at Ana Liffey Project?

- What is the best possible outcome for you?

- What is the worst possible outcome for you?

- Did you get any other help?

- .3. Questions on the general characteristics of the subjects, such as age, marital, accommodation and employment status were not permitted. It was felt that those who attend ALP are asked these questions too often by other agencies and people and that it was unnecessary to ask these questions for the purposes of this research as the information was available on personal records at the Ana Liffey Project.

4. When the research was completed a random sample of the questionnaires would to be given to ALP.

5. Only 5 interviews were to be carried out per day.

Study Design.

The format of the study was an informal personal interview using a questionnaire. The questionnaire was devised by the author and went through a number of changes at the preparatory stages of the research. Originally, the questionnaire was very structured and comprised only of close-ended questions. At this stage, some of the questions made specific reference to HIV, AIDS with the objective of trying to establish to what extent these factors influenced attenders to make contact with the agency.

The rationale behind adopting a structured approach to the questionnaire was to minimise the amount of interpretation of the answers at the analysis stage and also to simplify the coding of the answers for statistical analysis. However considering the nature of the topic, it was felt that valuable information would be lost if the questionnaire was too structured. In the discussions which followed with the agency who participated in the research it was not permitted to include any reference to HIV, AIDS in the questionnaire. It was felt that such questions would put pressure on respondents to state if they had these diseases and that this would be unacceptable. Concern was also expressed that the participation of prospective subjects could be hampered if an association was made between the questionnaire, HIV and AIDS. If subjects said that they were HIV+ or had AIDS it was recorded but not asked directly.

Considering the objectives of the study and the vulnerability of many people who use drugs, it was important that the interview should be informal and as comfortable as possible for the subjects. It was expected that asking subjects who had a history of drug-use or were currently using drugs to 'tell their story' could be difficult, and for some probably stressful or upsetting. Therefore, the sensitivity of the wording in the questionnaire and the informality of the interview were the main priority in collecting the data. While the conversational approach with open-ended questions was the most appropriate study-design to employ for this study it is important to emphasise some of the advantages and disadvantages of this design.

Sample Selection.

The sample used in this study was a presenting sample or sample of convenience. Because illicit drug-users are difficult to contact and the other drug-related agencies in Dublin did not participate in the study, it was not possible to use any of the random sample study designs.

Selection Criteria.

The selection criteria included that the subjects had been or were currently using illicit drugs and agreed to participate in the study. Any attenders who were visiting Ana Liffey for the first time were excluded as they would not fulfil the criteria for the third objective of the study. The selection criteria went through a number of changes in the course of designing the study. Originally the criteria for 'drug-use' included intravenous drug-use with the objective of concentrating on the reasons for agency contact among a group whose high-risk behaviour increases their chances of becoming positive for HIV or getting AIDS.

It was established in discussions with the staff at ALP that most of those who visited the centre had been or were currently intravenous drug-users. This was supported with evidence from studies carried out in Dublin (2,5,8,12,15,16) that among the illicit drug-users who made contact with the drug-related agencies, the preferred drug and method of use was to intravenously inject heroin. Rather than ask respondents at the beginning of the interview if they had ever used drugs intravenously which could have raised suspicions and feelings of anxiety, all illicit drug-users were included. The expectation was that the majority would be intravenous drug-users. This was correct, 46 of the sample of 50 had been or were at the time of the interview intravenous drug-users.

After the pilot study two questions were left out. One asked subjects how long they were using drugs before they made contact with all the drug related agencies they had attended. Respondents had difficulty recalling the number of years and tended to get confused. Another question asked respondents what were the reasons why they made contact with the person that had referred them to ALP. Including this question led to a lot of repetition in the interview and did not provide any extra or useful information.

The first 50 eligible candidates who visited the project were told about the study by one of the counsellors. This initial contact was made either at the end of a counselling session or at a quiet place away from the activity of the drop-in centre. At the planning stages, it was agreed that when asking subjects to participate in the study it was important that each initial contact by the counsellors be similar. The general points made were that;

- There was a person from Trinity College undertaking a piece of research on why people first make contact and continue to make contact with agencies like the Ana Liffey Project.

- That the staff at Ana Liffey supported the research and were interested in the final results of the study.

- The answers to the questionnaires were confidential.

Those who agreed to participate were introduced to the researcher and were either interviewed at this stage or made an appointment to be interviewed at a latter time.

A high participation rate was achieved. There was a lot of goodwill on the part of the respondents and many were delighted to be asked their opinion about the subject.

There were only three refusals. People were not asked why they did not wish to participate in the interview.

A total of 50 subjects were interviewed over a period of 4 weeks in the months of July and August. Interviews took place in a small room at the ALP.

Interviews lasted from 15 to 50 minutes and did not change significantly in length over the course of the study.

Interview No.	\bar{x} Length of Interview in Minutes.
1- 10	30
11-20	25.5
21-30	31
31-40	25
41-50	35

DATA COLLECTION.

The method of data collection used in this study was personal interview using a questionnaire.[See Appendix A]

The questionnaire was composed of the following sections;

1.Respondents Drug Taking History.

Information on each of the subjects drug-taking history, such as age when they first used drugs, type of drugs used, previous and current agency contact, length of time using drugs before making agency contact and contact with ALP and drug-use at the time of the interview.

As previously mentioned personal information on each of the subjects was obtained from the records at ALP.

2.Reasons for first contact to the Ana Liffey Project.

This included questions about whether subjects were formally or self referred to the ALP how they first heard about ALP and if they had any expectations on their first visit (formal referees only)

3.Reasons for continuing to visit Ana Liffey Project.

Particular reference was made in this section to the counselling service and 'drop-in' centre at ALP.

4. Scope for improvement.

Suggestions that would improve the service provided by ALP of the were investigated.

Analysis.

Analysis of the results was descriptive.'

Chapter III

RESULTS

Sections include;

- I. Respondent Characteristics.
- II. Reasons why respondents first made contact with the ALP.
- III. Reasons why respondents continue to make contact with the ALP.
- IV. Suggestions of respondents for improving the service provided by ALP.

Section I.

Respondent Characteristics.(From attenders' personal records kept at the Ana Liffey Project)

Ia. Personal:

1. Sex.
2. Age-range.
3. Marital Status.
4. Accommodation Status.
5. Employment Status.

Ib. Drug-Taking History:

6. First agency/professional contacted for drug habit.
7. Length of time using drugs before contact with first agency/professional.
8. Drug related agencies attended in the past.
9. Drug related agencies attended at the time of the interview.
10. Age when drugs were first used.
11. First drug used.
12. Other drugs used.
13. Method of use for heroin.
14. Length of time using drugs before contact with ALP.
15. Use of drugs on first contact with ALP.
16. Use of drugs at the time of the interview.

Ia Personal Characteristics.

1. Sex.

Sex.	No. of respondents (N=50).
Men	28 (56%)
Women	<u>22 (44%).</u>
Total	50 (100%)

Table

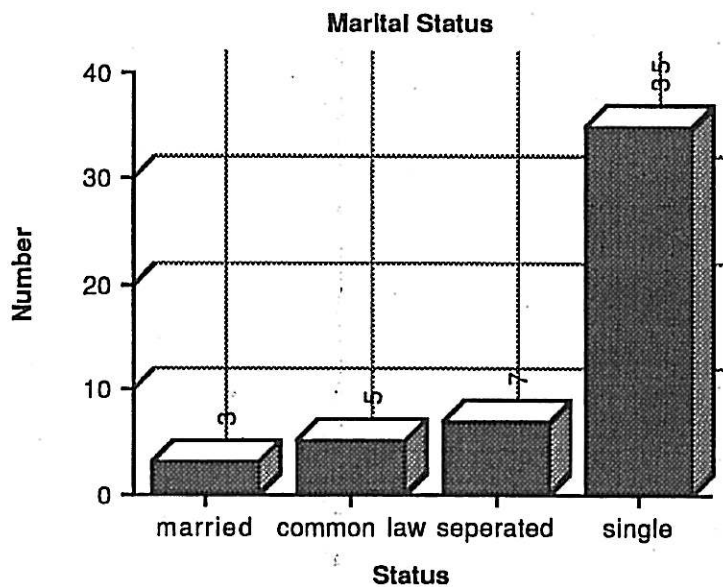
1.

2. Age.

Age-range (years)	No. of respondents. (N=50)
20 - 25	23
>25 - 30	13
>30	<u>14</u>
Total = 50	

Table 2.

3. Marital Status.



Common law relationship.

Figure 1.

* This usually refers to people who have been cohabiting for a number of years.

4. Accommodation Status.

The majority of the sample were living in local-authority accommodation. 10 were sharing local-authority accommodation with their parents, 21 lived in local-authority flats and 12 lived on local-authority houses. Only 4 of the respondents lived in private accommodation, 2 each in private flats and houses. 3 respondents were homeless.

5. Employment Status.

43 of the sample were unemployed. Of the remaining 7, 5 were working, 1 person was on a Social Employment Scheme (Government work opportunity programme) and 1 was in full-time education.

Ib. Drug-taking History

6. What was the first centre, helping agency, person or worker you visited for your drug habit?

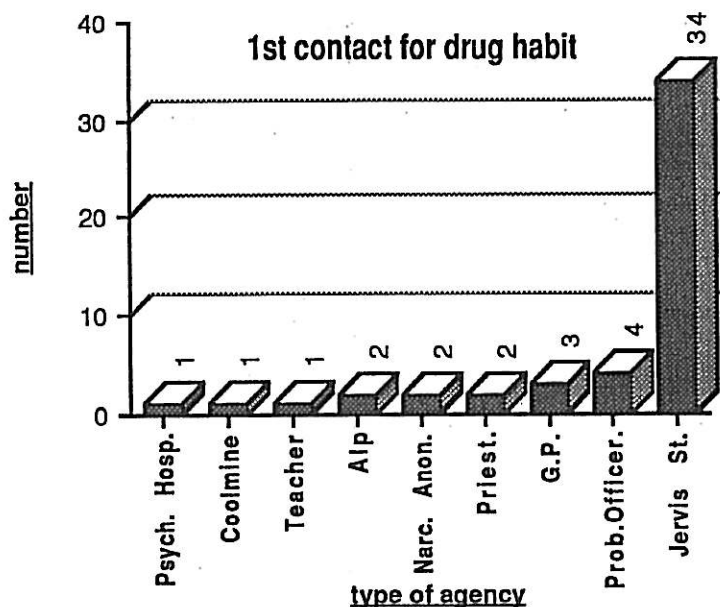


Figure 2.

7. How long were you using drugs before you made contact with the above?
(N = 50)

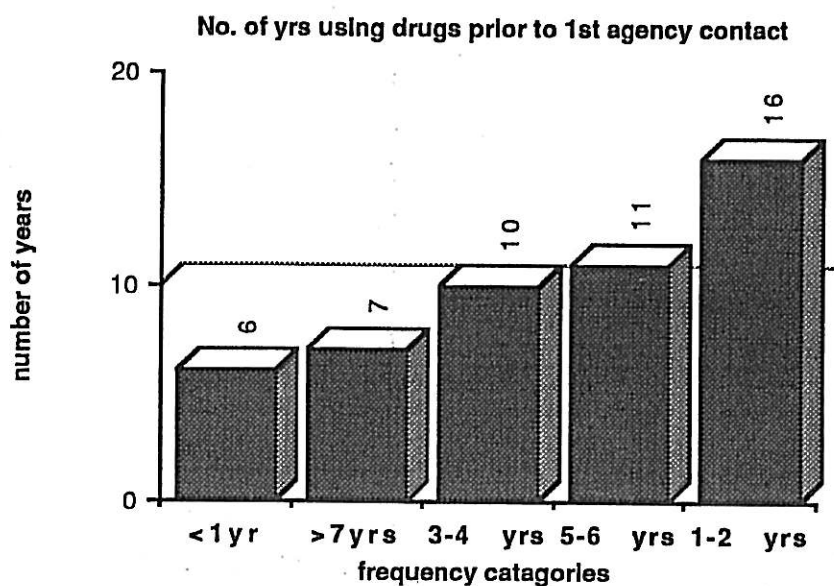


Figure 3.

8. What drug treatment/ rehabilitation centres have you attended in the past?

Drug Treatment/Rehabilitation Centre.	No. of Respondents. (N=50)
Trinity Court	45
Coolmine	25
Rutland Centre	9
Psychiatric Hospital	7
Narcotics Anonymous	2
Other *	5

*Other included: Centres attended in the UK, Talbot Day Centre, Sr. Consillio's Centre in Athy, Co. Kildare, and La Patriarch in France.

Table 3

9. What drug treatment / rehabilitation centres do you attend now?

Drug-related agency	No. of Respondents.(N=50)
Trinity Court	27
Narcotics Anonymous	8
Total 35*	

Table 4

*The remaining respondents only visit ALP.

10. How old were you when you first used drugs?

Range of years.	No. of Respondents. (N=50)
12 or less	4
13-15	30
16-19	14
20-24	2
Total = 50	

Table 5

11. What was the first drug you used? (N=50)

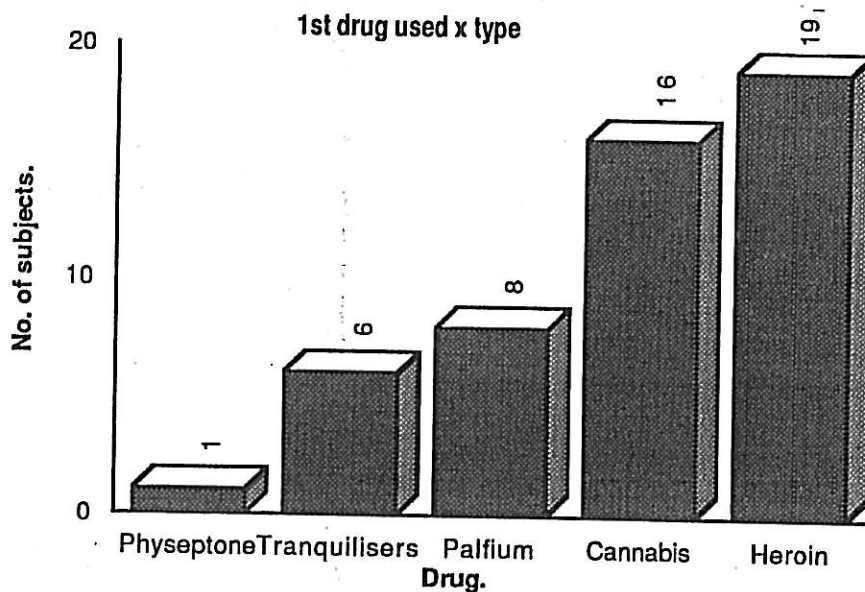


Figure 4

12. What other drugs have you used? (N=50)

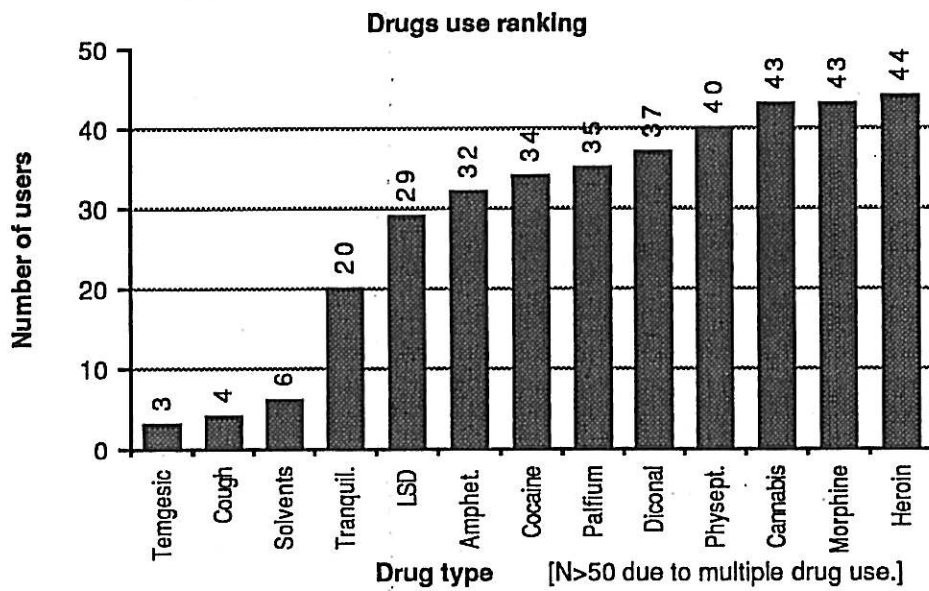


Figure 5

13. What was your method of use for heroin?(N=44)

All respondents said that the injected heroin.

14. How long were you using drugs before you made contact with the ALP?

(N = 50)

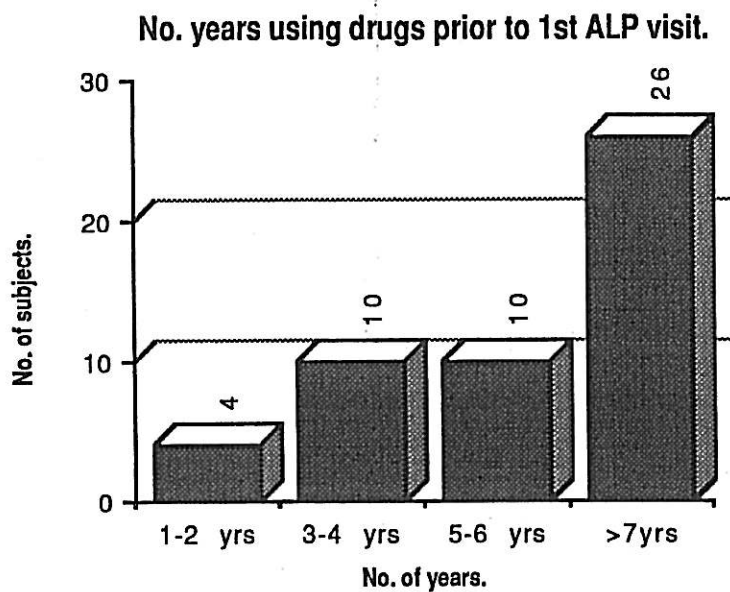


Figure 6

15. What was your drug-state when you first contacted ALP?

Drug-state.	No. of Respondents(N=50).
Using drugs.	24
Not using drugs	15
MMP.	<u>11</u>
	Total = 50

Table 6

16. What is your drug-state now? [At the time of the interview] Drug

State	No. of Respondents.(N=50)
MMP	28
Drug-free	18
Using drugs	<u>4</u>
	Total = 50

Table 7

Note: Though subjects were not directly asked if they were seropositive for HIV or had been diagnosed with AIDS, if they stated this during the interview it was recorded. 22 respondents said that they were positive for HIV. 7 said that they were diagnosed with AIDS.

SECTION II

Reasons Why Attenders First Made Contact with the Ana Liffey Project.

17. How did you first hear of the Ana Liffey project? (N=50).

Answers	Self-referred(N=35)	Formally referred(N=15).
Friends	10	3
Family member	7	0
Project worker from ALP	14	7
Narcotics Anonymous	4	0
Solicitor	0	1
Trinity Court.	0	4
Total	= 35	15

Table 8

18. Were you 'formally referred' to the Ana Liffey Project?

['Formal referral' is defined as when the person is directed by another agency or professional to attend the Ana Liffey Project.]

Respondents' answers.	No. (N=50)
Yes.	15 (30%)*
No	<u>35</u> (70%)

Total = 50 (100%)

Table 9

[*Note: One respondent said that he was 'self-referred', but in the course of the interview it transpired that he had been 'strongly advised' to attend ALP by his solicitor. He had been charged with selling and using heroin and his attendance at ALP was suggested in order to demonstrate to the court that he was "doing something about" his drug habit. As this subject fulfils the criteria for 'formal referral' he has been included into this category.]

Questions 19-21 were only asked to the formally referred group, (N=15)

19 Who referred you on your first visit to the Ana Liffey Project?

Referral Source:	No.(N=15)
Social Worker at Trinity Court	8 (16%)
Probation Officer	4 (8%)
General Practitioner	1 (2%)
Counsellor from the 'GMU Unit	1 (2%)
Solicitor	<u>1</u> (2%)
Total =15 (30%).	

Table 10

*Genitourinary Medicine Unit.

20. Why were you referred to the Ana Liffey Project?

Reason for referral.	No.(N=15)
1. Attendance at the Ana Liffey Project was a condition for participation on the methadone Maintenance programme.	8
2. Attendance at the Ana Liffey Project was part of the 'temporary release' contract from prison.	4
3. Needed help to 'get off drugs'.	1
4. To get 'extra counselling for HIV'.	1
5. Pending court case.	1
Total = 15	

Table 11

21. Did you have any expectations on your first visit to the Ana Liffey Project? (N=15.)

A variety of expectations were given all of which were described in relation to the respondents' use of drugs at the time of first contact. The most frequently mentioned expectation was to stop using all drugs, including physeptone [for those who were on the methadone maintenance programme].

21a. Needed support to become Drug-Free.

"I really wanted to come off all drugs, including 'phy' [physeptone]. I was just out of prison and I wanted to get my life together for example, to cope better, get my own place and settle down."

"I really wanted counselling to get off drugs, I wanted to show myself and others that I could live normally, without drugs , even though I have HIV."

"I wanted to show people that I was serious about coming-off drugs."

"I wanted to come-off drugs very badly, I was desperate."

21b. Needed support to Stay on the Methadone Maintenance Programme.

Specific reference was made by some subjects to the expectation and need to get support and encouragement from the Ana Liffey Project while they were on the methadone maintenance programme.

"My first priority was that I was not in good shape, I was in a bad way emotionally. I was getting started on the 'programme' [methadone maintenance programme] and getting myself together. I needed encouragement."

"I wanted to be able to cope over there [Trinity Court]. It is very difficult over there, they treat you awful, like an animal."

"That Ana Liffey would help me cope on 'phy' [Methadone maintenance programme.]. It was important that I stayed on that, otherwise I'd have been back using. If that had happened I wouldn't be here now, I'd be dead with AIDS."

"That was a mad time. I was just on the methadone maintenance after being very bad on heroin. I suppose I wanted, hoped, I'd make it. I wasn't sure at all, but I knew I'd never do it on my own. They [ALP] got me started. I needed a lot of help and support not advice.

21c. Counselling for HIV.

Expectations also included counselling for HIV.

"We both have the virus [subject and his girlfriend]. We are both under a lot of pressure and stress, you have to go somewhere to talk about all of that - it gets crazy."

21d. No Expectations.

Some respondents said that they had no expectations on their first visit to the Ana Liffey Project and one could not remember,

"I suffer from amnesia and forget everything at that time."

Respondents' Answers	No. (N=15)
'Needed support to become drug free.'	6
'Needed encouragement' to stay on the Methadone maintenance programme	4
HIV counselling	2
No expectations.	3
Cannot remember.	1
	Total = 16*

* [One respondent gave more than one answer.]

Table 12

22. Why did you first make contact with the Ana Liffey Project? (N=35, Self-referred group.)

a. Feelings of Desperation.

Nearly half of this group, 16 out of 35, described feelings which could be grouped under a general heading of desperation. 10 of the 16 were using drugs when they first contacted the ALP and each one clearly stated their need to 'stop using' because they had reached what could be described as a critically low point in their use of drugs, as one young woman said,

"I went to the Induction Centre in Coolemine, that was boring and I was under pressure [from Trinity Court] to go there, I didn't think I needed Coolemine. I was desperate - I was bad on drugs - I was in bits. I knew about Ana Liffey and said that I'd try the counselling for about 6 months. I was using [injecting morphine] when I came here, they didn't mind as long as I didn't arrive 'strung out'. It was good to know that I could come here and not be under pressure to give up drugs. I am still coming here after 2 years."

"I think I'd be dead if I hadn't come to Ana Liffey. I was in a really bad way from heroin and I needed help to get-off drugs. I didn't know where I was going before I came here - when you come off drugs you have to pick-up the pieces of all the time you've missed. It helps if you can share it with someone like a counsellor."

"I knew that I had to do something about my drug addiction - I was really strung out and was heavily involved in the drug scene. I knew I didn't have to come here ,I came for myself. I needed to talk, I needed somewhere to talk."

Others described themselves as being in 'dire straits' or that they were literally 'lying on the streets' prior to their first contact with ALP.

"I was lying in the street and in a bad way from drugs and drink. I wanted to sort myself out and give up drugs and drink."

Those who were on the methadone maintenance programme when they first visited the ALP described feelings of desperation on two levels. Not only were they trying to stop using heroin but they were also trying to cope with the demands of being on the methadone maintenance programme and for some the added anxiety of having been diagnosed with AIDS.

"I needed to come. I needed support on 'phy' [MMP] and to talk - I have AIDS. I wanted to suss the place out and see what it was like. I was rock-bottom. I suppose every junkie at some stage is 'rock-bottom'. I also wanted to be at peace with myself. ALP is a middle ground for the mature addict."

"I knew Frank [counsellor at the ALP]- he was always very helpful when I was depressed, so I went along when things got really bad- I was told I had the virus, I was in a bad state, I knew from past experience with Frank he'd help me."

"My life was a mess, I was in a very bad way with drugs and emotionally. I felt that there were no people there (Trinity Court) I could talk to on a confidential basis. I came here after my first visit on the methadone maintenance programme - I wanted help for coping problems, especially on the methadone."

Even those who were not using drugs when they first contacted ALP experienced 'feelings of desperation' that are often associated with the difficulties of trying to live without drugs after a long history of drug-use.

"It was only a matter of time before I'd kill someone. I was getting very violent. I had just given up drugs and drink after using them for 17 and 15 years and this was after a good few attempts. I was approaching 30, I'd made a complete shambles of my life. I was cracking up and I needed to share things with a counsellor, that I had hidden for 20 years. I really needed help."

"I was just out of Coolemine - it didn't work. My two kids, I gave up to a childrens' home. I had been in hospital [with hepatitis] and got locked - up again. I was sick of being on drugs. The counsellor from Ana Liffey gave me a lot of help in prison. I was in the horrors, I felt neglected, I knew that the counsellor here would care about me."

Similar feelings were expressed by another young mother,

"I was really depressed, I wanted something for myself to see would it do good for me. I have two kids and couldn't cope. I wanted to get off drugs and make a fresh start, otherwise I'd have had a nervous breakdown."

b. Ana Liffey Project - 'Somewhere to go'.

11 of the 35 respondents first made contact with ALP because they knew or had heard of ALP as a place where they could meet their friends or others who were using drugs or on the MMP. Those who were using drugs at the time wanted to 'check it out' as a place that would let them in them even though they were using-drugs.

"I knew that I could 'drop-in', have a chat, meet friends and talk about my problems. I wanted to get support because my partner was in the Separation Unit [A separate unit in Mountjoy Jail for prisoners who are seropositive for HIV or have AIDS.]

"I was in bits using and injecting everything. Plus I was curious, it was somewhere to go. What else is there to do all day?"

Those who were on the methadone maintenance programme, like their peers who were formally referred, said that part of their motivation to make contact with the Ana Liffey Project, was to "...come for comfort while on the methadone maintenance..." .The 'drop-in' facility at the ALP allowed people to meet and 'have a chat' often about the problems associated with the MMP.

"I started going with a friend, we'd meet other friends and have a chat. We were all on the methadone - we could talk about Trinity Court and all the hassle there."

c. Support to remain drug-free.

The need for support to remain drug-free was the primary reason for contacting the Ana Liffey Project for 4 ex-drug users, [who had been using heroin for an average of 7 years prior to first contact]. 2 had just come out of prison and wanted to take this opportunity to remain drug-free and 'start a new life after prison'. Their first contact with ALP was motivated primarily by the need to get support to remain drug-free. 'Slipping back' to 'using' drugs was a real fear,

"I was 'off-drugs' one and a half years, except for a few 'barbies' [barbiturates] when I first came here. I came here 1 or 2 times per week to have a chat about my problems. I was just about off 'hard' drugs and I had a problem with alcohol, but I knew I didn't want to slip back onto gear [heroin] and would need help with this - I got this at Ana Liffey."

One young man in his 30s, emphasized the importance of meeting other ex-drug users when trying to stay off drugs:

"At the start I was sussing it out, I had been through Rutland. I didn't do anything else at the time except fill my life with ex-drug users. It is important to surround yourself with ex-users, so I came here. I knew that it was the only way that I could cope and keep off drugs."

d. Other reasons.

There were a variety of 'other reasons' that contributed to respondents first making contact with the ALP.

Other Reasons	No. of Respondents(N=35)
Marital/relationship difficulties.	6
Unsuccessful with other drug-related agencies	5
Sexual abuse	3
Counselling because seropositive for HIV.	3
Felt that attendance at ALP as a way to get onto the MMP	<u>2</u>
	Total = 19

Reason for first contact	No.(N=35)
Feelings of desperation.	16
ALP was 'a place to go to'.	10
Support to remain drug-free.	4
Other Reasons.	<u>19</u>
	Total = 49*

*Some respondents gave more than one reason.

Table 13

SECTION III

Reasons Why Attenders Continue to Visit the Ana Liffey Project.

23. Why do you continue to attend the Ana Liffey Project? (N=50)

A. Answers of the Self-referred Group.(N=35)

a. 'Continue with the counselling.'

The majority of the group who were self-referred continued to visit ALP because they wanted to 'continue with the counselling'. Some of the reasons they gave included;

"I have lots of family problems. Here, I can get my problems out of my head. I get positive answers here and a great deal of support. They don't pity you. They'll help in whatever way they can."

"I've met a counsellor who understands me. I wanted and looked for a person who would understand me and I found one here."

"Even when I was clean I needed it [counselling] to cope, especially with the problems I have [incest and marital problems]."

"I feel I need to talk a lot especially the way my life is going. I can express myself here no problem."

"I know they helped me in the past. If someone helps me I'll come back slowly but surely. I've had my moments with Ana Liffey, but I always come back."

"I can tell things here to my counsellor that I would not tell my husband."

b. 'Like to drop-in.'

Being able to 'drop-in' to ALP without having to make an appointment was given as an important reason for continuing to visit ALP. This facility provided the opportunity for some to 'meet their friends and have a chat', while for others it was a place to go to while trying to 'give-up' drugs.

"It is somewhere to drop-in for a chat and a cup of tea. I've some good friends here and I've got a lot out of ALP. I love coming here."

"The first year of recovery is horrific - you want to hide. I hang-out here for hours and then go to N.A. [Narcotics Anonymous]. Otherwise, I'd lie in my house and end up suicidal. You have to be selective where you go."

c. 'Friendly Atmosphere' of ALP.

The informality and 'friendly atmosphere' of ALP were also referred to by this group as a reason that influenced them to return.

"Ana Liffey is somewhere where you can feel 'wanted' - like a second home. It is comfortable, like a home."

"I like the place - you can talk about anything and its very friendly."

"They are very supportive. Coming here is a way to get away from everything. There is a good family atmosphere here."

B Answers of the formally referred group.

a. Continue with the counselling.

Excluding the 6 respondents who continued to return to ALP because it was a 'part of their MMP or Temporary release, the main reason given for returning to ALP was 'to continue with the counselling'.

"I just come for the counselling. They listen to you here. They understand your problems when you talk them out - they guide you. You don't do all the talking."

"The alternative for me would be messing around the streets. I come here for the chat and the counselling - I've made it a habit."

"I come here for the counselling. They are very non-confrontational here."

2 respondents said that they needed counselling from ALP to 'cope on the methadone maintenance'.

b. Other Reasons.

Other reasons for continuing to visit ALP included specific aspects of the service provided by ALP, for example the womens' group. Also particular reference was made to the fact that ALP was a 'safe-place', safe from 'pushers' and 'dealers'.

"This is a safe house, and that is important. There are no pushers of dealers here. There are dealers around Pearse Street [Trinity Court] asking you if you want gear."

c. 'Like to drop-in.'

Similar to those who were self-referred, some respondents liked that they could 'drop-in' to ALP without having to make an appointment.

"I've no where else to go. You're not rushed out and it breaks-up the day. You can 'drop-in' when you like without having to make an appointment."

d. 'Friendly atmosphere of Ana Liffey.'

Many referred to the 'friendly' and 'homely atmosphere' in ALP as a factor that influenced them to return to ALP.

Reasons given:*	Self-referred(n=35)	Formally-referred(n=15)
'To continue with counselling'	29	4
'Like to 'drop-in' to ALP'	7	4
'Friendly atmosphere of ALP'	6	2
Other reasons.	9	0
'It was part of the MMP'	n.a	4
'It was part of the temporary-release.'	n.a.	2
	Total = 51	16

*Some respondents gave more than one reason.

Table 14

24. Do you see a counsellor here? (N=50.)

	Self-referred group(N=35).	Formally-referred group(N=15).
Yes	35	11
No	0	4
Total =	35	15.

Table 15

25. What did you find helpful about the counselling?

A. Answers of the self-referred group(N=35)

The main aspects of the helpfulness of the counselling for the self-referred group could be classified into 4 categories, the opportunity to talk, self awareness, support and practical help.

a. Self Awareness.

Many respondents referred to an improvement in awareness of their feelings and emotions. Their answers could be grouped under a general heading of self-awareness.

"I've discovered more about myself and how to deal with my feelings and emotions. When you're on drugs you forget or don't know how to deal with emotions."

"I've grown and I am more aware of my feelings - my confidence took a hammering when I was using."

"Everything is backwards in my head, counselling helps me to sort it out. I know I can always come here. I am more confident and can talk for myself more. I can rest my burdens here."

"I am more aware of my family problems and how they relate to me. I am more aware of my emotions and what they mean."

"Counselling has brought things out that I've locked-in. It helps me to cope with stress especially when I'm upset. It has helped me to come to terms with my health problems, I have AIDS, and emotional problems. It has changed my attitude towards life. I've grown-up from being locked in a kids' mind - now I act my age."

b. Support

The 'support' provided by the counselling ranged from support for those who had AIDS to those who were trying to give up drugs.

"Ana Liffey supported me, they understand especially as I have HIV. They know things about AIDS, dying and coping. I've faced up to a lot of problems and I accept responsibility more."

"Counselling directs you as all the answers come from yourself. When you're off drugs it's all about living and the daily hassle - counselling supports you; in this."

"Counselling helped me with family problems and to take responsibility. I opened up more. I used to keep a lot of resentments to myself. The counselling has been excellent. I have a good sense of relief, I feel more supported."

c. Opportunity to talk.

The helpfulness of the counselling included the opportunity to talk with someone not only about problems related to their use of drugs but also about other personal and family difficulties.

"It is nice to have someone to talk to. I've no one at home to talk to, especially with a crisis - like I have AIDS."

" I can talk about other problems, not just my drug problems. When I hear myself talking about the problem I almost sort it out myself and see to from a different perspective."

"The advice and the talking- it shows they care about you, you're not alone. It's great to know that you can talk to someone, for me opening up to someone has been great. I kept things closed for years."

"To talk about things bothering you. I've met a good few counsellors and social workers and the ones here are good. They are easy to talk to, you feel you've gained something."

"I've built up a relationship with my counsellor. I can come if I'd any trouble and don't have to carry it around all the time I can tell him. Nobody else would listen, only these people."

d. Practical Help

Many respondents referred to the practical help provided by the counsellors.

"The advice and practical help has been helpful for me. They organised for my child to see a specialist in Crumlin [Childrens' Hospital]. And they write letters for me for my boyfriend in prison when I can't get in to see

him. No matter what time you come in they go out of their way to see you. I don't feel so isolated or on my own.

"The counsellors are not only good listeners, like friends, they also help with problems or ring-up about things for you, it's practical help."

"The advice is always good and they give practical help like condoms."

Respondents Answers	No.(N=35)
Increase in self-awareness	23
Support.	18
The opportunity to 'talk'.	14
Practical Help	6
Total = 61	

*Some respondents gave more than one answer.

Table 16

B. Answers of the formally-referred group(N=11)

a. Understanding

The helpfulness of the counselling described by some of the subjects was the ability of the counsellor to 'understand' the problems associated with drug addiction.

"They understand your problems when you talk things-out. They don't judge you. You don't do all the talking. You don't keep saying yea, yea..."

b. "Chance to talk."

The opportunity to 'talk and discuss things' was mentioned by some as another helpful aspect of counselling. The chance to 'put a lot of points across' about themselves was the main benefit for some while for others counselling provided the opportunity to discuss 'other things' for example, family problems, getting a job.

"Counselling lets you talk about other things besides gear[heroin] and who is using. I need to avoid junkies and drug-talk. That is very important if you want to stay off-drugs."

c. Self-Reflection.

Another aspect of the helpfulness of counselling was described as '...being able to look at myself...' Being given the opportunity to '...see who I was myself...'and '...the counselling brought me out of myself, I am less shy now.' These comments could be grouped under a general heading of 'self-reflection' which one young woman felt she really needed to do:

"You can look at where you're at and begin to pick up the pieces of all that has happened in your life. I needed to do this, I had to tell someone really about my life."

d. Being 'Listened to'.

Being listened to was also referred to as one of the helpful aspects of counselling.

3 of the 11 respondents did not find the counselling helpful, their comments are recorded in the next question.

Respondents' Answers	NO (N=11)
Understanding	3
Chance to talk	3
Self-reflection.	3
'Being listened to'.	3
Did not find it helpful.	<u>3</u>

Total = 15

Table 17

26. What do find most unhelpful about the counselling?

A. Answers of the self-referred group (N=35)

a. No Criticism.

Most respondents did not have any criticisms of the counselling provided at ALP.

b. Various Criticisms

"Sometimes I was asked things I'd prefer not to be asked at the time. I wasn't always ready to discuss certain things because of personal or family pressure."

"I'm 29 and I still need help, that's the biggest put-down. They have the power if you have an argument, they can check with Mountjoy and put you back-in."

"'Bleeding-heart merchants' - 18 year olds who are going to change the world."

"They never have enough time."

"None of the counsellors have been drug addicts or were sexually abused - its a pity there are no ex-drug addicts or people who were sexually abused. They would know more than the stuff from books."

"Sometimes its text-book counselling."

"I saw lots of counsellors and I didn't find any of them helpful. What are they counselling you on. They advice you, but you know it already."

Respondents Answers	No.
No Criticism	19
Various criticisms.	<u>16</u>
Total	= 35

Table 18

B. Formally-Referred groups' Answers (N=11)

a. No Criticism.

Just over half of this group expressed no criticism about the counselling. The various criticisms of the remaining respondents were difficult to categorise.

b. Various Criticisms.

"I held a lot in, I never spoke about my problems no matter what I said, I didn't think they'd help me off-drugs. I'd listen but I wouldn't say much. There are days when you don't know what to talk about with the counsellor."

"It will take more than counselling to solve my life. I don't see results in it."

"How could they know what you're going through with gear?"

"Sometimes its tough, but that happens to everyone. I'd be lying if it didn't happen."

"The counselling can be painful - it is not easy."

Respondents' Answers.	No. (N=11)
No criticism.	6
Various criticisms	<u>5</u>

Total =11

Table 19

26. What do you find helpful about meeting the other people who visit the Ana Liffey Project?

A. Self-referred groups'Answers. (N=35)

a. Mutual Care and support.

Most respondents answers to this question were described in terms which could be described as an appreciation of the mutual care and support that can occur between people who have had similar experiences.

"I like to talk with others from Trinity Court. We talk about the methadone maintenance programme a lot. We are all in the same ship. The people here are like me, we stick together and help each other out."

"You can relate to them, when two ex-addicts meet there is no big image."

"It buks you up - you don't feel as sorry for yourself. They have the same problems as me and we can talk about them."

"It is a 'day at a time' for drug addicts. I can empathise with them."

"We can chat , especially on a one-to-one basis. They are going through the same as you and that's good. Two addicts can talk and help each other."

b. 'Compare my problems.'

For a small number of subjects, they said that they found it helpful to meet the people who were using drugs because they tended to 'compare' themselves with them and this comparison had the effect of reducing the size of their problem. For others it reminded them of the problems associated with returning to using drugs.

"I know most of them and I compare my problems with theirs and then mine don't seem half as bad."

"To see the circumstances that other people are in that puts fear into me sometimes not to use drugs."

"What helps me is seeing the others in a bad state - that is where I was and could go back to."

Some respondents did not find it helpful to meet the others, their comments are described in question 27.

c. Not Helpful.

Some respondents did not find it helpful to meet the others, their comments are described in the next section.

Respondents' Answers	No. (N=35)
Mutual care/support.	26
Compare problems.	4
Not helpful.	<u>5</u>

Total = 35

Table 20

B. Answers of the formally-referred group.

a. 'Chat and meet friends.'

The opportunity to 'chat and meet friends' was described as the most helpful aspect of meeting the other people who visited the ALP. For some to 'chat and meet friends' offered more than friendly conversation but also helped feelings of depression or helped ones self confidence. For one man meeting other drug users gave him,

"...more confidence, I was shy when I first came here, but that has faded out, I mix freely with everyone now."

For another man who said he had AIDS and often felt depressed he liked to chat ' because it helps with my depression".

For those who were attending the methadone maintenance programme at Trinity Court, it was helpful to meet their friends and 'chat' especially about the MMP.

"I know them all, its nice to drop-in. You need someone to talk to when you come out of the centre (Trinity Court)."

b. No comment.

A small number of respondents said that they did not 'mix with the others' and therefore had no comment to make about the helpfulness or unhelpfulness of meeting the other attenders at ALP.

c. Adds to the Informality of ALP.

Finally one man felt that meeting the other people at ALP 'added to its informality'.

Respondents' Answers	No. (N=15)
Chat and meet friends.	10
No comment.	4
Adds to the informality of Ana Liffey.	1

Total= 15

Table 21

27. What do you find unhelpful about meeting the other people who visit the Ana Liffey Project?

A. Self-referred Group. (N=35)

The unhelpful aspects of meeting the other people who attend ALP, as described by the respondents, could be described under 4 general headings.

a. Stressful reminder of the 'drug scene'.

"They remind me of my past especially when I see the kids. I am scared of slipping back into the scene, scared of the memories when I see others who are using."

"Sometimes it is stressful, when you're trying to get out of the scene you don't want to be around addicts."

"Some of them are a bad influence. They talk about being on drugs - I don't like to hear that. It brings me back to all that stupidity."

"Some of the people from Trinity Court on the methadone are annoying when they come in stoned. If you're trying to kick the habit, it can be difficult if users come here."

b. Temptation.

Meeting people who are involved in the 'drug-scene' was described by some as a 'temptation' to go back to using drugs.

"Sometimes there is a temptation to go off and take drugs with some people or some will give you bad advice."

"I want to get away from them - two ex-addicts meeting are a bad combination. I know them, it is too easy to slip-back."

"Meeting them I always know where to score and get stoned in Dublin - that can tempt you."

c. "Bravado"

Some got annoyed at the 'bragging' and 'bravado' by some people who visited the ALP.

"Some of them annoy me they are always bragging and spoofing."

"I know most of them. There is a macho bit about being an addict and a lot of bravado and messing."

d. Other comments

'Other' aspects of the 'unhelpfulness of meeting the other people who visited the ALP included criticisms of people who brought their children into the ALP,

"They [the children] shouldn't hear about gear and sexual abuse."

One woman felt that some of the people attending ALP were more suitable for Focuspoint [Agency for homeless people in Dublin]. Another young woman who was on the MMP, was critical of those who were no longer using drugs.

"Those drug-free people, 4 and 5 years off drugs and who go to N.A. (Narcotics Anonymous) - What do they know about hard drugs? They have it all together. They shouldn't be here."

Respondents' Answers	No. (N=35)
No criticism	16
Stressful reminder	10
'Temptation to go back using.	4
Bravado	2
Other reasons.	3

Total =35

Table 22

B. Formally-referred groups' Answers.(N=15).

a. No Criticism.

Most respondents did not express any criticism to this question.

b. 'Don't Like the Drug Talk'.

For the few who did, like those who were self-referred, they found the references to the drug scene upsetting' or 'tempting' to start using drugs again.

"Occasionally the odd one talks about still using drugs, I don't want that. I wish they'd shut-up. It puts ideas into your head."

"I don't like people talking about the drug scene. When you are drug-free, you don't want to associate with users."

"Meeting people who are very stoned can be upsetting."

Respondents' Answers.	No. (N=15)
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No criticism.	12
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'Don't like the drug talk.'	<u>3</u>
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Total=15

Table 23

SECTION IV.

Scope for Improvement in the Provision of the Service at the Ana Liffey Project.

28. Have you any suggestions or ideas that would improve the service provided by the Ana Liffey Project? (N=50).

It was very difficult to categorise the wide range of suggestions offered in the answer to this question. There were many suggestions that could be put under a general heading that would include ideas for change in the organisation of ALP. Some of these included;

28a. Change in the Organisation of ALP.

"ALP should open 24 hours a day."

"There should be separate facilities for using and recovering addicts."

"There should be a doctor and a social worker for the children."

"ALP should provide practical help , for example information on social welfare entitlements and help for unmarried mothers."

"ALP should be more like Trinity Court with things like the creche and occupational therapy."

"ALP should have a greater say in who gets onto the MMP or who gets a detox."

28b. Activities.

There were lots of suggestions to have a wide range of activities at ALP. Some of the suggestions included 'more weekends-away to Co. Wicklow' (ALP organises short holidays to Co. Wicklow twice a year). The provision of leisure classes included, cooking, arts and crafts and dancing. A few felt that it would be a good idea to show videos on drug addiction, HIV and AIDS. There was one suggestion that ALP should organise courses in painting and decorating that would improve prospects of getting a job.

28c. 'Don't change'

Another group of subjects felt that ALP should not change that it was 'just right the way it is'.

" Don't let it get any bigger, its nice and homely and its in a good location."

28d. More Counsellors.

Finally there was a request that ALP should employ more counsellors including a counsellor who was an ex-addict.

"Students come here for placements, psychologists, doctors from Trinity. Why don't we do that. Some of the counsellors should be ex-addicts. Instead of going on the dole [unemployment benefit] I'd rather be here as a counsellor."

Respondents Answers	No. (N=50)
Change in the organisation of ALP.	22
'More activities'.	7
'Don't change'.	11
'More counsellors.'	<u>10</u>
Total = 60*	

*Some respondents gave more than one answer.

Table 24

Chapter IV

Discussion.

"[R]elatively little is known about why many drug users fail to come to treatment or do so only after many years of drug taking. This lack of consumer research in this field means that we do not know enough about how to devise effective services to meet the particular needs of this client group nor about how to make the existing services attractive and relevant."

P. 635 (40)

The attractiveness and relevance of the services for drug-users would appear to be receiving more attention in recent times. Indeed, prior to the advent of HIV infection and AIDS among drug-users, it has been suggested by one commentator, that this group received minimal attention(42). One explanation for this sudden interest is that there is a belief in the literature that by attracting more drug-users to the various drug-related agencies their level of information about the risks associated with HIV and AIDS will be enhanced. The hope is that that the corollary of this would be that such knowledge would contribute in some way to reducing the incidence of HIV and AIDS. This rationale is dubious and the evidence to support the argument is mixed. The studies to date have primarily focused on the behaviour of drug users who have made contact with the drug related agencies and who therefore by definition are different from those who have remained outside of the services. Consequently, it is not possible to conclude that the changes in behaviour in one group will follow in the other group.

1. Help Seeking as an Important Issue.

The Advisory Council on the Misuse of drugs (1982 quoted in 40) pointed out that "treating the problem drug taker is beneficial both to the individual and to society". The reasons are obvious, and have become more pressing in the light of the increased risk of becoming seropositive for HIV infection through the sharing of needles and syringes.

However, currently in Dublin only a small number of illicit drug-users are, at any one time, in contact with the drug-related agencies. It is estimated that in Dublin in any one year only about 1400 drug-users make contact with the drug-related agencies, this may represent as few as 10% of the total number of estimated drug-users in Dublin. And even when they do make contact they have usually been using drugs for an average of 3 years prior to first agency contact.(36). The consequences of this are that in Dublin there is a group of drug-users who are engaging in high-risk behaviour, the intravenous use of drugs and for a considerable length of time before they make contact with the drug-related agencies and are therefore increasing their risk of becoming seropositive for HIV.

The avoidance of the drug-related agencies by the vast majority of drug users is very significant and in itself provides important information for those involved in the provision of services for drug-users. What is the profile of this group? What health services do they use, if any? Why do they avoid the established drug-related agencies? What is the prevalence of HIV or AIDS in this group? Have they changed any of their behaviour in response to the AIDS epidemic? These questions would probably reveal answers of interest and relevance to the existing services, that for the present only be speculated upon, as this group is diverse and not easily accessible.

2. Caution in the Interpretation of a Special and Limited Sample.

This was a restricted sample confined to a group of attenders who attended one drug-related agency in Dublin. This study concentrates on obtaining the clients' perspectives on help-seeking and their ideas for improving the service provided by one drug-related agency in Dublin. Accepting the limitations of this study design and the self-selected nature of the sample studied, it nevertheless, it is the first study of its nature to be undertaken in Dublin, a city that has a serious problem with intravenous drug-use and consequently a growing rate in the incidence of HIV and AIDS. Exploring the reasons why people behave and act as they do is always difficult as there is always the problem of gauging the discordance between what people say and what they actually do. This discrepancy together with the potential vulnerability of many of the people who use drugs, places limitations on a study of this nature and design.

Before discussing the results of the study it is necessary to underline these **limitations**. The data in this study are reported from interviews with 50 subjects who attended one drug-related agency in Dublin. It would therefore be wrong to generalise these findings to those who attend other drug treatment or rehabilitation agencies or to those who do not attend any drug-related agency. At best, the study presents a small glimpse into one part of a system in which the drug using population interacts. The wider system includes the other drug-related agencies, the legal system together with the prevailing social, political and moral beliefs in society. At present, we know all too little about this system, why drug-users seek help, their expectations and fears about the agencies they attend.

It is also important to emphasise that the **health service has limited resources** and therefore it is essential that the provision of services for the 'using' or 'recovering' addicts are appropriate (this also includes that the services are effective and efficacious) and attractive. It has been argued by some (43) that it would not be unreasonable to expect that with more effective and attractive services for drug-users

there would be an increase in earlier help-seeking among drug-users as there would be a better match between individual expectations and the help that is offered. This argument begs the question to define what is 'attractive' and 'effective' for drug users. From the results of this study some recommendations are offered based on the experiences of past and current drug-users. It is hoped that these recommendations will offer a small but important contribution to narrowing the gap between individual expectations and the help that is offered by the drug-related agencies.

3. Methodological Problems

As mentioned on the methodology section the study design adopted for the purposes of this research was an informal personal interview using a questionnaire. It is important to emphasise the advantages and disadvantages associated with this design and what efforts were made in this study to reduce bias.

3a. Advantages of the Study Design.

The conversational interview using open-ended questions allows:

1. The respondent to express a wide range of responses.
2. The respondent can reply using his/her own words and with emphasis when required.
3. Questions and answers can be clarified if necessary by the interviewer or the interviewee.
4. An atmosphere is created that can be conducive for the respondent to reflect and 'tell their story' in a relaxed and meaningful way.

3b. Disadvantages of the Study Design.

1. People may find it difficult to recognise and articulate their thoughts when asked open-ended questions.
2. Respondents may be unwilling to openly discuss their feelings, experiences and thoughts with a stranger.
3. More skill is required of the interviewer in directing the interview.
4. Open-ended questions are more difficult to code for statistical analysis.
5. This methodology is particularly subject to a number of biases, namely, interviewer, respondent and inter-subject variation bias.

4. Bias.

The main biases in this study were; interviewer, respondents and subject interaction bias.

4a. Interviewer Bias.

In design used in this study, to tape-record each interview prevents the interviewer from selectively recording what she wants to hear. However, since it was not permitted to tape-record the interviews, this bias was impossible to reduce. Also, there still remains the problem of the bias associated with the soliciting and interpreting of the data.

4b. Respondent Bias.

In order to minimise the effect of this bias, in the introduction before each interview, the anonymity and confidentiality of each respondents' answers were emphasised. However this bias is still impossible to eliminate and difficult to estimate the direction of its effect.

4c. Subject Interaction Bias.

This bias is difficult to predict, but it was expected that those who were interviewed would probably talk about what happened during the interview. To reduce the effect of this bias it was agreed among the staff at the ALP to encourage those who participated in the study not to discuss the interview until the research was completed. Even with this proviso, it is impossible to eliminate this bias and difficult to estimate the direction of its effect.

5. The Results.

5a. Respondent Characteristics.

Previous studies of drug-use in Ireland have concentrated on measuring the prevalence of specific drug-use or describing the socio-demographic characteristics of well defined groups of drug users (44,45,46). These have included for example heroin-users attending one general practice (47), the use of opiates in Dublin (3,5,8,12,13,14,36) and other selected counties/boroughs (7,10). The differences in the objectives and methodologies used in the studies do not permit easy comparison between the various studies.

The typical profile of the subjects in this study was male, between 20 and 25 years of age, unemployed and living in local-authority accommodation. Similarly, in one study (7) just under half of the sample, 40 out of 88 were between 20 and 24 years of age. This result was repeated in a follow-up study by the Medico Social Research Board on 1984 (13), in a sample of 74 illicit drug users 37 were in the 20-24 age group. Only one Irish study (7) asked subjects about their marital status, 62 out of 74 were single and the remaining 12 were either separated or married. The results from this research reported that 35 out of 50 were single and the remaining 15 were either married, separated or cohabiting. In all the studies that asked respondents about their employment

status (7,13,36) the majority were unemployed, a result that concurs with the sample in this study.

Comparing the sample characteristics of the previous studies carried out in Dublin with this study, the sample studied here shares many similarities. While this enhances the representativeness of the sample used in this study to other studies of drug-users who make contact with the drug-related agencies, the results are not generalisable to all those who make agency-contact and as previously mentioned, to all drug-users.

5b.Respondents' Drug Use.

The lack of uniformity in most of the questions relating to respondents' past and current use of drugs makes any comparison between the studies difficult. The studies (7,13,33,44,47) that asked subjects about the extent of their drug-use all reported multiple drug-use. The principal drugs used are morphine-type with cannabis and barbiturates the next most frequently mentioned. In this study heroin was used by 44 out of the sample of 50. Morphine, cannabis, physeptone and Diconal were the next most frequently used drugs. Two studies (7,47) asked subjects about their method of opiate use and reported that in one sample (47) everyone in the sample used heroin parenterally and the majority in the other study (7) injected heroin. Similarly all the respondents in this study who used heroin (N=44) said that they injected the drug.

The length of time respondents were using drugs before they made contact with their first drug-related agency was for 28 out of 50, 3 or more years. 34 out of 50 stated that the Drug Advisory and Treatment Centre (Trinity Court) was the first agency they contacted for their drug-use. The length of time they used drugs before making contact with ALP was significantly longer. Over half, 26 out of 50, were 7 or more years using drugs before they made contact with ALP. From this result it may be speculated that the first agency contact is probably the result of a need to get a detoxification or some specific medical help for a drug-related problem and that it is only after a significantly

longer number of years that some drug users make contact with a non-medical but therapeutic-oriented agency.

In conclusion then, despite the variation in the questions asked in the different studies, there are many consistent features between the studies, for example the education and employment records, the age at first drug-use, the repeating patterns of contact with the agencies and for many reverting back to the using drugs following detoxification(3). The drug-user faces the many vulnerabilities associated with poverty and the daily demands of trying to cope with addiction. As one young woman in this study said;

"The way we're brought up - drugs they're all around us, it's where we live, our neighbours are pushers, you get offered drugs when you're only a kid and all your friends use gear [heroin]. They don't realise that once a junkie, you always have that vulnerable point, It can take anything to set you back. If you want to stay off drugs you have to leave you friends and your neighbourhood."

5c.Reasons for First Making Contact.

Zola (37) in his article exploring the reasons why people resist seeking help for their symptoms, hypothesises that there is a physical, personal and social accommodation by each individual to the symptoms of their disease and it is when this accommodation breaks down that the person seeks or is forced to seek help. In this study, both groups of respondents gave answers that conveyed either a deep desire to stop using drugs (The 'Other Expectations of the Formally referred group Q.21 Chapter 3) or gave answers that were categorised under the heading of 'Feelings of Desperation'. Both these replies could be interpreted as the result of a breakdown in the accommodation to their use of drugs.

In the study on 'Why Drug-Users Sought Help' at one London Drug Treatment Clinic by Sheehan, Oppenheimer and Taylor (43), they concluded that the most likely reasons why

drug users came for treatment were emotional or were related to the actual experience of being addicted to drugs. The single most frequently claimed important reason for coming for treatment was given in the statement, 'My life is out of control' (72% N=50). 50% of the men and 80% of the women gave this as an important reason for coming to the drug treatment centre. In this study, nearly half (16 out of 35) of the self-referred group described feelings that have been grouped under the heading, 'Feelings of Desperation'. This could be described as similar to the category 'My life is out of control'. Both categories convey a sense of a critically low-point that is reached by a significant number of attenders in their use of drugs before they make contact with the drug-related agencies.

Other important reasons for coming for treatment in the Sheehan et al (43) study of 50 illicit drug-users included; 'Having been depressed' (58%), 'Having started using opiates' (52%), 'Loosing a great deal of weight' (64%) 'Feeling ill much of the time' (40%), "Realising had no self respect' (48%) and 'Having been arrested' (38%). Beyond this the other items on their list included concern about being arrested, parents discovering their use of drugs and being out of work for some time.

Likewise in this study, there were a variety of 'Other reasons' expressed by the subjects that contributed to their decision to first make contact with ALP. These included marital and relationship problems, a history of sexual abuse, being unsuccessful with other drug-related agencies, HIV counselling and the belief that attendance at ALP was a way to get onto the MMP. Such a variety of events and reasons precipitating first agency contact concur with the English studies and highlight the many complexities and diversities of the help-seeking process.

5d.Reasons for Continuing to Attend.

The absence of any literature on the reasons why attenders continue to attend the drug related agencies is striking. Identifying the particular aspects of a service that influence

attenders to return is of particular importance not only as feedback in the evaluation of any service but it may also provide ideas for the development of future services.

The most frequently mentioned reason among the self referred group (29 out of 35) for returning to ALP was to 'continue with counselling'. The specific aspects of the benefits of the counselling were elicited from the question, 'What do you find most helpful about the counselling?' The answers to this question were similar to the general objectives of counselling, some of which would include; greater insight, support and the opportunity to express ones' feelings. Accordingly, 23 out of 35 subjects referred to various improvements in an 'awareness' of their feelings, emotions and their self-confidence. 18 out of 35 referred to the supportive aspects of counselling. For those who referred to the benefits of counselling as the 'opportunity to talk'. There was the impression that they had no one else to talk to except their counsellor especially when faced with serious problems, for example a diagnosis of AIDS or deciding whether to get the results of their HIV test.

The informality and organisation of ALP along with specific aspects of the service provided by ALP were also important reasons that contributed to both groups' decisions to continue to attend ALP. This reference to the informality of ALP included the opportunity to meet the other attenders who 'dropped-into' the centre. The helpfulness of meeting the other attenders was for the majority of those in the self-referred group described in the category of 'mutual care and support'. This reason is frequently mentioned among people who have had similar experiences for example, in self-help groups.

The **open-door policy** of ALP would contrast quite differently from the other drug-related agencies in Dublin. In the other agencies attendance is dependent upon participation on specific treatment programmes to become drug-free or to substitute opiate-use with methadone. ALP imposes few restrictions on attenders, the main one is

that attenders do not become disruptive or unmanageable in the centre. The ability to drop-in and the 'friendly atmosphere of ALP' were for a significant number of attenders, (N=13, out of 35 in the self-referred group and (N=6, out of 15 in the formally referred group) factors that influenced them to return to ALP. Some respondents made specific reference to the fact that the freedom to 'drop-in' or see a counsellor irrespective of ones' use of drugs on arrival at ALP was an important factor that influenced them to return to the centre.

Excluding those who continued to visit the ALP because attendance there was a condition for their participation on the MMP or Temporary Release from prison, the remaining subjects in the formally-referred group said that they continued to visit ALP because of the 'informal' and 'friendly atmosphere'. These characteristics were often expressed in relation to the helpfulness of meeting the other people who 'dropped-into' ALP. For this group the opportunity to 'chat and meet friends' was the most helpful aspect of meeting the other attenders at ALP. For those who were on the MMP meeting other attenders provided the extra support they needed to cope with the daily demands of the MMP.

Unlike the self-referred group, to 'continue with the counselling' was only mentioned by 4 of the 15 subjects in this group as a reason for continuing to visit ALP. Though the numbers are small this would lend support to the argument that when attendance is made a conditional part of receiving something, for example, methadone, participation will be different from those who decide for themselves to avail of the service. It does pose questions about the appropriateness of such conditions which may not only be self-defeating but are also contradictory to the philosophy of ALP which is based on the voluntary participation of attenders. (With a few exceptions, as mentioned in the Introduction.) Also in support of this argument, it is worth noting that the differences between the two groups, self-and formally referred, in relation to how they described the helpfulness of the counselling. The formally referred group do not identify

any one aspect of the counselling as particularly helpful unlike the self-referred group who emphasised an increase in their self-awareness as the main benefit of the counselling.

6. Scope for improvement.

The questions included in this section are the ideas as suggested by the sample that would improve ALP and their criticisms about the counselling and meeting the other attenders who visit ALP.

6a. Ideas for Improving the Service Provided by Ana Liffey Project.

Suggestions for improving the service provided by ALP centred around increasing the provision of certain services for example the opening hours and the number of counsellors (including an ex-addict counsellor) and activities (for example, classes, weekends away). These ideas for change emphasise the importance of easy accessibility to a centre like ALP as well as appreciating that the need to 'drop-in' or see a counsellor does not always correspond with the 5 day week or business opening-hours. The reference to more activities was mentioned by many because they described themselves as bored. In fact, for some their reasons for continuing to visit ALP were to 'fill in the day ' and alleviate feelings of boredom.

6b. Criticisms of the counselling.

Most respondents, in both groups, expressed no criticism about the counselling. This is to be expected as counselling is an intrinsic part of the service provided by ALP and naturally for many who attend ALP the counselling would be their main reason for attending as was demonstrated in the results to question 23. It was difficult to distinguish if the criticisms some respondents expressed about the counselling were based on the all of the counselling they received at ALP or were the reflections of the last counselling session. For a few respondents the latter was definitely the source of their criticism. Criticisms of the counselling included the need to have an ex-addict counsellor and that the counselling was sometimes 'tough' or that there was not always enough time. It is

difficult to propose how these last two criticisms could be acted upon, as it is recognised that counselling can be tough (some would even argue that this as an essential part of the counselling process) and giving more time to one person may mean less time for another. However to employ an ex-addict counsellor at ALP is possible and shall be included in the recommendations.

6c. Criticisms of Meeting the Other Attenders at the Ana Liffey Project.

There was a suggestion by one respondent that ALP should be separated into two sections; one for those who are what he described as 'recovering addicts' and the other for 'using addicts'. The rationale behind this suggestion was that meeting attenders who were using drugs was a source of temptation for those who were trying to abstain from using drugs. Implementing any change that would keep these two groups apart would be extreme and for most respondents unnecessary.

7. Conclusions.

It has been suggested by Robertson (48) that developing a rational response to the problems of illicit drug-use requires the development of a 'hierarchy of goals'. The 'hierarchy' devised by Robertson includes a range of medical and non-medical services from the provision of clean needles and methadone to support for social and domestic difficulties that may be experienced by the drug-user. He stresses, that the accessibility as well as the flexibility of the services are paramount if the drug-related services are to claim to be relevant to the needs of the drug-user.

Devising and adopting services that are more accessible and varied would concur with the ideas suggested by the sample questioned in this study. However, adopting even some of the relevant services for drug-users, for example, the provision of needle exchanges, methadone maintenance are still a source of controversy in Ireland. The sluggishness in providing even these services not to mention considering making methadone available at the local pharmacy is justified by the Department of Health in their belief that each of

these options may have limited value and must be implemented only as part of an overall programme for drug users and others at risk for AIDS.

My reflections after interviewing 50 'recovering' and 'using addicts' are that this group, who showed enormous good-will and cooperation in the study, are thoughtful, articulate and opinionated. The vulnerability of the group is the result of poverty and their use of drugs is a symptom of this poverty. They have few opportunities and in many ways their lives are complicated by the demands of multiple and simultaneous agency contact, even in their efforts to stop using drugs.

They are seldom asked their opinions, indeed this study is the first in Ireland to ask those who attend one drug-related agency their opinion about the service provided by the agency. They described with great clarity the struggles and tensions in their daily life. Even if the drug-related services were changed it is difficult to predict if the number of attenders would necessarily increase.

The stigma and possible legal implications of admitting to illicit drug use have long been barriers which prevent drug-users from seeking help, even from caring agencies. As long as these barriers continue to exist any efforts to educate drug users to change their high-risk behaviour or to meet the needs of the drug user will be futile and will ultimately beg the question do we really care at all?

Chapter V

Recommendations.

1. In view of the results of this study the drug related services should provide a broad range of services that are accessible and respond to the needs of the drug user.

2. In the development of new and existing services those who attend the agencies should be involved in the planning and running of the service.

3. Illicit drug use is a symptom that is caused in part by poverty and lack of opportunity. Social and political change is required to begin to tackle these problems.

4. Further research should focus on those who do not make contact with the drug-related agencies with particular reference to:

What is the personal and social profile of this group?

What is the prevalence of HIV and AIDS among this group?

What health related services does this group use?

What are their reasons for not making contact with drug-related agencies?

How would they like the drug-related services to be different?

A starting point for a future study could be a survey of the number of illicit drug-users who attend general practitioners and a description of their health needs.

Chapter VI

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Chapter VII

Appendix

Questionnaire

Pre-recorded Answers

Length of Interview:

Code No.

1. How did you first hear of the Ana Liffey Project?

Family

Friends

Other

2. Were you formally referred to the Ana Liffey Project?

Yes (Go to Q3.)

No. (Go to Q. 5)

3. Who referred you on your first visit to the Ana Liffey Project?

Drug centre

GP

Social Worker

Police

Other

4. Why were you referred to the Ana Liffey Project?

MMP

Temporary Release

Other

5. Why did you first make contact with the Ana Liffey Project?

*Hopes.

*Fears

*Motivations.

*Why ALP?

*Why now?

*Key words used if question was elaborated

6. Did you have any other expectations on your first visit to ALP?

Come off drugs.

Get a detoxification

Other

7. Why do you continue to visit the ALP?

8. Do you see a counsellor?

Yes (Go to Q 9)

No. (Go to Q. 11)

9. What do you find most helpful about the counselling?

10. What do you find unhelpful about the counselling?

11. What do you find helpful about meeting the other people who visit the Ana Liffey Project?

12. What do you find unhelpful about meeting the other people who visit the Ana Liffey Project?

14. Do you have any suggestions or ideas that would improve the service provided by ALP?

Drug-Taking history.

I would like to finish by asking you some questions about your drug taking history. Again I would like to stress that this information is strictly confidential.

1. What was the first centre, helping agency, person or worker you visited for your drug habit?

Trinity Court
Coolmine
GP
Social Worker
Other

2. How long were you using drugs before you made contact with (refer to answer to last question.).

>1 year
1 - 2 "
3 - 4 "
5 - 6 "
>7 "

3. What drug treatment / rehabilitation centres have you attended in the past?

Trinity Court
Coolmine
Rutland Centre
Psychiatric Hospital
Other

4. What drug treatment / rehabilitation centres do you attend now?

Trinity Court
Coolmine
Rutland Centre
Psychiatric Hospital
Other

5. How old were you when you first used drugs?

<1year
1 - 2 "
3 - 4 "
5 - 6 "
>7"

6. What drug was it?

Heroin
Palfium
Diconal
Amphetamines
LSD
Cannabis
Cocaine
Morphine
Temgesic
Other

7. What other drugs have you used?

8. What was your method of use? (for those who used heroin)

9. How long were you using drugs before you made contact with the Ana Liffey Project?

<1 year"

1-2 "

3 - 4 "

5-6 "

>7"

10. What was your drug-state when you first contacted Ana Liffey Project?

Drug-free

MMP

Using,

What drug was it?

11. What is you drug state now?

Drug free

MMP

Using,

What drug is it?

