



Drug Abusers in the Dublin Committal Prisons: A Survey

by

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and

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**A joint research project by the Probation and Welfare and
Psychological Services, Department of Justice.**

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FOREWORD

The meeting of the Mountjoy Prison Liaison Group (which consists of representatives of the Department of Justice and prison administration along with prison officers, medical officers, chaplains, psychiatrists, teachers, welfare officers and psychologists working in the prison) over a period identified a need for more specific information on persons committed to custody, who have been abusing drugs. It was decided that the Welfare and Psychological Services would cooperate in a survey of the drug abusers in all three Dublin committal prison (i.e. Mountjoy Male and Female Prisons and St. Patrick's Institution) and the findings be used as a basis for discussion of the problem and possible treatment approaches. Any opinions expressed in this the resultant report are those of the authors and do not necessary represent the official views of the Minister for Justice or his Department.

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Chapter 1

ADDICTION AND ITS TREATMENT

Addiction takes a great many forms and therefore is not easily defined. Possibly the most basic definition, which covers all classes of addiction, is that addiction is the habitual or compulsive use of a psycho-active substance, that is any chemical which acts upon the central nervous system. This definition is wide enough to include such disparate behaviours as the frequent, regular use of coffee (caffeine), the frequent use of large or small amounts of heroin and the infrequent but compulsive intake of large amounts of alcohol, as in uncontrolled binge-drinking. These are all instances of addiction, though with clearly different implications for the addict legally, socially and in terms of personal health and well-being.

While the essential component of addiction is the compulsive or habitual use of a psycho-active substance there are three further aspects of addiction which, depending on the individual involved and the substance abused, can be very important. These are (1) tolerance, (2) physical dependence and (3) psychological or, perhaps more properly, psycho-social dependence.

The term tolerance refers to the process whereby over time, given continued use, a psycho-active substance loses its effectiveness, with the result that every larger amounts of the substance are required to produce the same effects. The tolerance process is chiefly a property of the drug not the individual involved. Some drugs such as cannabis and L.S.D create little or no tolerance while alcohol has moderate tolerance and heroin has severe tolerance-inducing effects. The tolerance effect is occasionally an indirect cause of death for addicts, as, for example, when a prisoner on release takes the dose of heroin to which he has become accustomed before the enforced abstinence of imprisonment – a dose which has now become a lethal overdose since he has lost his tolerance for the substance. Another important point about tolerance is that, with certain substances, while tolerance grows for the perceived mood-changing effects of the drugs, the tolerance for the adverse and possibly lethal effects does not change. This is the case with alcohol and barbiturates so that a regular user of these substances will tend to continually increase his dose and thereby narrow the gap between his normal dose and the fatal overdose. Cross-tolerance between various substances can also occur, for example,

between all the narcotic drugs and also between alcohol, the barbiturates and the minor tranquillizers. A person who has developed a tolerance for alcohol will also have developed a tolerance for barbiturates possibly without ever using them. This cross-tolerance phenomenon is frequently a contributory cause of accidental death due to an overdose of a mixture of alcohol and barbiturates.

The term physical dependence refers to the process of physiological change, engendered by the habitual use of a psycho-active substance, which causes withdrawal symptoms if the drug-taking is halted. In other words a person is physically dependent on a drug if his abstinence from that drug would cause unpleasant physical symptoms. Among the most common of withdrawal symptoms are vomiting, convulsions, trembling and confusion. However, withdrawal symptoms vary greatly depending on the substance involved and the habitual dose. Breaking a habit of coffee-drinking can lead to several days of minor unease and irritability while the addict who abstains from heroin can undergo up to ten days of extremely unpleasant symptoms accompanied by an overwhelming craving for heroin. Several potent drugs including cocaine, amphetamine, L.S.D. and cannabis cause little or no physical dependence. Although in many cases there is a correlation between the tolerance-inducing effects of a drug and the severity of physical dependence caused by the drug, as, for example, with caffeine, alcohol and narcotics, this is by no means a necessary relation. Cocaine and amphetamine are substances to which marked tolerance can develop even for the adverse effects, for instance an addict to these drugs often has a regular dose well above that which would be fatal for the normal person. However, these substances cause little physical dependence in the sense that sudden abstinence will not cause severe withdrawal symptoms.

Finally as opposed to physical dependence there is psychological or psycho-social dependence, which can be said to be present in all cases of addiction. This term refers to all the social and psychological influences that make an addict's use of a substance habitual or compulsive. The term, therefore, covers a very broad canvas but in its narrowest sense can be understood to refer to the addict's own felt need or desire for the substance beyond any physical craving he might experience. The psycho-social dependence of the addict is a highly complex matter which is by no means fully understood but in this it is not unlike many facets of human behaviour.

In a sense the psycho-social dependence of the addict is the essential core of his addiction, since it is in this area that we must seek the reasons why the addict first began using a substance and also why he continues to use a substance despite in many cases (e.g. cocaine) little physical dependence and otherwise (e.g. heroin) the ready availability of detoxification programmes that can quickly and easily remove physical dependence. The case of cigarette-smoking is a good example of the fundamental importance and strength of psycho-social dependence. All traces of physical dependence on nicotine disappear within the first two weeks of abstinence from tobacco yet it is an extremely

common experience that people return or feel compelled to return to smoking after and sometimes long after this period of physical withdrawal. In such cases people return to smoking because it serves psychological and social functions for them. Similarly the compulsion felt by abusers of alcohol, heroin and all the other psycho-active drugs has important psychological and social components.

Concepts of Addiction

There are many different perspectives on addiction. Some perspectives contradict and compete with each other but in general it is possible to extract something of use from each viewpoint. Indeed different perspectives can be complementary and expand on each other, often referring to different levels of the problem, for example the biological, the psychological or the social. Certain views of addiction, although widely believed, are no more than unsubstantiated myths, while others, at least to a degree, are underpinned by scientifically based theory.

One widely held but incorrect view is that drug addiction is a medical disease. Dr. Frederic Glaser of the Pennsylvania Medical College¹ considers this view an example of medical ethnocentrism which he defines as “the tendency of physicians and others to regard all behaviour which they do not understand as a manifestation of illness.” According to Glaser the addiction as disease viewpoint takes three forms, the metabolic, the infectious and the psychiatric. The metabolic view holds that addiction, for example to heroin, occurs in those people who have experimented with heroin and also happen to have an inherent metabolic defect which makes heroin a basic physiological requirement for them. As Goldstein² describes it, becoming addicted to narcotics “would be as though an undiagnosed diabetic accidentally discovered insulin.” Unfortunately, so Glaser tells us, there is no scientific evidence at all to support this metabolic theory of narcotic addiction.

The view of addiction as an infectious disease began as a useful metaphor, that is as an aid to the understanding of the often epidemic-like spread of the use of the psycho-active substances. The problem, according to Glaser, is that for many people the metaphor has become a dead metaphor. People have ceased to be aware that their view of addiction as an infection is not literally true. This fading of the awareness of the metaphor is aided by the fact of frequent epidemics among addicts of genuinely infectious illnesses like hepatitis, which are spread by a lack of hygiene in the taking of the drug but are not essentially related to the addictive process.

The issues are more complex regarding the view that addiction is a psychiatric illness, since it is not unusual for compulsive behaviours of a similar type to drug addiction, such as gambling and over-eating, to be classified as neurotic illnesses. However this is rather specialised use of the term illness which implies little more than that an individual has become caught up in a pattern of hurtful, self-defeating

behaviour. The actual incidence of clearcut, psychotic mental illness amongst drug addicts is small. A report from the U.S Public Health Service Hospital at Lexington, Kentucky³, which has had the most extensive experience of narcotic addicts of any hospital in the world, states that, over a 29-year period, approximately only 2 per cent of addict admissions could be diagnosed as psychotic, which is not significantly different from the incidence of psychosis in the general population. Although it is not useful to conceptualise drug addiction itself as a medical disease, addiction is, of course, the direct cause of or associated with a great deal of serious disease. This includes infectious illnesses like hepatitis, damage to organs particularly the brain, kidneys and liver, abscesses and malnutrition. Psycho-active substances are, after all, poisons which are damaging to health and, in large doses, lethal. Clearly addicts will often require medical attention, in particular during the process of detoxification, which is the weaning of an addict from a psycho-active substance. Medical supervision is here needed to ensure the control of withdrawal symptoms. On the other hand it is important to note that these medical interventions are of a secondary nature, that is to say they tackle the consequences of addiction rather than the addiction itself.

A different perspective with some currency⁴ interprets drug abuse as a form of suicidal behaviour. This view holds that the motivation behind addiction springs from an individual's fundamental but probably unconscious self-hatred and desire for self-destruction. This apparently far-fetched hypothesis does in fact receive some scientific support from the frequent studies that show greatly elevated levels of suicide and attempted suicide among drug addicts. Estimates range from that reported by O'Donnell⁵, which shows drug addicts committing suicide at 5 times the rate of the general population, to the report of James⁶ that the rate of suicide in English male heroin addicts is 50 times greater than that in the general population. Nonetheless, this concept of addiction is not entirely convincing since the increased suicide rate of the addict is very possibly the result of changes brought about by the addict's lifestyle. Serious emotional, physical social and legal difficulties are almost inevitable accompaniments of drug abuse and it seems unnecessary, when explaining high rates of suicide, to additionally invoke a long-standing personal disposition to self destruction.

Another relatively popular concept of addiction is that it is associated with a particular set of personality characteristics, in other words that there is an addict personality type. Many psychological studies have investigated the personality profile of different categories of addict. At various times associations have been found with the following traits; low self-esteem, high anxiety, depression, social non-conformity, experimenting and risk-taking attitudes. However a recent study⁷ has concluded that "Psychologists are searching for evidence demonstrating that personality characteristics predispose people to heroin addiction. However no personality characteristic common to compulsive users of heroin has yet been isolated; in fact heroin addicts

vary remarkably in personality traits and types.” Furthermore, most research in this area is ambiguous and in the final analysis unconvincing because the “personality types” have only been described after people have become addicts. It is quite possible that the physical, social and psychological processes of addiction are themselves the major determinants of these “personality types”. Indeed another report⁸ concludes that in fact “personality characteristics are related primarily to drug preference rather than actual drugs use”.

A related question concerns the connection between criminality and drug addiction. There are two popular but inconsistent views on this connection. First, it is often held that criminals and drug addicts are both similar, deviant, anti-social personality types. However, the evidence for recognisable criminal personality types is no stronger than that for addict personality types. The other somewhat contradictory but widely held view is that the criminal career of an addict usually begins with a drug offence and is thereafter chiefly motivated by the “economic necessity” of providing sufficient finance to maintain the drug habit. This viewpoint would appear to differentiate the addict involved in crime from the run-of-the-mill criminal rather than equating the two. However, there is considerable evidence, according to Kraus⁹, that adult drug abusers frequently have a previous history of school truancy and juvenile delinquency. Kraus also reports several studies which show that the majority of both addict prisoners and drug abuse treatment patients with criminal records acquired their drug habit after their first arrest. Kraus argues on the basis of this information that “the use of drugs and criminal behaviour are not causally related.” By this he appears to mean that the criminal behaviour of addicts does not arise primarily from their drug abuse. However he does suggest that sociopathic character development is a common denominator in both drug abuse and juvenile delinquency. This labelling of criminals and addicts as sociopathic is not very fruitful since it does little more than beg the question. Drug abuse and crime are generally considered anti-social activities, therefore those that engage in them are by definition anti-social, i.e. sociopathic characters. This type of thinking is clearly circular and does little to elucidate the multi-faceted nature of crime and drug abuse and their interrelation.

Eventually it may be possible to implicate particular personality characteristics in the causality of crime and drug abuse but it is unreasonable to believe that they have more than a minor role in the explanation of such complex behaviours. They need to be considered alongside the many other influential factors, social, economic and situational. For example in the U.S.A and elsewhere a strong association has been established between certain types of drug abuse as well as crime, and socio-economic indicators such as race, unemployment, inner city residence and poverty. Cultural, social and economic conditions also control the availability of drugs and limit or increase the opportunity for abuse. It is clear that a useful explanatory model of addiction must be able to accommodate a wide range of cultural

and socio-economic influences as well as any personality factors that may in the future be proved relevant to the addictive process.

A sociological concept of addiction has recently been formulated by Sackman and his colleagues.¹⁰ This somewhat idiosyncratic, but nevertheless insightful view describes heroin addiction as an occupation. In other words the lifestyle of the addict is described in terms appropriate to the description of a professional or vocational career. Being an addict is like having a job and satisfies at least some of the needs normally satisfied by employment. Being an addict confers membership of a select, exclusive in-group (the profession) and involves the individual in a network of important social and often commercial relationships. For the addict there is a sense of belonging and of direction to life. The extraordinary demands, which the addict has imposed on himself, of maintaining a drug habit create tension and excitement and, at least superficially, lend life significance and purpose. The addiction lifestyle is hazardous and difficult but it offers a well-defined social and task-oriented role which serves to fill the "existential vacuum" facing many unemployed, bored and confused young people. Although by no means the whole story, this sociological perspective helps us to understand how some people find the addict lifestyle attractive and in ways fulfilling.

Perhaps the most adequate approach to the understanding of addiction is provided by social learning theory. According to this view addiction is an acquired habit, that is a specific pattern of learned behaviour. As such, addiction is governed by the same rules as those pertaining to more commonplace learning experiences. The habit of drug abuse is acquired because drug-taking is initially reinforced in a variety of ways, which is to say no more than that the individual finds early drug-taking rewarding. A different set of reinforcers then serve to maintain the acquired habit. Drug-taking behaviour which is reinforced can quickly become established as habit but the operation of reinforcers is essential. Two kinds of reinforcers are involved in the process, positive and negative. Positive reinforcers are those which involve direct reward for the individual, such as the pleasant sensations induced by the drug, while negative reinforcers are all the unpleasant, aversive aspects of the environment, which the individual seeks to avoid through drug-taking.

The strength of the learning theory perspective is that it embraces the entire range of motivating forces physical, psychological and social. For instance, it emphasises the influence of peer group pressure, modelling of drug-taking behaviour and availability of drugs as much as the straightforward physical reward attained from a drug. Important negative reinforcers that play a role in the acquisition and maintenance of a drug habit can be: social, for example, economic disadvantage or an ugly urban environment; psychological, for example, anxiety, depression, boredom or fatigue; or physical, for example, withdrawal symptoms. Clearly avoidance of negative reinforcers such as these often makes addiction a form of escapism as much as a positive search for pleasure.

One interesting piece of research by Lindesmith¹¹ lends credence to the learning theory perspective. This research suggests that many addicts have even had to learn to interpret the physical sensations induced by opiates as pleasurable. Lindesmith found that most normal, pain-free individuals find the initial effects of opiates unpleasant. Indeed people unused to heroin rated a completely inert placebo as more pleasurable than heroin. Learning, involving the social context and environmentally derived psychological expectations, obviously makes an important contribution to the development of addiction.

The learning theory perspective has important implications for the treatment of drug addiction. If addiction is simply a habit, the best approach to breaking that habit is to attack the specific reinforcers that maintain it. One recent formulation¹² has stressed the need to: 1. decrease the reinforcing properties of drug-taking both primary (e.g. physical pleasure) and secondary (e.g. satisfaction of social dependency needs); 2. teach the addict new behaviours which are incompatible with drug-taking; 3. rearrange the social and vocational environment of the addict so that maximum reinforcement is received for activities not involving drug use. This proposed treatment approach is wide-ranging and extremely demanding, however it probably represents the basic requirements for successful, persisting change of drug abusers.

Finally, on this topic of different views of drug addiction, mention should be made of the recent report¹³ of the Drug Abuse Council of New York based on seven years of extensive research and study. This report emphasises the need for a major change in attitude towards drug abuse and recommends the reappraisal of both official and popular viewpoints. Perhaps most controversially, the report argues for the blurring of the distinction between legal and illegal drugs and for the sharpening of the differentiation between use and misuse of drugs. It states that "the primary goal the Council urges is that society seek to minimise the harm and dysfunction that can accompany the misuse of any psycho-active substance whether that drug is currently classified as licit or illicit. To accept this goal entails accepting factors which up to now have not enjoyed wide acceptance, e.g. the continued use of illicit drugs by many Americans. It also entails accepting that not all illicit drug use is necessarily harmful. Further, it indicates that seeking to minimise harm from drug misuse is not synonymous with seeking to eliminate drug use."

One particular popular concept this report attempts to demythologize is that to use heroin is to be addicted to it. It states that "there is convincing evidence that more individuals use heroin than are addicted to it." For example, one important study¹⁴ shows how patients given narcotics for the relief of pain often develop signs of physical dependence, but "the overwhelming majority do not develop a psychological dependence, do not become compulsive users and discontinue the drug when the medical condition is relieved." Another major study¹⁵ surveyed Vietnam war veterans. Prior to the war only 2% of the sample had used heroin but one-third used heroin while in

Vietnam and half of this subgroup (i.e. 16%) became addicted to heroin by the criterion of physical dependence. However ten months after return from Vietnam the group's heroin use had returned to pre-war levels with fewer than 1 percent of the veterans continuing as daily users of narcotics. These results are encouraging, suggesting as they do that the prevalent defeatist attitudes about treatment of drug abuse are not fully justified. The results emphasise the importance of the context of the use of the drug, especially its social acceptability, and the utility of the drug against specific conditions, e.g. physical pain or psychological stress. Both patients and war veterans, although they had become physically dependent on narcotics, found they could do without them in a new situation where basic discomforts had been considerably relieved and use of narcotics was widely condemned. The learning theory perspective with its emphasis on a wide range of social, psychological and physical reinforcers is strongly confirmed by these findings. Unfortunately this still does not provide us with a magical prescription for addicts, since it is not usually possible to arrange such a dramatic and beneficial change of circumstances (i.e. reinforcers) as those of the patient returning from sickness to health or of the soldier returning from the theatre of war to a peaceful, stable society.

Treatment approaches

Over the last 15 years or so a great deal of experience has been gained in the U.S.A. with a variety of treatment methods for narcotic drug abusers. For example in 1980 there were at any one time about 78,000 individuals in methadone maintenance programmes and about 132,000 in drug-free therapeutic community treatments. There are currently two other popular forms of treatment in the U.S.A., out-patient drug-free programmes and out-patient detoxification programmes. However despite the vast experience in the U.S. there is still a lack of reliable and concrete information on the treatment methods. The Drug Abuse Council¹³ states "Perhaps the most frustrating problem is the fact that no one – including the Council – appears able at this time to provide definitive, persuasive answers about the comparative effectiveness of the various treatment approaches."

The aim of methadone maintenance treatment is to substitute the use of methadone for the use of heroin. Methadone is a synthetic opiate with similar properties to heroin but with a duration of effect of 24 hours compared with heroin's 3 or 4 hours. Methadone is taken orally in the form of a syrup. Once the addict is stabilised on a daily dose of methadone he can be offered counselling, job-training and other supports that help him develop a more productive way of life.

The effectiveness of methadone maintenance is very much in question. One study¹⁶ of over 11,000 addicts who stayed in treatment shows that gainful employment increased while arrests and heroin use decreased. Methadone maintenance also has relatively low drop-out

rates, which is a serious problem with most treatment approaches. However the low drop-out rate and decrease in heroin use and arrests are hardly surprising, since this form of treatment involves the legal supply to the addict of a substitute, addictive narcotic drug. Another major study¹⁷ found that methadone maintenance achieved a limited stabilising effect on the lives of many addicts. However, although 89% of drop-outs from the programme had either been arrested, died or relapsed into disabling drug abuse, a still very considerable 47% of those remaining in treatment experienced continuing serious problems with drug abuse (e.g. using heroin as well as the prescribed methadone), alcohol or criminality.

Detoxification is the process of controlled weaning of an addict off the drug on which he is physically dependent, usually heroin. Detoxification is designed to relieve withdrawal symptoms, for example by the ever-decreasing use of methadone over a one to three week period. The aim is to free the heroin dependent person, at least temporarily, of his addiction. However, as has already been discussed, it is naive to consider a person free of addiction simply because he is no longer physically dependent. Indeed most detoxification programmes in the U.S.A. explicitly admit this, for they incorporate a process of referral to some further form of rehabilitative treatment.

As far as its immediate goals are concerned detoxification is reasonably successful. For example one study¹⁶ of over 60,000 clients of a detoxification programme shows that 43% were successfully weaned from their physical dependence within 6 days. However the long-term beneficial effects of detoxification are very much in doubt. One study¹⁸ has shown that only 40% of detoxified clients complete the rehabilitative programme to which they have been referred. This completion rate decreases as the number of detoxifications undergone by the client increases. Other studies¹⁹ indicate that as few as between 2 and 7 per cent of clients who have experienced detoxification remain abstinent for substantial lengths of time.

Out-patient drug-free programmes in the U.S.A. are often associated, as referral units, with detoxification or methadone maintenance programmes. They cover a wide variety of approaches including individual follow-up counselling, intensive group therapy of the Alcoholics Anonymous type and job-training and employment assistance. The Drug Abuse Council¹³ reports that it is difficult to interpret the evaluative statistics on drug-free out-patient centres. However they do state that the drop-out rate is generally high and that, as with most other forms of treatment, the impact on heroin abuse seems small.

Finally among the currently popular American treatment methods is the drug-free, residential, therapeutic community. These communities, often run by ex-addicts, demand strict abstinence from drugs. There is usually an underlying philosophy which emphasises the personality development of the addict. The addict is confronted with crucial faults of his personality and character by fellow addict peers. Attention may be focussed on various aspects of the individual's personality. However, these difficult encounters

always take place within an overall context of support, encouragement and comradeship. Therapeutic community programmes are usually quite lengthy, up to and over one year, and are often based on behaviour modification techniques, with a strong reliance on social reinforcers, such as the approval or disapproval of fellow inmates. For example, these programmes may be structured on hierarchical lines, where an individual can progress to duties and roles involving progressively more responsibility and trust. At each step the individual must convince his fellows that he is capable and worthy of the promotion. In a sense this approach is designed to build both the character and the confidence of the addict and thereby provide him with the strength to avoid drug-taking.

The evaluation of these programmes has been moderately positive. On the one hand, a large scale study²⁰ has shown that about 20 per cent of clients who completed a programme were entirely drug abstinent and leading constructive lives four years after beginning treatment. Another 25 per cent were leading constructive lives but were either relying to a lesser, not seriously disabling, extent on drugs or were taking part in other treatment programmes. On the other hand a major problem for therapeutic communities is the large drop-out rate. In 1976, for instance, throughout the U.S.A. 50 per cent of those leaving therapeutic communities left in the first 8 weeks. It is generally thought that the vast majority of these early drop-outs very quickly return to disabling narcotic abuse.

In addition to the four popular treatment modalities already discussed there are a number of less tested and experimental approaches. For example, Naltrexone is a narcotic antagonist which does not itself create physical dependence but completely blocks the effects of injected heroin. It is, therefore, used, in much the same way as Antabuse is used in the treatment of alcoholics, as a pharmacological support which eliminates or reduces the physical reinforcing effects of narcotic use. To date there has been experimental work with over 1,000 addicts in the U.S. and results indicate that Naltrexone has provided significant support for heroin abstinence and is to a degree linked with the achievement of social rehabilitative goals. However, as with Antabuse the voluntary compliance of the addict is essential for the success of the treatment and so there is a requirement for a degree of consistent motivation rare among drug addicts.

Another approach which is apparently growing in popularity²¹ is that of treating alcoholics and drug addicts in the same rehabilitation programmes. The reasoning behind this movement argues that the addictive processes underlying both alcoholism and drug abuse are fundamentally similar. Advocates of this approach point in particular to the common mental mechanisms such as denial and delusory notions, and to the common personality problems such as immaturity and low self-esteem.

Mention should also be made of the English treatment approach, which involves maintaining the addict on heroin itself. A limited number of doctors in England are permitted to prescribe regular doses

of heroin and other psycho-active drugs for use by addicts. The implication of this approach is that the addict is a sick person in need of a continuous drug regimen. However, since, as has already been discussed, the physical dependence of an addict is only a relatively minor component of his addiction, this drug maintenance approach can hardly be designated an attempt to treat the addiction. Indeed this approach can be said to support continued addiction. The advantages of the approach are in the area of reduced criminality. The legal and free provision of these drugs is thought to limit the growth of a drugs black market and to decrease the need for addicts to get involved in crime in order to finance their habit. Unfortunately even here the prescription approach is not very effective since it is known²² that some addicts sell drugs, prescribed for them, and then resort to crime. Also, more importantly, the number of addicts receiving drugs by prescription is only a small minority of the total number of addicts in Britain so that, despite the availability of a legal maintenance service, there is a flourishing black market in drugs. In February 1982 there were 3,800 addicts (incidentally an increase of almost 1,000 over the figures for December 1980) receiving drugs from doctors. However, as the Observer newspaper²³ has recently stated, "Everyone, including the Home Office, agrees that this 'known' number of addicts is a massive underestimate of the real number of heroin users. Informed guesses of the true national figure range up to 30,000".

Interestingly, the recent final report of the Drug Abuse Council of New York¹³ recommends a "more active phase of research and experimentation with heroin, particularly regarding the potential of using the drug itself in the treatment of heroin addiction". However they do not have in mind the continued maintenance of an addict on heroin, as in England, but that heroin might be a useful part of treatment at specific stages in a well-planned therapeutic process aimed at eliminating misuse. A related point has come from Ellner and his colleagues²⁴ that "the current evidence is suggestive enough for researchers to at least entertain the possibilities of a marijuana regimen in the treatment of heroin abusers".

In the U.S. many different programmes for drug abusers have been attempted within correctional systems. The largest establishment is the Lexington Hospital which takes male criminal addicts from all the Eastern states and females from the whole country. Basically it involves a detoxification treatment followed by four to five months of intensive group therapy and a work programme which stresses the development of good work attitudes. The work emphasis is strong because having previously been in steady employment or retaining new employment on release from treatment have consistently been found to be among the best predictors of success for the treatment of addicts.

Other programmes, for example the Wharton Tract programme in New Jersey²⁵ entail the operation of a fully-fledged drug-free therapeutic community, within a prison system. The Wharton Tract programme is one of the very few programmes where thorough evaluation

of effectiveness, including control groups and careful follow-up, has been attempted. Even in this special case, however, the research is vitiated by the failure to randomly assign prisoners to the control and treatment groups. Follow-up of over 300 addicts did indicate a slightly better performance for those who had experienced the treatment programme on the normal criteria of reconviction for drug and non-drug offences, employment and abstinence from narcotics. However, to put this in proper perspective only 37% of the treated addicts were considered by their parole officers to have made a good adjustment at the end of a 2-year follow-up period. A large-scale study of treated addicts released from the Lexington Hospital²⁶ indicates that only 9 per cent remain voluntarily abstinent in the following 6 months. However, five years later a much more impressive 25 per cent of this group were voluntarily abstinent. These figures are comparable with those of a summary of the research literature²⁷ which suggests that, although only about 10 per cent of addicts remain abstinent for the six months after a treatment programme, 30 per cent of the whole group will be abstinent five years later.

In general it should be noted that, as the Drug Abuse Council¹³ point out, "the overall efficacy of treatment cannot be judged on the basis of a brief episode of treatment or by the immediate achievement of abstinence". Abstinence even for six months after treatment is not a guarantee that the problem has been resolved. On the other hand, it appears that exposure to several episodes of treatment, perhaps involving entirely different approaches, has a cumulative effect and eventually may contribute to a complete "cure". Of course rather than any experience of treatment, the process of aging and of psychological maturation along with increasing vulnerability due to the many physical, psychological and social hurts suffered may well account for the tendency of the addict to eventually stop abusing drugs.

Chapter 2

TREATMENT FACILITIES IN DUBLIN

There are two main centres in Dublin which offer treatment to drug abusers, the Drug Treatment and Advisory Centre, Jervis Street Hospital and the Coolmine Lodge Therapeutic Community. Several other centres and agencies offer help to addicts but on a much smaller scale.

The Jervis Street Centre runs a nine bed in patient unit and a large out-patient practice. The staff of 11 includes the medical director, two Psychiatric Registrars, two Senior House Officers, two Nurses, three Psychiatric Social Workers and one Psychologist. The largest component of the treatment work at Jervis street is methadone detoxification. The detoxification is usually a two-week process following an initial assessment period of 3 days. Over the two-week period the addict receives daily methadone in amounts which decrease every second day. Urinalysis is undertaken daily to ensure that the addict is not taking drugs apart from the prescribed dose of methadone. An addict's first detoxification is usually on an out-patient basis but a second detoxification is frequently carried out in the in-patient unit. If, as often happens, an addict returns for a third detoxification, a strenuous effort is made to obtain a commitment from him or her to seek admission to the Coolmine Community or to at least talk over the possibility with representatives from the Coolmine Community.

Several other treatment approaches are attempted in the Jervis Street Centre, supplemental to the detoxification process. Each addict is discussed at a weekly case conference and depending on the addict's particular mix of problems, that is depending on whether the addiction is compounded with serious social, psychological or psychiatric problems, the addict will receive additional supportive counselling or treatment from a social worker, psychologist or psychiatrist. The supportive counselling often has an informational and educational bias but can also involve family therapy where the active engagement of the parents is sought as an additional resource for the addict. The counselling service is intended to be a long-term support for the addict, extending, on a weekly basis, far beyond the two weeks of actual detoxification programme. However in practice the Jervis Street Centre finds that only approximately 20 % of patients maintain contact with the service after completion of detoxification.

Presently the counselling in the Jervis Street Centre is on a one-to-one basis. However, in the past the centre has experimented with group therapy sessions and may well be attempting this again in the future. The centre also has some experience in the past with running methadone maintenance as opposed to detoxification programmes, but this approach was found to be unsatisfactory and has been discontinued.

As of May, 1982 the Jervis Street Centre was receiving approximately 40 to 50 entirely new addict patients per month in addition to those returning for second, third or even further detoxification. This rate of new contacts compares with a rate of approximately ten per month two years previously. Ongoing evaluation at the centre also indicates, as well as an alarming increase in new cases, that there is an increase in heroin use in particular, that the age of the new contacts is tending to decrease and that the social class background of the new contacts is widening.

Coolmine Lodge Therapeutic Community is a drug-free residential treatment programme similar in concept to many in the U.S.A. (and now worldwide) but particularly to the Daytop Village in New York. The community is run according to a well-defined philosophy which can be summarised by the following principles: (a) the addict's reliance on drugs obscures his real problems and prevents him from reaching solutions to them; (b) the most common personality problem of the addict is that of emotion immaturity, characterised, for instance, by irresponsible and demanding attitudes, avoidance of unpleasant reality and the inability to communicate effectively, and (c) the assumption that addicts are helpless and incapable people is wrong and ultimately deprives them of the opportunity to help themselves in their recovery and for accepting responsibility for their lives. There are two fundamental rules of the community, that the residents should remain drug-free and that there should be no violence or threat of violence.

The community is run on self-help lines with all members engaged in productive activity aimed at the normal maintenance and management of the community. This is carried out under the general direction of four staff members, themselves often graduates of the programme. However the individual addict's responsibility for his own behaviour and in his assigned role in the community is maximised by the hierarchical structure of the community, by the frequent encounter session and by his accountability to every other member of the community. Particular emphasis is laid on the need for the addict to develop self-awareness and the ability to cope with frustration, guilt, stress and anxiety.

The normal programme runs for 18 months, approximately a year of which is spent in phase I, where to a large extent the resident is cut off from the outside world. A further six months is normally spent in phase II, the period of re-entry into society. This entails residence in a separate building and at this stage the resident is expected to re-establish his position in society, moving out from the secure and

supportive base of the community. The resident is expected to seek employment during this period and eventually, if successful, will travel out to work from the community.

Coolmine has room for approximately 30 residents in phase I and 16 in phase II. The most recent available statistics refer to the period January, 1980 to October, 1980. These show that within that period 53 drug abusers were accepted into the community and that of these 29 left against staff advice. Six people were in the re-entry stage. The vast majority of the 53 entrants were referred by the Jervis Street Centre (40) but three were self-referrals, six were referrals from psychiatric hospitals and four were referrals from Mountjoy Prison. The drop-out rate is clearly a problem though it does not necessarily mean that those dropping out have not benefited from their drug-free period and their experience of the community. Research is presently being undertaken to find out how in fact drop-outs have subsequently coped with their drug problem.

In May, 1982 the community was full with 30 residents in phase I and 16 in the re-entry phase. Approximately 50 addicts were seeking admission or making serious enquiries and 22 of these were on an active waiting list.

The Rutland Centre in Clondalkin offers a limited service to drug abusers. This centre is primarily a therapeutic residential centre for alcoholics but it does occasionally take individuals with a drug abuse problem, generally wishing to keep the proportion of drug abusers to a limit of 5% of the residents. Also the centre selects only drug abusers who have not got a record of anti-social behaviour and who have an involved and supportive family. The centre offers a residential course of six weeks duration which entails much group psychotherapy based on the principle of reality therapy, emphasising confrontation and the need for individual responsibility. There is a two year after care programme involving weekly group psychotherapy.

One recent piece of research carried out by the Rutland Centre indicates that of 302 clients who took part in the course over an 18-month period nine were drug abusers. At follow-up, which varied between eight and 18 months after the completion of the course, it was found that five of the nine drug abusers were still voluntarily abstinent.

The Adam and Eve Counselling Centre, Merchant's Quay, is another centre that occasionally offers aid to drug abusers. At present this takes the form of individual psychotherapeutic counselling, but the centre hopes in the future to develop group therapy for drug abusers along the lines of the Alcoholics Anonymous programmes.

Mention should also be made of the various psychiatric hospitals which also treat drug abusers, though usually only in small numbers and when the addiction is compounded with a psychiatric problem such as depressive illness. In the early 1970s the Eastern Health Board did in fact run a Special Drug Abuse Clinic within the Central Mental Hospital, Dundrum. However, due to financial and staffing difficulties and to the belief prevalent at the time that the drug abuse problem

was in fact abating, this project was discontinued. A new development presently being set up is the provision of drop-in centres and advice centres in certain deprived areas of the inner city where heroin abuse is particularly rife. The aim of this movement is not only to educate young people and their parents but to marshal the entire resources of the local community, as a community, to the effort to combat drug abuse.

Within the prison service there have been some recent developments in the treatment available to drug abusers. Methadone detoxification has for some time been available for drug abusers who enter prison while still physically addicted. Also the professional services of psychiatrists, psychologists and social workers have been available to drug abusers who seek individual counselling for their addiction problem. However, very few addicts have made use of this service.

A new development has been the running of a weekly group therapy session, specifically intended for drug abusers, within St. Patrick's institution. This has been jointly run by a psychiatrist and a psychologist and has normally involved about eight juveniles.

Another new programme has been run in Mountjoy Female Prison by the Probation and Welfare Service. This programme is basically informative involving films, books, talks and discussion groups. The programme runs over 4 weeks and guest speakers from outside agencies such as the Coolmine, Jervis Street and Rutland Centres are invited into the prison.

A special temporary release programme has also been developed by the Probation and Welfare Service in Mountjoy Male Prison. Until the advent of this programme drug abusers were not permitted temporary release. However, this new programme ensures satisfactory supervision of drug abusers on temporary release and so both corrects an inequitable situation and also encourages drug abusers to keep themselves drug-free in the community. The programme involves a 3-times weekly urinalysis (provided by the Jervis Street Centre) and the continuation of the temporary release of the offender is entirely dependent on negative results from the urinalysis. To date six offenders have been considered suitable for early release under this temporary release scheme and four have succeeded in remaining drug-free.

Finally mention should be made of the special unit presently being prepared in the grounds of Mountjoy Prison. This unit of 30 places was originally intended as an experimental treatment unit for drug abusing offenders. However, since the decision was made to close the military detention centre at the Curragh, these original plans have been pre-empted as only this new unit offers suitable space to house the offenders presently in the Curragh detention centre. Consideration is now being given to the adaptation of some of the existing accommodation in Mountjoy as a self-contained unit for the drug abusers.

Chapter 3

The Survey: Mountjoy Male Prison

A list was compiled by the Probation and Welfare Officers in Mountjoy Prison of 29 prisoners who had on committal been identified as drug abusers by the Prison Medical Service. The list was restricted to abusers who had experience, to the point of addiction, with drugs other than marijuana, alcohol and minor tranquillizers.

Of the 29 prisoners in the list five refused to admit to a problem. One refused to take part in the survey and one other only partially answered the questionnaire and his response was treated as a refusal. Twenty-two prisoners voluntarily admitted to drug abuse and took part in the survey freely and with a high degree of cooperation.

The Prisoners' Background

Age:

The men interviewed range in age from 19-32 years of age. Table 1 shows the age breakdown.

Table 1

Age	19-21	22-24	25-27	28-30	31-32
No:	5	6	6	3	2

Area:

Ballymun and Dublin 8 accounted as the place of origin of almost half the sample. Table II a and b gives the exact breakdown.

Table II (a)

Area	N.F.A	Co. Dublin	Co. Wicklow	Ballymun
No:	1	2	2	4

The remaining 13 come from Dublin City.

Table II (b) gives a breakdown of the Dublin City participants in relation to their Dublin Postal Districts.

Table II (b)

Postal Area:	2	6	8	10	12	3	5
No:	1	2	5	1	2	1	1

Marital Status:

TABLE III

Married	Single	Separated
4	16	2

Of the 16 who said they were single five live with women in a common-law relationship, one of the five has two children by different women and the other four have no children. None of the other 11 single men have children.

The two persons who are separated are now living with other women and have children only by their marriage, one has two children and the other has one.

The four men who are married all have children.

One has five children ranging in age from 6-11 years.

One has two children aged 6 and 8 years.

Two have one child each, aged 3 and 4 respectively.

Accommodation:

One described himself as being of no fixed address and as staying anywhere he found a bed.

Three squatted in flats owned by the Local Authority.

Five lived with their parents in flats rented from the Local Authority.

Five lived with parents in houses which the latter owned.

Six lived in rented Local Authority flats with their families (i.e. wife and children or girlfriends).

One lived in a rented Local Authority house with his wife and children.

One lived in a house owned by his aunt and uncle.

Families of Origin:

Fifteen of those interviewed had both parents alive but in the case of three the parents were separated. Three had lost both parents while two had a father only alive and two others had a mother only alive.

There was a wide spread in the number of siblings in the family of origin, ranging from none to sixteen.

Table IV adequately demonstrates this. It is notable that in only four cases was the family size less than four children, while 11 i.e. 50% of the sample were from families with at least eight children.

TABLE IV

No. of Siblings	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
No. of Sample	1	1	2	3	2	1	1	2	1	1	2	0	2	1	1	0	1

Siblings and drug taking:

The majority of those interviewed were the only members of their families who took drugs.

TABLE V

No. of Siblings Taking Drugs	0	1	2	more than 2
No. of Sample	15	4	1	2

Of the seven who stated that other members of their families took drugs five said that older siblings took drugs before them and two stated that younger members started on drugs while they were addicted.

Education

Leaving school early with no qualification is the lot of many of those interviewed. Fifteen of the 22 had achieved no education certificates and 11 had left school at 14 years or under. The usual pattern was primary school followed by a period at Vocational School. All claimed to be able to read and write adequately. None of those interviewed had attended 3rd level colleges or University.

TABLE VI (a)

School Leaving Age:	14 and under	15 years	16 years	17 years
No. of Sample:	11	2	8	1

TABLE VI (b)

School Attended:	Primary only	Primary and Technical	Primary and Secondary	Primary and Reformatory
No. of Sample:	8	9	3	2

TABLE VI (c)

Certs. Obtained	None	Primary	Group	Intermediate	Leaving
No. of Sample:	15	1	3	2	1

Employment

The most common pattern of employment that emerged was many different jobs for short periods of time. Fifteen of those interviewed had six or more jobs since leaving school and 14 held jobs for periods of less than two years. All had worked at some time since leaving school but only four had been employed just prior to coming to prison.

TABLE VII (a)

No. of Positions:	1-5	6-10	11+
No. of Sample:	7	9	6

TABLE VII (b)

Longest time in One Position:	Less than 6 months	6 to 12 months	1 to 2 years	2 years +
No. of Sample:	7	4	3	8

From the tables it is very obvious that very few had training in a trade or profession.

One completed an apprenticeship as a Chef.

One spent three years in the Army School of Music.

Five spent short periods in apprenticeships in wood-work, welding, fitting and commis-waiting.

The remaining 15 had no recognised training in any trade or profession. However, as well as the seven who completed or partially completed apprenticeships five others felt that they had acquired useful skills in their work experience – two on house-painting, one in trawler-fishing, one in managing a record shop and one in ornamental copper work.

Criminal Records (As per Criminal Record Office Returns to the Prison)

Seven of the sample were serving their first sentences in prison in Ireland. Three of these had served sentences of detention in St. Patrick's Institution and one other had served several sentences of imprisonment in England. For the purposes of the survey only three were in custody for the first time.

Length of Sentence

One man was serving 3 years while two of the sample were serving 18 months and the remainder were serving between two months and 12 months. The breakdown is illustrated on Table VIII.

TABLE VIII

Length of Sentence:	years 3	months 18	months 12	months 9	months 6	months 5	months 4	months 3	months 2
No. of Sample	1	2	8	1	6	1	1	1	1

All but *one* of the eleven serving sentences of less than 12 months had previously served one or more sentences of detention or imprisonment. Six of the eight serving sentences of 12 months had served several previous terms of imprisonment or detention.

Two had served nine terms while four served five or more terms. One had served just one previous sentence and the last was serving his first period in custody. All the 12-month sentences involved multiple charges. Of the three men serving more than 12 months two had served previous sentences while one (18 months) was serving his first sentence.

Offences:

Only four of sample were serving sentences for offences under Misuse of Drugs Act, 1977.

One was serving 18 months for smuggling cannabis into the country.

One was serving 12 months for possession of dangerous drugs (morphine) and breaking into a series of chemist shops.

Two were serving 6 months each for possession of dangerous drugs (Palfium and Diconal).

The remaining 18 were serving sentences for assault, larceny etc. Table IX gives the breakdown of offences and the number of persons involved in each category.

TABLE IX

Offence:	Manslaughter	Assault	Breaking and Entering Larceny	Larceny from Person	Unlawful taking and Larceny from cars	Possession drugs	Importation of drugs
No. of Sample:	1	2	8	4	3	3	1

It will be noted that violence played a small part in the offences committed, with only three of the sample charged with crimes involving violence. Larcenies from the person, buildings and cars amount to 15 of the offences. Those interviewed usually claim that these offences were committed to acquire money to buy drugs.

Previous Sentences:

When looking at the previous sentences served by members of the sample, time served in detention, i.e. St. Patrick's is taken into account as in custody. Table X shows the breakdown of the number of sentences served by each.

TABLE X

Sentence:	1st	2nd	3rd	4th	5th or more
No. of Sample:	3	5	2	4	8

Eight men served five or more terms of imprisonment while two of these were on their 10th term in custody.

If one includes the present sentence, the 22 men have served a total of 76 terms in custody between them. Only a total of 11 terms were served or are being served for specific drug offences, i.e. possession. B/E chemist shop, forgery of prescription, or supply of drugs. One member of the sample was unique in that both his previous sentence and his present one were for drug related offences. The present offence being possession and the former was for being in possession of a forged prescription.

Drug-taking in relation to first sentence

If one compares the ages at which the men interviewed started taking drugs with when they served their first sentence the following facts emerge.

Two had already served a sentence prior to taking drugs.

Three commenced taking drugs just prior to the time they started their first sentence.

Four were about a year abusing drugs before coming to prison or detention.

Nine were abusing drugs for at least 1 to 4 years prior to serving their first sentence.

The remaining *four* were abusing drugs for 4 or more years without coming to prison. One of these was on drugs for eight years before he began his first sentence.

Use of Drugs

As will be noted from Table 1 the age range of the sample was 19-32 years. When questioned as to when they started taking drugs 4 of the sample were 20 years or over and one started as young as 13 years.

The most common age at which members of the groups interviewed stated was 16-17. Table XI gives the breakdown.

TABLE XI

Starting Age:	13	14	15	16	17	18	19	20	21+
No of Sample	1	3	2	5	5	1	1	2	2

If one compares the present age of the sample with ages at which those interviewed give for starting on drugs the following picture emerges.

Five men have been on drugs for 10 years or more while one of those admitted to 17 years of drug abuse.

Eleven have been taking drugs for between 5 and 10 years.

Six have been taking drugs for 2-4 years.

None of the sample have been on drugs for less than 2 years.

Table XII explains the situation.

TABLE XII

Length of time of drugs	2-4 years	5-7 years	8-10 years	11+ years
No. of sample	6	3	9	4

It should be noted that this table refers to everything that the subjects regard as drug-taking, including cannabis use.

As previously mentioned many of those whose drug-taking has extended over a prolonged period have served one or more prison sentences during this time.

For the purposes of analysis all 22 interviewed could be described as heavy or chronic users of proscribed drugs.

Twelve gave heroin as their latest addiction

Three gave Diconal.

One was addicted to methadone and one other to barbiturates.

Five used L.S.D. as the main part of their daily intake of proscribed drugs.

Heroin users

A fairly typical pattern emerged from the twelve heroin users. Their daily dosage consisted of $\frac{3}{4}$ to $1\frac{1}{2}$ grammes of heron administered intravenously in several "fixes" during the course of the day. The cost of the heroin habit per day varied between £60 and £180. The £20 pack, being the unit of purchase at the time of committal, contains anything from $\frac{1}{8}$ to $\frac{1}{4}$ gramme of heroin.

Six of the twelve were on heroin for between 3 and 5 years while 3 others had been using the drug for 1 to 2 years. The remaining 3 were on the drug for 6 months. In the case of two of the latter this corresponded to the period since their release from prison on a previous sentence.

Six of twelve gave Diconal as their second preferred substance while three each took cocaine and morphine as their second choice.

Eight of the twelve heroin users stated that they got their supplies from a street pusher while the other four saw themselves as regular clients of a particular dealer.

Diconal users

Three of the sample gave their most recent addiction as Diconal. Their daily usage was much the same i.e. 2 or 3 Diconal 8 to 10 times daily. They had maintained their present habit for 3 years, 2 years and 6 months respectively. Their main source of supply was different for each. One broke into chemist shops and augmented his supply from street pushers, another normally got his supply on forged prescriptions and the third had what he described as a regular dealer. In answer to the question on second preferences, one each liked cocaine and morphine while the third use Paracodeine syrup in large quantities.

Barbiturates and Methadone

Two of those interviewed gave their most recent addiction as methadone and barbiturates respectively. The methadone user had been on the drug for 3-4 years having been introduced to it as a treatment maintenance dose in England. His daily usage was about 20 "tablets" and he stated he used any other tablets that he could acquire. His usual source of supply was street pushers or breaking into chemist shops.

The barbiturate user had been on the drug for several months. He also consumed a large amount of tablets per day but refused to specify. His usual source of supply was from friends. Both men stated that cannabis was their second preference in drugs.

L.S.D. users

The remaining members of the sample all used L.S.D. as the main part of their daily consumption of drugs. The amount used by each varied between 1 and 3 tablets of L.S.D. per day, a "tablet" of "acid", as it is known, was defined as the amount required for a 2 to 3 hour "trip". All five had been using this drug for less than a year.

All five used other drugs during the time that they were on L.S.D.

One stated that he used as much alcohol as he could get.

Two others used large numbers of Amphetamines.

The remaining two used cannabis.

All five stated that street pushers were their normal source of supply.

Drug-related illness

Sixteen of those interviewed were suffering from the initial stages of withdrawal when they arrived in prison and received phisepitone treatment for the first 4 to 5 days after arrival. Two of the L.S.D. users stated they were disorientated on arrival and received no medical attention, while another man was suffering more from the effects of alcohol rather than drugs.

Sixteen of the sample experienced drug related illnesses, nine claimed hepatitis and two claimed other damage. All sixteen claimed that they suffered from abscesses.

Twelve had overdosed and most of these had done so more than once. One man reports doing so as many as ten times.

Six has seriously attempted suicide and two of those six had attempted it twice.

Variety of drugs used

All 22 men interviewed had used a wide variety of drugs. Some of the drugs were more widely used than others and many found it difficult to put their drug-taking in order of time except for drugs they took regularly for some time. Only six of the sample had experienced glue-sniffing or used cough bottles and these for a short time only. For all 22 men their introduction to drugs started with cannabis, L.S.D. or speed (amphetamines). Table XIII gives an idea of drugs first used.

TABLE XIII

Drugs first used	Cannabis	L.S.D.	Speed
No of sample	19	2	1

All 22 men used cannabis regularly, 13 had used L.S.D. but apart from the five who used it regularly prior to coming into prison the other eight had only used it occasionally. Most of the 22 had used amphetamines but on a very irregular basis. Very few saw alcohol as a drug.

Fourteen of the sample had used barbiturates but apart from one who was addicted to the drug and two others who had used it extensively before going onto heroin, this drug was not widely used.

The following table gives a picture, of the range and order of experiences leading up to present addiction for opiate users.

TABLE XIV

Drugs	No. of sample
Heroin-Palfium-Diconal	2
Heroin-Cocaine-Palfium-Diconal	1
Heroin-Cocaine	3
Heroin-Methadone-Cocaine	2
Heroin-Diconal-Cocaine	2
Heroin-Barbiturates	2
Diconal-Palfium	3
Methadone-Heroin-Cocaine	1

All sixteen of this group had also used cannabis and amphetamines, 12 had used barbiturates and seven L.S.D. However they had used cannabis so regularly and the other substance so irregularly over a long period of time that they found it impossible to place their use in a time order.

The majority of the sample went on to heroin from cocaine or the synthetic opiates (Palfium of Diconal).

In the case of the five L.S.D. users, no clear-cut progression emerged. Prior to committal all still tended to use combinations of L.S.D. cannabis, amphetamines and alcohol.

The barbiturate abuser also continues to abuse his first drug cannabis regularly.

Experience in treatment

Six of those interviewed had no personal experience of treatment.

Three of them belonged to the group that took L.S.D.

One was a heavy user of heroin (1½ grammes per day).

The other two were addicted to barbiturates and Diconal. They had never made any serious attempt to give up drugs and had no strong desire to do so. When asked what might be a useful method of treatment, five said they had no idea while a sixth felt that the Coolmine Therapeutic Community approach offered some prospect.

Sixteen of the sample had been exposed to some form of treatment.

Twelve of these men had received detoxification in Jervis Street for periods of one week to five weeks. Many had been there more than once. Table XV (a) and (b) sets out the number of times members of the sample went for detoxification and the lengths of time spent.

TABLE XV (a)

Number of times	0	1	2	3	4	5
No. of sample	4	5	2	2	2	1

TABLE XV (b)

Length of stay	1 week	2 weeks	3 weeks	over 4 weeks
No. of sample	7	2	0	3

It should be borne in mind that the number of sample in Table XV (a) is the 16 who had received treatment for their drug problem and the number of 12 in Table XV (b) refers to the men who have received detoxification. From the table it is obvious that most of those interviewed spent a week or so in detoxification and this usually corresponded to a court appearance or new charges being preferred.

Eight of those who received treatment had been on maintenance doses of methadone (phiseptone) for periods of one week to several months. One man had spent several years on methadone in England.

Eight of the sample had been to Coolmine, seven for periods of 1 day, 3 days, 4 days, 5 days, 6 days, 2 months, 2½ months, the eighth person was there on four occasions for a few weeks each time.

One had tried “cold turkey” by staying at home for a few days at a time, while three had tried the same treatment in prison, i.e. they chose not to look for medical treatment (phiseptone) on their arrival in prison.

Three of those interviewed had spent time in the drug unit in the Central Mental Hospital while one spent 2½ months in the Rutland Centre.

Five of the sample had spent many short periods in psychiatric hospitals mainly St. Brendan’s and St. Ita’s, Portrane.

Four of the sample regarded regular contact with the psychiatrist or Probation and Welfare Officers in prison as a form of treatment.

Comments were sought from those interviewed on the value of their treatment experiences. Apart from the six who had no experience of treatment four others felt that none of their treatment were of any use.

Five felt that methadone (phiseptone) treatment was useful in the short term but became as difficult to do without as the drug they were addicted to and they normally returned to their addiction. Two spoke favourable about group encounters in the Rutland Centre and Dundrum and felt that they were valuable. Three of the eight with experience of Coolmine felt that it was useful but they left because it was “hard”, “weird” or they missed their family. The others made no comment.

“What do you consider a helpful treatment for your drug abuse?” This question brought the following replies. *Four* of those interviewed saw detoxification followed by a Coolmine type community as a helpful treatment. *Three* others saw hospital drug units followed by back-up medical and social work help as the best way forward. *Three* more saw their giving up of drugs as a matter of willpower or self help. It is interesting to note that one of these was a heroin addict for the past 3 years. *Two* felt that meetings for drug addicts like A.A. meetings would be helpful. The remainder of the sample failed to offer any suggestions.

In response to the question “Have you received any treatment for your drug problem while in prison?” the answer in all cases was *no*. This was despite the fact that sixteen had received phiseptone on arrival in prison and four regarded their contact with psychiatrists and welfare officers as treatment.

While in prison ten of the sample spent the day on “hospital exercise”, i.e. they sat or walked around the grounds while the rest of the prison population worked. The remaining 12 worked in the various shops within the prison. Nineteen of the men had been in

prison or detention previously and the following table sets out the time they stayed drug-free on leaving.

TABLE XVI

Drug-taking on release	Same day	Within one week	3 months or more
No. of sample	7	6	6

Thirteen of the 19 were back taking drugs within one week and none stayed off drugs for longer than about 8 months.

In response to the question, "Do you intend to give up using drugs"? Thirteen said "yes", five said "no" and there were four "don't know's".

The thirteen who answered "yes" were further asked if they really thought they would never use drugs again. Five answered "yes" the other eight said they "did not know" or "they would try". One man said that his wife had given him his last chance while another said he was now "dried out" and he was going to stay that way.

When the sample were asked how many prisoners did they think took drugs, six said they did not know or gave answers like several or a few, three more put the number at over 100 while the remainder put it at between 10 and 40.

General observations

Much discussion has taken place about the size of the problem of serious drug abusers in Mountjoy. Having consulted Welfare and prison records as well as the officers who work in the prison hospital and the answers given by those surveyed, the number of 30 or about 8% of the convicted prison population would seem to be accurate for the night of 18th May 1981.

Current thinking suggests that drug abuse extends across the whole socio-economic spectrum, if this is so it is not reflected in the drug abusers that come to prison. The survey shows that the vast majority come from deprived areas. The educational record of those interviewed is very poor with only three achieving Inter Certificate or higher. Eight of the sample had spent 3 years or longer in a particular job.

The majority of drug abusers surveyed were sentenced in the District Court and will thus serve at the maximum nine months actual imprisonment. Coolmine, with its 12 month plus intensive programme, is not an attractive alternative to prison where the routine is far less demanding.

The level of drug-taking and the prolonged period over which it has extended for most of those surveyed is a matter of concern. If one couples this with the incidence of drug related diseases and in-

vidence of overdosing it is surprising that some of the sample have survived so long.

It is in the area of treatment that most concern can be expressed. It cannot be said of one of those surveyed that they ever made a conscious, consistent effort at treatment. The efforts at treatment can be best described as a week here and there when a new prison sentence or a new charge was at hand. The level of motivation to give up drugs is very low and the presumption that drugs can be abandoned without treatment is high. Indeed only five of the 22 men expressed any resolution in their intention to give up and remain off drugs.

The closure of the Drug Unit in the Central Mental Hospital has created a void. No unit currently exists for treatment under the Misuse of Drugs Act, 1977. It is quite obvious that prison sentences as served at present by drug addicts do nothing for their problem except keep the abuser alive for a while longer. It is unlikely that enclosed exposure to treatment will be provided in the foreseeable future by any agency outside prison.

Chapter 4

THE SURVEY: ST. PATRICK'S

Nine boys were seen in St. Patrick's. The list of nine was compiled with the help of the Welfare and Medical Services and was of known and admitted cases who had experience, to the point of addiction, with drugs other than marijuana, alcohol and minor tranquilizers. It was thought to be a comprehensive list of such cases who were in St. Patrick's on June 8th, 1981. All nine took part voluntarily; there were no refusals and indeed the general level of co-operation was high.

The Boys' Background

Three boys were aged 17 years, three 18 years, two 19 years and one 20 years. All nine were single. However four claimed to have been living with a girl, as man and wife, and two were fathers to a young child by the girls with whom they had been living. All lived in rented accommodation; (three in flats with girlfriends, the remainder in the parental home (five flats, one house). Their homes were all in the Dublin Inner City area; three on the North side, the remainder in the inner South side, including five boys from within the Dublin 8 postal district.

The majority of the boys were from very large families. The number of children in the nine families were 14, 12, 11, 10, 10, 10, 8, 5 and 3. In seven cases both parents were still alive but in one case the parents were living apart. One boy had lost both parents and another had lost his father.

The pattern of schooling was very similar for all nine boys. This was National School followed by an often fleeting experience with a Technical School. This was the case with five boys while two others had in addition the benefit of a year in the special school at Lusk, following their time in a Technical School. Two boys benefited from education in Loughan House, one after a short period of time in a Technical School, the other directly following National School. Contact with formal education finishing at 13 years for two boys, at 15 years for five, and at 16 years for two. Five boys had no educational qualifications whatsoever and four had one or more subjects taken at Group Certificate level, including one boy who had additionally taken two subjects at the Intermediate Certificate level. However seven of

the boys were able to read and write adequately, one poorly, and only one not at all.

Seven boys had no trade or vocational training. One had completed a six week AnCO course in metalwork and another had followed an AnCO course in woodwork for five weeks. Only one boy had never worked but the pattern of employment for the other eight tended to be either informal or erratic. Two boys had worked selling coal from a horse and cart and two had worked as day labourers in the vegetable markets. They had done no other jobs but had worked at these jobs over several years off and on. Two boys had worked as a messenger, in one case for 11 months and in the other for eight months. Another boy had worked for three years, part-time in a warehouse after school, but since then had only worked for two weeks as an apprentice barman. The final boy worked occasionally assisting his father at small-scale painting and decorating jobs. Four of the nine boys were in some kind of employment just prior to their imprisonment.

Criminal Record

Five of the boys seen were serving their first term of imprisonment, though two of these had previously been detained in Loughan House. The sentences and charges for these five are as follow:-

- 6 months—Dangerous driving (in a stolen car).
- 12 months—Attempt to steal from person, Pickpocketing and Larceny.
- 6 months—Trespass and Larceny (previously in Loughan for Common Assault).
- 12 months—Assault on a garda, Larceny, Taking a car without consent and Robbery.
- 12 months—Robbery of £200 (previously in Loughan with many charges of Trespass and stealing).

The cases with more than one period of imprisonment were as follows:-

1. 12 months, Larceny of handbag, value £56 – 9 months, Two counts of robbery of £200 and £115 – 12 months, Larceny and attempted robbery.
2. 6 months, Larceny from chemist shop – 12 months, Trespass with intent to steal, robbery, three counts of Larceny from the person and four charges under the Road Traffic Act.
3. 3 months, Dangerous driving – 1 month, Dangerous driving – 6 month, Larceny.
4. 6 months, Obstructing a garda – 1 month, Common Assault and charges under the Road Traffic Act – 6 months, Driving without insurance, Trespass and Larceny – 15 month, Resisting a garda and Larceny from the person (several counts involving £10, £24, £30, £425 and £550).

It can be seen that many of the boys have been charged with offences that obviously relate to joy-riding in stolen cars. Apart from this the majority of the charges involve the stealing of cash. This is consistent with the answers given by the boys to the question of how they raise money to purchase drugs. They all readily admit that they steal for this purpose from whatever source they find available i.e. handbags, homes and shops. They are mostly only interested in cash. Some will admit that they have faced charges for only a small proportion of the robberies that they have committed. Perhaps the most striking fact about the list of charges against these boys is that not one of them has been convicted of a drug-related offence. There is evidence on the files, however, that two boys have at some time faced charges of possession of dangerous drugs. It would appear that these charges were not followed through or not proven because they were not convicted under them.

Drug use

The nine boys fell into a reasonably clearcut division between light and heavy users of drugs. Five could be described as light users. The five were asked what was their most recent addiction. Four of the five light users were daily users of heroin up to the time of imprisonment. The fifth was a daily user of three or four tablets of Palfium but he also took heroin about three times a week. The normal daily dosage of heroin for all five light users was a £20 pack which they variously described as about $\frac{1}{8}$ or $\frac{1}{4}$ of a gramme. The usual manner of taking was by fixing i.e. injection and most boys would make two fixes out of a £20 pack. The Palfium user claimed that his habit had been maintained over a period of about a year and the four heroin users said that they had been taking their most recent dosage for four months, four months, five months and eight months. In these four cases it seemed apparent that they had not significantly increase their dosage since their first experience with heroin.

Three of the heroin users stated that their second preferred substance was Palfium, dissolved in water and injected. The Palfium user described heroin and Diconal as second preference. The fifth boy gave no second preference.

Four of the five light users described their source of drugs as pusher on the street. The fifth stated that he "bought from other fellows".

Four of the five claimed to have been high when taken into custody, one saying that he had snorted a £20 pack of heroin while being held in the Bridewell. Two of the five received phisepitone for a short period after their arrival in St. Patrick's for help with withdrawal symptoms. Three reported no drug-related illnesses while one reported a bout of jaundice and abscesses, and another abscesses only. One only of the five had experienced an overdose, but this was previous to his taking of heroin and involved Roche tablets taken together with wine. He had had his stomach pumped out in hospital. One of the boys, a different one, claims to have made a serious suicide

attempt. In answer to the question, "Have you received any treatment for your drug problem while in St. Patrick's?" all five boys said no.

The four heavy users were all users of heroin. Two had been using it for over one year and two for over two years. Two reported that heroin in particular was their habit because it was the most available substance to them. Again their source of the drug was street-pushers but one admitted that he went to the pusher's home for his supply. One boy was taking up to $\frac{3}{4}$ gramme per day in 6 or 7 fixes and two said that when they had the necessary money they would take up to $1\frac{1}{2}$ grammes per day, again in several fixes. The fourth boy spoke of a more complicated habit involving a mix of drugs. He would take separate fixes of heroin, Diconal and morphine. For these four the daily cost of the normal preferred dosage would be between £80 and £180. For two, Diconal was the second preferred substance, for another morphine while the boy who described a complex daily dosage did not state any further preference.

Three of the boys were on phisoptone treatment on their arrival in St. Patrick's. Usually this was initiated by themselves, knowing that they were about to be imprisoned. The fourth described himself as 'strung out' on admission, i.e. craving heroin. Three of the four received phisoptone after arrival in St. Patrick's. All four had experienced drug-related illnesses; two reported hepatitis, one jaundice and the fourth liver damage. Abscesses were also common. None of the four had attempted suicide but one had overdosed on two occasions. In relation to treatment within St. Patrick's two boys mentioned the therapeutic group run by a psychiatrist and a psychologist within St. Patrick's but felt it was not relevant to his particular problem, while a third boy said he was hoping to join the group thinking that it might offer him something.

All nine boys were asked about the variety of their experience with drugs and the time order of their use of different drugs. A very definite pattern of developing experience and use emerged, culminating, as has already been pointed out, in a habit of heroin use. First it is possible to single out certain substances as rare and little used. None of the nine had used barbiturates or been involved in glue-sniffing. Only one admitted to drinking cough medicines. Three of the nine had used L.S.D. but on only one or two occasions. Only two had occasional experience with amphetamines (speed).

On the other hand all nine had experience of marijuana and most with minor tranquilizers, which they termed 'Roches'. In all but one case the first experience with a drug had been with one or other of these substances and often at as early an age as 11 years. However most boys perceived marijuana and Roche tablets in an entirely different light to other drugs. They seemed to regard them as a commonplace on much the same level as tobacco or alcohol. Often when asked which drug they had first experienced they spoke of heroin or Palfium, when it later emerged that they had in fact had previous experience of marijuana and Roche tablets.

The first experience with a heavy drug was most usually with Palfium. This was so in six of the nine cases. Use of Palfium always started with “dropping”, i.e. simple ingestion of the drug in its original tablet form. Three of the six boys progressed from “dropping” Palfium directly to the use of heroin (in one case heroin and cocaine together). One moved from dropping Palfium to dropping Diconal and then to heroin. However two boys progressed to snorting ground Palfium tablets and then fixing, i.e. injecting dissolved tablets of Palfium, before moving onto other substances. One of these boys progressed to fixing Diconal and then to heroin while the other moved directly to fixing heroin. In two of three cases where the first experience was not with Palfium the boys’ first “serious” experience was with heroin and in the case of the ninth and last boy it was with morphine. Except in the cases where an experience of fixing had already occurred with Palfium the development of the use of heroin tended to follow a regular pattern. This was first, the snorting of the powder, second, “skin-popping”, that is intramuscular injection with the needle of the syringe, and finally injection of the dissolved powder into a vein. All nine progressed to this final stage in heroin use.

The following table gives a picture of their range of experience of serious drugs:—

						Boys
Heroin	Cocaine					A
Heroin	Palfium					B
Heroin	Palfium	Diconal	Marphine			C
Heroin	Palfium	Diconal	Marphine	L.S.D.		D
Heroin	Palfium	Diconal	Marphine	Cocaine		EF*G*H*
Heroin	Palfium	Diconal	Marphine	Cocaine	L.S.D.	I

Boys A and E had only one experience of cocaine and boy I only two experiences of L.S.D. and 1 (one) of cocaine. The three boys, F.G. and H who had used cocaine fairly frequently tended to mix it with Diconal or morphine and inject it. The boys asterisked are those considered heavy users.

In cases where there had been previous imprisonment boys were asked how long after their release they again took drugs. Three took drugs on the day of release, including at least one who was under intensive supervision. One stayed drug-free for about a week and another for about 1½ months. The boys were asked how many other boys in St. Patrick’s were serious abusers of heavy drugs. It was the opinion of the Welfare Service in St. Patrick’s that there were considerably more than nine serious abusers in the institution on June 8th. It was felt that many boys hide their drug abuse, feeling that opportunities for drug abusers within the prison system were restricted, e.g. if their drug abuse was known it might prevent transfer to Shanganagh Castle. The responses from the boys were very varied. Two felt there were eight or nine other serious abusers while three put the number between 20 and 50. Four boys considered that

there were between 12 and 15 other serious abusers in the institution. It would seem reasonable to assume that there were other drug abusers in St. Patrick's who were not in the sample but it is also probable that they were only small number. Eight of the boys claimed that no one else in their family used heavy drugs. The ninth spoke of a younger sister being a user and said she started using after him.

Experience of treatment

Five of the nine boys had no personal experience of treatment for their drug problem whatsoever. Four of these five were light and relatively short term users. These four appeared never to have made a serious attempt to stop using drugs and also, apparently, had no strong desire to do so. These boys were asked what they would consider to be a useful treatment for their drug problem. Of the four, two said that it was not something they had ever considered. One said he would like to be sent to Coolmine and the fourth suggested that the only solution was to lock up all the pushers. Two of these boys did, however, point out that for them peer pressure was an important factor in their taking of drugs. One felt that, if he was to stop taking drugs, he would have to totally avoid his usual gang of friends. The other said that "he would rather stay off but with so many taking, and thinking of the good times he had had on them with friends, he would probably go straight back on".

The fifth boy with no experience of treatment was a heavy user. He had little regard for treatment, for example he felt that people "come out of Coolmine funny". He thought the answer was 12 months detention, in which time one could be drug-free, and then to be released to a job. From that point it was "up to oneself and that was the only way it could be".

The boys were asked if they intended to give up using drugs. They were then asked did they really think they would never use drugs again. Of this group one boy answered yes to both questions. This was the boy who was hoping to be sent to Coolmine. One boy answered no to both questions. The other three boys said that they did intend to give up but expressed various levels of doubt about whether they would ever use drugs again, generally feeling that they would.

Even in the case of the other four boys, three of whom were heavy users, the experience of treatment was minimal. The light user had approached Jervis St. at a point when he wished to give up. They offered to help him obtain a place in Coolmine but refused to prescribe him drugs. He was dissatisfied with this response and broke off contact. For two of the others the only experience of treatment was of detoxification on phisepitone in Jervis St. for a short period. In both cases they had initiated this, knowing that they were about to begin a sentence and not wishing to go "cold turkey". The fourth boy had experienced two periods of about two week of phisepitone detoxification in Jervis St. In one case he went into the hospital when his

family discovered his drug problem and put pressure on him to seek treatment. In the second case he was in hospital because of an attack of jaundice. On both occasions he took drugs on the day of release from hospital. The following are his comments on these experiences. "The thought was there. You are on 'phi.' And you say, well, I'm not going back on drugs. But you're stoned anyway (on phi.) and as soon as they stop (giving phi.) you get back on gear".

On the other hand, two of the heavy users had experience of attempting to give up drug use entirely on their own, staying at home and going cold turkey. One had lasted two days, the other four. Both found it too tough. In both cases much of the motivation appeared to come from girlfriends. Not from pressure from girlfriends but from the surprisingly altruistic desire to show good example and help the girls break a drug habit. In one case the girlfriend was pregnant and using drugs, which further strengthened the boy's motivation.

All four of this group said they did intend giving up drugs but all four thought they would probably use drugs again. On the question of intention they appeared to have more motivation than the other group but on the question of total avoidance in the future they answered with more pessimism and fatalism. For example one boy said he was sick of hearing himself say it (that he would give up) but that "he hoped he would be able to stay off".

On the question of possible treatments they had the following to say. One felt "it's really all your own willpower. The experience of a bad trip sometimes gets people off". On similar lines, another thought that "it's all in your mind, there's nothing only yourself". One, who had in the past enjoyed sport and youth clubs, felt that if he had a job and clubs to occupy him in the evening and weekend he could, with the support of groups and doctors, stay off drugs. The fourth boy felt there was a need for a place like Jervis St. that could offer medical services but without strict conditions, such as having to stay drug-free for 4 or 5 days. He also felt that such a place should emphasise voluntary participation and personal responsibility.

A common theme with all but one of the boys was their disregard for Coolmine. They reported no interest in going there, indeed they found the prospect unpleasant and threatening. One boy described a friend as "twice as much in the shits as before she went in there (Coolmine)". Several stated that they knew many people who had gone there but knew none to come out and stay off drug permanently, though some had managed to stay off for six or eight months. One boy said he had never known anyone who had been cured in Coolmine but had heard of some who had. In general the boys' negative feelings about Coolmine centred on the idea that freedom was greatly restricted there (more than in St. Patrick's) and a strict and bizarre discipline was imposed, which often involved personal humiliation for the addicts.

General Observations

The social backgrounds of the nine boys were very similar. Not only were they all from working class, inner city environments but most were from such large families that it was almost inevitable that they would receive little parental attention. Their schooling was also uniformly poor and often marked by a bad attendance record.

The criminal records of the boys imply that most of them were involved from an early age in a subcultural setting, in which stealing and vandalism were a commonplace. Although in time much of their stealing was undertaken to finance a drug habit, it is reasonable to assume that many of them were or would have been involved in such activity apart from their drug abuse problem. An alarming fact is that their subcultural environment has, in most cases, been a prominent cause of their involvement with drugs. Not only is drug taking fashionable in their neighbourhoods but most boys tell you that everyone in their circle of friends takes drugs of one kind or another. Several clearly felt pressure from peers to get involved with drugs. Awareness of the dangerousness of developing a drug habit and other similar deterrent attitudes would appear to be of minimal influence when many of the young people around you are indulging in heavy drugs, enjoying the experience and not suffering any obvious ill-effects. The fashionable nature of the drug-taking by young people in Dublin Inner City is also underlined by the relatively stereotyped patterns of the development of the habit and of the drug use found in his survey.

Another significant factor was that most of the boys and in particular the heavy users had a good understanding of their drug problem. That is to say they were well-informed about such facts as the body's increasing tolerance for a drug and the continuing need for higher dosages. Most seemed well aware of the usual pattern of growing dependence on a drug and of the damage that drugs can cause to bodily systems. Indeed some boys believed they had nothing to learn from education about drugs, thinking that they had already had a surfeit of what could be said.

On the other hand, many of the boys, the light users in particular, had a delusion of psychological control over their drug habit. They felt that if they really put their mind to it they could take or leave drugs. There was a sense that they felt their willpower was not only intact but indeed strong. It was just that it had not been tested. They chose to take drugs because their friends did, because there was nothing else to do and, most of all, because they enjoyed it. They had little or no insight into the fact that in the circumstances of their continued drug use their notion of their own willpower was becoming progressively more meaningless and unrealistic.

A related point could be made about the manner in which several boys, speaking on the topic of treatment, kept returning to the notion of personal responsibility and willpower. The general lack of interest, indeed disdain for treatment found in the survey can be connected with this belief in the importance of willpower as much as with lack

of motivation. Much of this unhelpful emphasis on willpower would appear to derive from this age group's need for independence and self-reliance. Nonetheless some of the boys also realistically appreciate the breaking a drug habit is impossible without facing up to the task of taking personal responsibility for one's own behaviour. Still there remains the problem that resistance to centres like Coolmine is linked to the boy's strongly felt need for independence and self-control. As regards treatment three points seem worthy of discussion:-

1. It seems essential to deal with the group phenomenon of drug-taking, i.e. as a fashion within a gang. Not only is widespread use of drugs within a subculture aiding the rapid growth of drug-taking but it also reinforces those taking drugs and, by example, thoroughly undermines the deterrent effect of a young person's initial caution and fears about dangerous drugs.
2. There is the problem of the beginner's and the light user's strong delusion of control. This makes them difficult to approach and difficult to persuade. By the time they begin taking a more realistic approach they are usually already heavily addicted and psychologically dependent.
3. On the other hand, the independent-mindedness and self-reliance of the young can be regarded in a positive light as an aid to treatment. Several of the boys made their only seriously motivated attempt to break the drug habit on their own when they were not under external pressure from any authority. This is precisely the type of motivation that needs to be tapped and supported. This suggests the need for a centre which can offer understanding support, but which, above all, respects the young person's independence and the voluntary nature of the helping process.

Chapter 5

THE SURVEY: FEMALE PRISON MOUNTJOY

Three girls were interviewed in the female prison. They were the only drug addicts imprisoned on May 11th, 1981. Two girls were 21 years old, the other 18 years. One 21 years old girl was married (to an addict) and had two young children. She lived in the parental home, a corporation house. The other two girls were single but each had a 1½-year old child. Both lived in corporation flats in the inner city area, one the parental home, the other a flat of her own.

The parents of all three girls were alive but in one case living separately. The number of children in the three families was five, seven and nine.

The three girls had poor school records. Two had attended National School and a Technical School, the other only National School. They had stopped attending at 12, 12 and 14 years and all had left school without any qualification. However all three could read and write well and impressed as being reasonably intelligent and capable of benefiting from a much higher level of education.

Their work records were also poor. One had never worked, while the other two had experience of several (three and eight) periods of employment lasting only one to three days. One girl had spent eight weeks on a training course in Catering but had been admitted to hospital before completion of the course.

One girl was serving concurrent terms of two and three months for feloniously stealing (mainly from handbags) sums of £45, £33, £43, £25, £250, and £296. The second girl had previously served one month for assaulting a garda and was presently serving terms of nine months and 12 months for stealing (£93), attempted larceny and attempting to steal an article, value £9.99. The third girl was serving her first sentence of 12 months for feloniously stealing a jumper value £2.99.

Serious drug-taking began for these girls at 14, 15 and 17 years of age. Their pattern of development of use was very similar to that for the boys in St. Patrick's. Early, somewhat disregarded use of marijuana and Roche tablets followed, in two cases, by a first use of Palfium. In the third case the first serious experience was with heroin and cocaine used together. The two girls who started on Palfium both progressed first to Diconal and then heroin. The sequence of methods of use was also similar to that of the boys i.e. 'dropping' tablets, snorting powder, 'skin-popping' and eventually 'fixing'.

However an interesting fact is that the girls appeared to have a wider experience of drugs. In addition to Palfium, Diconal and heroin, all three had used cocaine, two had used both amphetamines and barbiturates and one had used L.S.D. None of the girls had used morphine.

The most recent habit for two of the girls was heroin, in one case up to 1 gramme per day, in the other up to 1½ grammes per day. This had been their habit for three and two years respectively. Dissolved Diconal (in one case often 30 tablets per day taken in fixes of 5 tablets) was the second preferred substance for both. The third girl had a complex daily habit. She had been receiving phiseptone from a clinic for long periods and tended to take both Diconal (10 tablets per day) and heroin (¼ or ½ gramme per day) in addition to the phiseptone. Her habit had been similar for almost three years. All three girls bought heroin on the street or in pubs. One frequently obtained Diconal on fraudulent medical prescriptions, while the others bought Diconal at £5 per tablet. One girl said she frequently bought up to £600 of heroin at a time. This girl stole mainly cash. A second girl financed her habit by shoplifting and fencing the stolen goods. The girls who used fraudulent prescriptions claimed not to be very seriously involved in stealing. All three girls can clearly be classified as heavy users. All three had sisters using serious drugs, in one case before and in two cases after they themselves started using them.

Two girls were on their regular drug habit on arrival in prison and received phiseptone treatment. The third was already on phiseptone and received none in prison. All three had overdosed; one on one occasion, the second two times (one of which resulted in a two week stay in the Richmond Hospital) and the third 'many times'. One girls had suffered conjunctivitis, jaundice and a kidney infection, another kidney problems and abscesses, and the third, abscesses only. One of the three girls claimed to have made a serious suicide bid on two occasions.

The girls had considerably more experience of various treatments than the heavy users among the boys of St. Patrick's. One had been on a detoxification programme in Jervis St. on nine or 10 occasions, lasting from 10 days to eight weeks. However, it should be noted that she was abusing this treatment insofar as she was taking phiseptone from the clinic and then in addition fixing heroin and Diconal. The same girl had spent 7 months in a psychiatric hospital after an overdose and 7 months in Coolmine. The second girl had been on phiseptone detoxification in Jervis St. four times. She also continued to use heroin while on these programmes. This girl also had experienced daily psychotherapy, over an 8-week period, with a psychiatrist in a remand centre in England. This psychotherapy was directed at her drug problem. The third girl had not experienced detoxification and this was because she had sought out-patient detoxification at Jervis St. but had only been offered in-patient treatment. This she refused, presumably because in-patient status makes abuse of treatment more difficult. This girl had, on the other hand, spent 7 months in Coolmine.

The girls had many pertinent comments to make about their experience with treatment. The two with in-patient experience in Jervis St. both stated that they used it only because of their state of imminent physical collapse. One girl said, “it rebuilds your physical strength to enable you to take more drugs. You get your veins back and your abscesses cleared up. I was using it as another source of drugs (phiseptone). I never gave it a chance”.

The two girls with experience of Coolmine had strong negative feelings about it and appeared to have found the regime far too strict for them. One girl said she would rather spend 2 years in prison than 6 months in Coolmine. “I thought it was doing my brain in” she stated. “I didn’t see any point – only getting roared and screamed at, all the time. There’s nothing about drugs there. They try to turn you into a machine and turn you off your family.”

The second girl said it was too hard and too long and a “mad, stupid, different world. I felt like a machine. It was childish being told what to do, how to talk, what to talk about. The longer I stayed the harder it got. I was terrified of the groups, the shouting and the crying”. However, this girl now felt that on reflection she had benefited. She now considered her situation more objectively and had made important realisations about herself. It is significant that she went to Coolmine without a full commitment to giving up drugs. She said, “I went out because there was nothing else but I knew in my heart that I would not give up, because I love drugs”.

The girl who had been an in-patient in a psychiatric hospital demonstrated the same lack of motivation, indeed to the extent of manipulation of the situation in the hospital. She reported that she would claim she was depressed, when she was not, in order to obtain more tablets and get “stoned”.

It seems clear from these findings that the facilities available in Dublin for drug abusers, that is Jervis St. and Coolmine, are not serving a very useful purpose for the type of addicts who end up in prison. Of course it is also true that this is primarily because of the addicts’ lack of motivation and lack of commitment to breaking their habit.

On the other hand, it would not be true to state that these girls totally lack the motivation to give up drugs. Unlike the boys in St. Patrick’s these girls do not have a delusion of control over their habit. On the contrary, they are dispirited and consider that their lives are in disarray and out of their control. In this situation drugs offer them one of the few direct pleasures of life and an escape from disorder, disappointment and pressure. At the same time, in part at least, they are appalled at the situation they have got into and sincerely desire a return to normality.

All three girls reported a feeling of emotional detachment from their children, husbands/lovers and people generally. Their dulled neutral emotional reaction to others is not only isolating but also the source, for them, of a great deal of guilt. One girl said “I think for a few moments about death and my kids but I can’t think for more than

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

The other two girls had a reasonably strong (but that is not to say determined) intention of giving up drugs. One said with obvious feeling, "I don't want to go out to lead the same life again". Both suggested the Narcotics Anonymous groups would be of benefit to them and one had experience of such a group at the Adam and Eve Counselling Centre. A day-centre for non-using addicts, which could offer support and occupation, was also suggested. One of the girls thought a Narcotics Anonymous group should be introduced within the prison. However these two girls were not at all sure they would never use drugs again.

It is reasonable to conclude that within the present structure of services the outlook for these three girls is not good. Where there is a desire to abandon drugs it is real enough but probably not strong enough. It needs to be matured and strengthened by almost continuous support from outside themselves. A major problem is that, for them, any genuine commitment to breaking their habit (referring to their psychological not physical dependence) is immediately followed by a confrontation with the actual disorganisation of their social and emotional lives. Long neglected responsibilities and concomitant guilt feelings immediately press in on them and they find themselves entirely unable to cope. It was apparent, with at least two of the girls, that this problem is compounded by the fact that their lives have centred around drugs from such an early age that they have never developed a 'normal' maturity. Their perceptions of life and of themselves, and their ability to form adult relationships are impaired by their lack of experience of a relatively normal adolescence. On the other hand, the criminal activity of these girls is more clearly secondary to their drug problem than is the case with the boys in St. Patrick's

To conclude on a further pessimistic note it should be pointed out that, according to a survey by the Welfare Officer in the Female Prison, 14 different female drug users have been in the prison in the period from January 1st to June 1st, 1981. Of these girls 11 were thought to be users of heavy drugs. At one point in this period 9 drug users were resident in the prison.

Chapter 6

SUMMARY

Thirty-four offenders were interviewed from the three institutions. 22 from Mountjoy Male Prison, nine from St. Patrick's Institution and three from Mountjoy Female Prison. The age range of the group was 17 to 32 with an average age of 22.2 years. Seven of the total group of 34 were married (two separated) but 12 of the 34 subjects had children.

Eighteen of the 34 were still residing in the parental home. In five cases the parent of the offender had separated and in five cases both parents had died. In a further two cases the mother only was dead and in a further three cases the father only was dead. In short, in 15 out of 34 cases the family of origin was not intact. Nineteen of the 34 subjects were from families with at least eight children and only five were from families with less than four children.

Twenty-three of the total group had left school by 15 years of age and only one of the 34 had experienced schooling after the age of 16. Seventeen had never retained a job for more than one year and six of the remaining seventeen, who had experience of longer term employment, were in casual, part-time jobs.

Of the 34 offenders four were serving sentences for crimes under the Misuse of Drugs Act. Seven were serving their first term in custody. But altogether the 34 offenders had been sentenced to 102 separate terms of custody, only 11 of which were directly related to drug offences.

The main drug of abuse for 28 of the total group was a narcotic analgesic and in 23 cases heroin was the most frequently used narcotic. Of the remaining six, one individual was addicted to barbiturates and five regularly used L.S.D. All the non-narcotic users were in the older Mountjoy Male Prison group. Twenty-three of the total had received methadone detoxification treatment after their arrival in prison. Eleven reported having suffered hepatitis and a further four spoke of jaundice but did not specify hepatitis. Seventeen of the 34 had at some point overdosed while eight reported that they had made at least one serious attempt at suicide. Of the group 11 had at least one brother or sister seriously abusing drugs and in five of these cases the sibling started drug abuse after the subject.

Eleven of the group claimed to have no experience of treatment whatsoever. However, 17 had undergone methadone detoxification outside the prison and ten of these on more than one occasion. Ten of the group, including two females, had experience of the Coolmine Therapeutic Community but five of the ten remained there for less than a week. Both females remained at Coolmine for seven months but the longest period spent there by a male was 2½ months. In no case, therefore, was the complete programme of treatment experienced.

Of the twenty-seven offenders who had served a previous term of custody all returned to using drugs, though drug-free while in prison, and 19 were abusing drugs within one week of release. Twenty-three of the 34 subjects answered yes that they did intend to give up using drugs, however only six of these people really thought that they would never use drugs again. The other 11 subjects were virtually certain they would use drugs again.

Finally, to give some indication of trends in the number of drug abusers being committed to prison a comparison was made of the numbers involved at the time of the survey in May, 1981 and the corresponding numbers in the three committal prisons one year later on a single day in May, 1982. In 1981 there were 29 'serious' drug abusers in Mountjoy Male Prison, nine in St. Patrick's Institution and three in Mountjoy Female Prison. The corresponding figures for 1982 are Mountjoy Male Prison 45, St. Patrick's Institution 18, and Mountjoy Female Prison six. These figures denote a considerable upward trend in the number of drug abusers being committed to prison.

Appendix
THE QUESTIONNAIRE

QUESTIONNAIRE

Age of subject:

Is S. Married:

Separated:

Single:

Widowed

Does S. live with a (wo)man:

Has S. Children: Specify number and ages and by whom:

Does S. live in a:

Squat--Specify

House--Self or own family	rented	owned
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with parent	—	—
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with others	—	—
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Hostel--Specify:

Rough

Other--Specify

What types of school did S. attend:

Age S. left school:

Qualifications:

Does S. read:

Does S. Write:

Has S. any 3rd level, Trade or Vocational Qualifications: Specify:

Has S. ever worked

How many jobs has S. had:

How long did the longest job last:

Which job involved the most skills:

Was S. working just prior to imprisonment:

Has S. had any useful vocational experience: (Specify if yes).

Approximately on how many charges has S. been convicted (including fines, probation, imprisonment etc.)

Under what headings do the charges fall (enumerate):

Drug-related—(a) Possession

(b) Supply

(c1) Other (specify)

(c2) Stealing from Drug depots, (Chemists etc.)

Other — (d) theft

(c) assault

(d) other (specify)

How many terms of imprisonment has S. served:

How long were the terms:

Where served:

When was S's. first conviction: (a) drug-related

(b) other

When did S. start first imprisonment:

(a) drug-related

(b) other

Are S's. Father: and Mother: still alive

If yes do they live together:

How many brothers: sisters: does S. have.

Has any one else in S's. family taken drugs? If yes was that before S.

At what age did drug-taking begin:

Which of the following has S. Taken:

Amphetamines	Alcohol
Hash/Marijuana	Barbiturates
L.S.D.	Cough Bottle
Heroin	Glue-sniffing
Cocaine	Others (specify)
Methadone	

(Place these in time order i.e. put 1. beside drug first used. 2. beside drug next used etc.)

What is S's. most recent addiction:

How long has S. been addicted to the (these) drug (s):

What is S's. normal dosage (specify amount and frequency):

What is S's. second preferred substance:

What is S's. normal source of drug:

Has S. been exposed to any of the following treatments, if yes, specify number of times S. has experienced a treatment and how long each treatment lasted and where administered.

(a) Detoxification

(b) Methadone Maintenance

(c) Other physical (specify)

(d) Psychological–Coolmine

–Other

(e) Psychiatric (specify)

(f) Other (specify)

What condition (vis-à-vis drug) was S. in, on arrival in Prison.

Has S. received any drug substitutes in Prison: Specify:

Has S. received any other drugs in Prison: Specify:

Has S. received any treatment for drug problem in Prison: Specify:

What is S's. normal activity within the prison:

Has S. ever overdosed: How many times:

Has S. suffered drug-related illnesses. e.g. Hepatitis: Specify:

Has S. ever made a serious suicide bid: How many times:

Ask S's opinion about each treatment he has experienced: Does he think it effective, valuable, difficult etc.

What does S. consider would be a helpful treatment for S's drug abuse:

When (if) S. last left prison how soon was it till S. again took drugs:

Finally ask S. in these words: Do you intend to give up using drugs?

If answer yes ask: But do you really think you will never use drugs again?

How many drug addicts do you think are in (St. Patrick's etc.)?

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