

ecstasy

and young people

NATIONAL
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CÓNASCADH
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HEALTH
PROMOTION
UNIT

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INTRODUCTION

There has been a considerable increase in the use of ecstasy by young people in recent times. In 1995, the Gardai seized over 120,000 ecstasy tablets. This compares with a seizure of under 2,000 tablets in 1993. The scale of recent seizures, together with the highly publicised deaths of a number of young people in Britain and Ireland, through ecstasy use, has generated much public concern on the issue.

The perception of those working with young people is that young people themselves still regard ecstasy as a relatively safe drug. Despite all the adverse publicity ecstasy is still perceived by many as a safe social drug causing pleasant sensations with no side effects for most of those who use it. It has become an integral part of a youth sub-culture closely linked to the rave scene. It assists its user in “*dancing the night away and having a good time*”, sometimes resulting in a tragic loss of life.

As the use of ecstasy as a ‘*recreational drug*’ is relatively recent, with its upsurge taking place within the last five years or so in Ireland, little reliable research has taken place to inform on the physical and psychological dangers of using ecstasy, both short and long term.

Consequently, the discussion to date around the problem of ecstasy has been clouded by the myths, preconceptions and misinformed opinion on ecstasy that govern the public and media debate. Therefore, a clear need exists for quantitative research to be undertaken in an Irish context to examine this recent ‘phenomenon’ with young people to ascertain how and why it has become such a part of a youth sub-culture. There is also a need to produce clear, reliable, understandable information for a concerned public to help them develop an awareness of what ecstasy is, the issues surrounding it and to debunk some of the myths that have developed.

New and more creative approaches to drug prevention will need to be developed to respond to this recent phenomenon. The focus of most drug education initiatives and programme responses to drug use in Ireland to date has been on the use of hard drugs such as heroin and/or the socially accepted drugs such as alcohol and tobacco.

Any future educational and preventative campaigns on ecstasy should take into account international experiences of initiatives and projects in countries such as England, Scotland and The Netherlands where specific awareness campaigns on ecstasy have been successfully implemented. A particular focus on raves and night-clubs emphasising harm reduction measures for ecstasy users should be a key dimension of such preventative measures. Such a campaign in Scotland focusing on harm reduction has resulted in no reported ecstasy related deaths in an eighteen month to two year period.

This timely publication (which was informed by a national seminar on ecstasy and young people, see Appendix A), undertaken by the Irish YouthWork Centre with the support of the Health Promotion Unit of the Department of Health and the National Youth Federation provides useful data and critically analyses the aforementioned issues, among others.

All those wishing to redress the blight of drug misuse, and in particular, ecstasy use, will find this information-based piece of secondary research an invaluable resource in debating the issues and more importantly, in recommending preventative action in the interest of all concerned.

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WHAT IS ECSTASY?

The chemical name of the compound Ecstasy, is **3,4,-methylenedioxyamphetamine or MDMA** for short. It is classed as one of the group of hallucinogenic amphetamines whose effects combine those that occur with the usage of amphetamines and/or LSD. Hallucinogenic amphetamines induce a state of excitation of the central nervous system causing central autonomic hyperactivity, which manifests itself as changes in mood (usually euphoric but occasionally depressive) and perception. What would technically be regarded as a true hallucination rarely occurs contrary to popular opinion.

This category of hallucinogenic amphetamines contains over one thousand compounds and includes the MDA (3,4,-Methylenedioxyamphetamine) family which includes MDMA (Ecstasy) and MDEA commonly known as 'Eve'. Compounds in the MDA & MDMA family are produced synthetically from chemicals which occur naturally in the oils of various natural products such as calamus, crocus, dill, nutmeg, parsley, saffron and sassafras. The structure of the compounds governs whether the effects will be akin to amphetamines or LSD. They will vary greatly in their level of potency although those in the MDA family are regarded as being mild in comparison with most in the hallucinogenic amphetamine group (ISDD, 1993). Their effects will generally be psychedelic rather than hallucinogenic. Psychedelic effects normally manifest themselves in the form of enhanced experiences of vision, colour and sound whereas hallucinogenic effects would manifest themselves in the form of distorted imagery, visions and seeing things that do not exist.

In Britain ecstasy is classified as a Class A drug which is the most restrictive classification. This classification includes drugs such as heroin and cocaine. However, this classification is relatively recent, up until 1985 ecstasy was available on prescription by doctors as an anti-depressant. Table 1 below gives a breakdown of the classification of illegal drugs.

Table 1: British Illegal Drugs Classification

CLASSIFICATION GRADE	TYPES OF DRUGS INCLUDED
CLASS A	cocaine, crack cocaine, ecstasy, heroin, LSD, PCP, magic mushrooms (possession, production & supply), opium.
CLASS B	amphetamines, barbiturates (some), cannabis, methamphetamine, methaqualone, stimulant drugs. If any of these drugs are prepared for injection they become Class A.
CLASS C	milder amphetamines, tranquillisers, benzodiazepine, dextropropoxyphene (<u>distalgic</u>)

(NABC, 1984/HEB, 1987)

This classification system is British and has no legal basis in Ireland. It does however, provide a useful indicator of where ecstasy fits with other illegal drugs. Under the Misuse of Drugs Acts 1977 & 1984 ecstasy is categorised as a Schedule 1 drug. There are five schedules in total and how these schedules relate to legal penalties in Ireland is outlined in Chapter 4.

The physical appearance of ecstasy varies considerably and many of the nicknames associated with it are derived from the various forms it can be found in or the symbols on the tablets themselves. It is normally found in tablet or capsule form often with a dove symbol (love doves), shamrock symbol (shamrocks), red and black capsules (Dennis the Menace), red and yellow capsules (Rhubarb and Custard) etc. Other commonly used nicknames include 'E', 'disco biscuits', 'disco burgers', 'Adam' 'Edward' 'Essence' and 'XTC'. Ecstasy can also be acquired in powder and liquid form. Many herbal forms of ecstasy are also available which is not surprising considering that the basic ingredients for ecstasy are derived from natural products.

The potency of an ecstasy tablet/capsule varies greatly depending on the make-up of the compound used in its production. Less than half the drugs bought as ecstasy are felt to be pure ecstasy and many tablets sold as ecstasy contain no ecstasy at all (Health Promotion Unit, 1996). For example there is a type of ecstasy tablet called a cracker which would be regarded as mild and gives the user extra stamina and hallucinations. However at the other end of the scale are power thrusters which would be regarded as the strongest tablets on the market. The reason for this is that these tablets usually contain heroin and/or horse steroids. Taking these will normally completely immobilise the user with exhaustion for approximately two hours ("How ecstasy danced its way into Ireland", Irish Times, April 1995).

Many tablets which are sold as ecstasy are cut and mixed with a variety of stimulant or hallucinogenic substances such as amphetamine sulphate and LSD. As mentioned above heroin and steroids are commonly used to cut ecstasy tablets. MDA, the parent drug and MDEA (Eve) are commonly sold as ecstasy (Lifeline, 1996). It is also felt that there is an increasing use of both anaesthetic (Ketamine) and depressant (barbiturates) drugs to cut ecstasy tablets and in some cases pure anaesthetic or barbiturate tablets are passed off as ecstasy (Health Promotion Unit, 1996). In Ireland the drugs most commonly sold or passed off as ecstasy, other than pure ecstasy (MDMA), are:

- MDEA (Eve)
- MDA (parent drug of ecstasy)
- Amphetamine/caffeine
- Ephedrine/caffeine
- Amphetamine/LSD
- Ketamine

(Corrigan, 1996)

Recently there have been media reports of ecstasy tablets containing rat poison, fibreglass and various toxic substances. However, there has been no scientific confirmation of these reports to date. Irrespective of this, the increasing use of other drugs being passed off as ecstasy represents a dangerous development and clearly illustrates that taking ecstasy involves a leap of faith and an experiment with the unknown.

HISTORY

MDA, the parent drug of the MDA group of drugs, was first developed by two German chemists in 1910. Little interest was shown in the new drug and it was largely forgotten about until 1939 when the drug was tested on animals during research on the effects of adrenaline. In 1941 the drug was tested as a relief for Parkinson's disease, but rejected when one trial subject experienced increased rigidity. At the same time, the US pharmaceutical manufacturer Smith, Kline and French dropped plans to market the drug as an appetite suppressant because of side effects.

Ecstasy (MDMA) a derivative of MDA was first developed between 1912 and 1914 by a German pharmaceutical company Merck. It is rumoured that it was originally sold as a slimming pill although it was never formally marketed. This may have been due to rumours that it caused some 'strange' side effects. It did not come to prominence again until 1953 when the US army tested a number of drugs as potential chemical warfare weapons to see whether they could be used to disorientate the enemy. The military were trying a whole range of drugs for use in chemical warfare, to extract information from prisoners and to immobilise armies. MDA was coded EA1299 by scientists at the Edgewood Chemical Warfare Service (ECWS) in Maryland (ISDD, 1993).

The man regarded as the father of Ecstasy's development as a recreational drug is Alexander Shulgin. After obtaining a PhD in biochemistry from the University of California at Berkeley, Shulgin got a job as a research chemist with Dow Chemicals, where he invented an insecticide which was commercially hugely successful. As a reward for this Dow gave Shulgin his own laboratory and a free hand to research whatever interested him. Shulgin first synthesised and experimented with ecstasy as a recreational drug in the mid sixties, but it was only after hearing reports in the early seventies from others experimenting who had also synthesised and tried ecstasy that he took a serious interest (Saunders, 1995).

USA

At the same time some American psychologists and psychotherapists were using ecstasy, or 'Adam' as it was then commonly known, with people who were in therapy. They believed that its empathetic, mellow and mood-altering qualities could assist and even shorten the therapy process. However, they also realised the more commercial potential of the drug and that if it became popular as a recreational drug there was a danger that it would be criminalised by the American Government. As a result they kept their work with the drug relatively quiet and were successful in keeping the publicity attached to a minimum. Ecstasy's development as a widely used recreational drug was very gradual. Although it was being used by various groups in a variety of ways it was not until the early to mid-eighties that it began to take hold as a dance drug (Saunders, 1995).

By 1984 ecstasy was being used widely among students in America. It was beginning to replace cocaine as the drug of choice among yuppies. It was openly sold in bars and clubs all over the USA and was even accompanied by a booklet of 'flight instructions' outlining how to enjoy the drug and avoid potential difficulties (Community Drug Advice Team, 1996). This brought the drug to the attention of the American government who decided to introduce legislation outlawing it.

In 1985 ecstasy hit the media headlines in a big way when a small group of people sued the US Drug Enforcement Agency in an attempt to prevent them from outlawing the drug. The controversy in effect provided free advertising which resulted in a huge upsurge in ecstasy use throughout the USA. The media focused on portraying ecstasy as an extremely harmful drug and as a result the US Congress passed a new law allowing the Drug Enforcement Agency to put an emergency ban on any drug it thought might be a danger to the public.

On July 1st 1985 this legislation was used for the first time to ban ecstasy. Furthermore, ecstasy was put in the most restrictive category of prohibited drugs (Class A), reserved for damaging and addictive drugs without medical use. The effect of prohibition was to prevent research into the drug without changing the attitudes of recreational users (Saunders, 1995). Similar measures have followed globally in the intervening years.

Europe

Ecstasy was brought to Europe by two distinct groups of users in the mid eighties. First were the followers of Bhagwan Rajnessh, an Indian guru whose disciples wore orange. They brought it with them when they moved out of their home base ashram in Oregon, USA. Their rationale for using it was as an aid to self enlightenment.

At about the same time it arrived on the hedonistic club/rave scene in the Spanish resort of Ibiza which traditionally has been heavily dominated by the British tourist presence. These British tourists brought it back home with them and dispersed it to the emerging rave scene throughout Britain. This is discussed in greater detail in the section *Ecstasy and Rave Culture* later in this Chapter.

Ireland

It is generally felt that up until 1988 ecstasy usage was confined to small groups in Dublin and Cork with small amounts being smuggled into the country for personal use (*"How ecstasy danced its way into Ireland"*, Irish Times, April 1995). Then the house music scene arrived in Ireland and the dance/rave culture took off similar to Britain and with ecstasy being integrally linked to the rave scene its popularity grew in tandem with the dance/rave scene.

WHERE DOES IT COME FROM?

Until relatively recently it was widely accepted that all ecstasy products were imported from abroad. The majority of ecstasy tablets are imported from the Netherlands where they are manufactured on a large scale in illicit laboratories. Smaller amounts of ecstasy tablets have been imported from Liverpool and Manchester and some has come in through Northern Ireland, although it is unclear whether the tablets were manufactured at these locations or came via the Netherlands (*"Ecstasy market to expand in coming weeks"*, Sunday Business Post, September, 1995). The tablets are purchased from these 'laboratories' for £2-£3 and their current street value is approximately £10-£15.

In July, 1995 the Gardai discovered an ecstasy making plant in The Ward in North County Dublin which was ready to go into production. The raw material for the plant had been manufactured in a house in Lucan, County Dublin where a laboratory had been set up (*"How ecstasy danced its way into Ireland"*, Irish Times, July 1995). This combined with the drop in the price of ecstasy leads most people with a working knowledge of the drug scene to believe that ecstasy is being produced in the Republic.

ECSTASY AND YOUTH SUBCULTURE

Youth is often regarded as a time of rebelliousness and there are three particular forms that are particularly attractive to many young people: delinquency, radicalism and bohemianism and these elements will be common to many subcultures (Matza, 1962). Many young people are also subject to the impact of occupational, educational and economic changes at particular times in history. One of the most common responses by young people to the uncertainty, disenfranchisement and isolation that these changes can cause is to become involved in or identify themselves with a particular subculture. These are experienced not only in class terms but also in generational terms. Most subcultures that are regarded by society as being deviant in nature or focus (as is the case with the dance/rave scene) have been working-class, youthful subcultures as this is the group most vulnerable to economic changes (Brake, 1985).

Subcultures offer a perceived solution to real relations which cannot be otherwise solved. The particular time in a young person's life that a subculture has an impact is also notable as it usually occurs in the period between, or near to, the end of the school career when education is regarded as not worthwhile in relation to a

young person's work prospects (if any exist), and normally lasts until marriage or some other event which initiates the 'settling down' process (Cohen, 1972). As stated these subcultures are predominantly working-class and;

"infuse into the bleak world of the working-class adolescent a period of intense emotion, colour and excitement during the brief respite between school and the insecurities of the early days of working and settling down to marriage and adulthood" (Brake, 1985).

Traditionally, this type of subculture has been closely linked to music, and almost exclusively to a new type of music that breaks away from the mainstream popular music of the period. In the late 1950's it was rock and roll, in the 1960's (hippy/folk), early 1970's (glam-rock), late 1970's (punk) and in the early 1980's (new romanticism). In the late 1980's and into the 1990's dance/rave music has become the medium of expression for this type of youth sub-culture.

ECSTASY AND RAVE CULTURE

The rise of Acid House, rave and its accompanying dance culture occurred in the mid to late 1980s. The musical and cultural origins of Rave music stem from 'Acid House', which itself was a derivative of 'House Music' which initiated in the U.S.A., particularly Chicago. Acid House disc jockeys and music producers used a range of innovative recording techniques to produce dance music which was '*bass-driven, repetitive, hypnotic and psychedelic*', (Merchant & Robinson, 1994). However, it was the culture of Acid House that was regarded as more important i.e. the dancing and the friendly empathetic atmosphere. Sources such as Evans (1990) and Redhead (1993) have described the phenomenon of British disc jockeys and dance music fans on holiday in Ibiza in the mid-80s being so impressed with:

"the so-called 'Balearic Beat' music, the relaxed, friendly attitude and the energetic dancing amongst club-goers (many of them British holiday makers) that they smuggled both music and dance culture back to, what at the time was, a stale UK club scene"
(Merchant & Robinson, 1994)

By 1988, Acid House had taken root in the club cultures of many cities in Britain. Although the word 'acid' referred to the music, the use of drugs, and ecstasy in particular, became synonymous with the Acid House club and party scene. The use of ecstasy and other dance drugs has become intrinsically linked to this culture in the same way that cannabis and LSD were an intrinsic part of the hippy culture in the 1960's. The similarities between these two subcultures is striking in that the central 'ethos' both attempt to achieve is a sense of unity and belonging and general 'feelgood' factor. This in all probability represents a reaction to the harsh climate that surrounds them. The drugs used act as a facilitator to help achieve these aims.

The rave culture does deviate from those previously mentioned in that it is not regarded as wholly a working-class phenomenon. Fraser et al (1991) suggested that rave culture was a middle class affair. Rave nights are commonplace among middle-class students in higher education. In Ireland it is generally regarded that ecstasy crosses class boundaries and is as common to middle class environments as it is to working class environments.

The rave culture further deviates from other youth cultures in that it is not a preserve of those who are unemployed or are regarded as '*dropouts*'. Merchant & McDonald (1992) carried out a study on ecstasy use by young people & the rave culture in the North East of England, which is predominantly working-class. They found that while participants in raves were mainly working-class teenagers (in first jobs, unemployment, on Youth Training and in colleges), many were also in their late twenties and even thirties and in well-established, working-class careers.

As is evident rave culture crosses class and employment boundaries. It also crosses age boundaries and many rave clubs in Britain cater specifically for those over the age of 25 ("*Party On Mature Clubbers - with One foot in the Rave*", The Independent, April, 1993). Thus, any interventions aimed at responding to ecstasy use by young people must be prepared to take into account all these influences and also the societal factors that create the circumstances that encourage young people to become involved and identify themselves with the dance/rave scene.

HOW DOES IT WORK?

When taken, ecstasy triggers the neuronal release of two neurotransmitters in the brain. Neurotransmitters control the messages transmitted between brain cells (neurons). The two that ecstasy triggers are dopamine which affects pain and *serotonin* which affects mood. This probably explains the immediate stimulatory effects that occur. One of the by-products of taking ecstasy is that it causes a prolonged depletion in the neurotransmitter *serotonin*. *Serotonin* neurones in the brain are linked to the area of the brain that deals with moods and emotions. A prolonged absence of *serotonin* is thus a likely explanation for the short-term depressive after-effects that some ecstasy users undergo when the effects of taking ecstasy wear off (Gay Times, September, 1994).

Ecstasy normally takes effect in approximately 20-60 minutes and remains at its height for about three to four hours, although its effects can last for much longer. It is digested in the stomach and then enters the blood stream which carries it to all parts of the body.

IMMEDIATE EFFECTS

The immediate effects that taking ecstasy produces are well documented and normally include:

- feelings of relaxation, calmness, happiness and a general feeling of well-being in the user.
- feelings of empathy, warmth, unity and a sense of belonging between users.
- giving the user a burst of high energy to dance the night away
- sometimes causes a loosening of the user's natural inhibitions
- makes the user experience things more intensely and vividly.

(Health Promotion Unit, 1996).

However, there are also a number of negative immediate effects and these are outlined later in the section on *Negative Effects - Short Term*.

Julian Madigan is a young man from Dublin who has been through the ecstasy experience and has written an insightful book with his father on his involvement in the drug culture and the rave scene. His account in the book of his first experiment with ecstasy provides an excellent illustration of exactly what the initial attraction of ecstasy is to those who use it.

"I decided to try Ecstasy. Harry and I met in our local pub/club one night, and we dropped down to another club nearby to buy a very special kind of Ecstasy, one called White Dove. We bought one White Dove for twenty pounds and returned to the comfort of our local club. We split the tab and took half a White Dove each, washed down with a pint because the taste of Ecstasy is absolutely putrid! Within fifteen minutes, I realised what everyone meant when they said that Ecstasy was the business. We were sitting at a table by the dance floor when suddenly I just had to get up on the floor and dance, dance, dance! Everyone in the club was my friend. The rushes through my body were electrifying. I smiled from ear to ear. The music was absolutely brilliant. I wanted to dance non-stop all night long.... This was our first real Ecstasy buzz. As we travelled home that night, we both agreed...Ecstasy...this is really the business. The next morning I woke up feeling totally refreshed, vibrant and happy. I didn't know that I was still on the Ecstasy buzz from the night before! I thought that this was the wonder drug. The one for me...no side-effects, no hangover, loads of energy the next day. The perfect drug."
(Madigan, 1996)

NEGATIVE EFFECTS

Short Term

The short-term 'side' effects of using ecstasy like the potential medium and long-term effects will be highly individualistic to the user and are dependent on a number of factors including their user's general state of health, their metabolism, the exact contents of the ecstasy tablet and the precautions they take (see Harm

Reduction). However, there are a number of short-term negative effects that are common to many who take ecstasy:

- intense sweating
- dryness in the mouth
- increased heart rate
- increased blood pressure
- loss of appetite
- nausea/convulsions
- dizziness
- pain and stiffness in arms, legs and jaws
- teeth grinding
- agitation
- desire to urinate
- increased sense of vulnerability

In certain cases, as has been highlighted by the media, ecstasy use can result in coma and/or death. Many of these cases have been of people using ecstasy for the first time.

Medium Term

Medium and long term effects of ecstasy use are difficult to predict and categorise due to the relatively recent development of ecstasy as a recreational drug. Certainly there are no detailed quantitative figures based on large-scale studies upon which to rely. However, there are incidents of a variety of effects that can happen to ecstasy users in the days and weeks after ecstasy has been taken. These may include:

- depression
- lethargy
- insomnia
- anorexia and weight loss
- bouts of panic
- bouts of confusion
- poor concentration
- psychosis
- impaired judgement
- memory loss/amnesia
- hallucinogenic episodes

Most of the incidence of the above occurring has been associated with consistent usage of ecstasy and usually of higher than normal doses (*Health Promotion Unit, 1996/ISDD, 1996*).

Long Term

As stated earlier ecstasy has not been in use as a recreational drug long enough for in-depth research to have taken place. Medical research is only beginning to explore this area and it will probably be 10-20 years before a clear picture begins to emerge. A great deal of confused and at times contradictory information is being given at the moment on the possible long-term effects of the drug. In this regard ecstasy can be regarded the cannabis of the 1990's. When cannabis came to the fore in the 1960's it was commonly regarded as a harmless recreational drug. It was not until 10-20 years later when qualitative research had taken place that it emerged that cannabis had a negative impact on attention, memory and co-ordination levels when used consistently. A similar picture may or may not emerge with regard to ecstasy as may the occurrence of permanent damage to internal organs (see below).

Small scale studies, animal research and autopsies on ecstasy-related deaths have indicated signs of brain, heart, kidney and liver damage. A number of these studies are highlighted below.

- **In 1995 Professor Roger Williams, King's College, London disclosed eight instances of acute liver damage suffered by people who had taken ecstasy. Four of these people died while a further three had to undergo liver transplants.**

- **Dr. Tom Fahy, Maudsley Hospital, London's largest psychiatric hospital has seen over 20 cases of ecstasy users over the last five years which seem to indicate a strong link between ecstasy usage and severe psychiatric disorders (The Big Issue, 1996).**
- **Animal studies in America have shown ecstasy to be neurotoxic i.e. it damages the neurones in the brain. These experiments have also shown that ecstasy destroys nerve terminals and lowers the levels of Serotonin in the brain thus leading to depression (Ricaurte et al, 1988).**
- **The National Poisons Unit in Britain recorded seven cases in 1992 of ecstasy use causing liver damage, where one person required a liver transplant and another died.**
- **There have also been a number of cases of jaundice and acute hepatitis linked to ecstasy use (British Medical Journal, 1992).**
- **A study of seven autopsies in 1996 undertaken by Sheffield University on young men who died after taking ecstasy revealed signs of brain, heart and liver damage. One of the victims had severe swelling of his brain tissues resulting from drinking 14 litres of water. This further highlighted the risk associated with drinking too much water after taking ecstasy which came to light with the tragic death of Leah Betts in England, much publicised at the time. However those who undertook the study admitted that it was unclear as to whether the organ damage discovered could be attributed solely to ecstasy ("Ecstasy can lead to brain damage", Evening Herald, February, 1996).**
- **Results from a recent study carried out by the Department of Psychology at University College Swansea indicate lasting neuro-psychological deficit associated with ecstasy use. The study surveyed three distinct groups of students at the university; regular ecstasy users; individuals who had used other proscribed drugs; and a third group who had never used illicit drugs. In a mental agility test of the three groups, ecstasy users performed considerably poorer than the other two groups. Four of the ecstasy users were unable to complete the test (Cork Examiner, April, 1997)**

This research is very provisional and by virtue of it being conducted on a small scale one cannot attach any global significance to it. However these studies do indicate some of the patterns of major damage to internal organs related to ecstasy use that may emerge later when more in-depth research is undertaken. Any research undertaken will also be complicated by the fact that many ecstasy tablets contain other substances as previously illustrated in Chapter 1, many of which are physically addictive and carry their own side effects.

SEXUAL AND PSYCHOLOGICAL EFFECTS

One of the myths that surrounds ecstasy use is that it increases sexual desire. There is no evidence to support this. What ecstasy does contribute is to increase empathy between users which can enhance the sensual experience of sex rather than stimulate sexual desire or sexual activity or increase sexual excitement. However, it has also been found that in some cases ecstasy can inhibit male erection. It has also been found in some cases to reduce the ability of both men and women to reach orgasm. More importantly as ecstasy loosens an individual's inhibitions it may have a detrimental effect on the use of 'safer sex' practices which can result in its own serious consequences (ISDD, 1993).

Little in-depth research has taken place to date in the area of ecstasy and sexual desire. Henderson in a symposium paper on *Women, Sexuality and Ecstasy Use* stated that she was aware of only one study on the topic. This study stated that:

"It is curious that a drug which can increase emotional closeness, enhance receptivity to being sexual and would be chosen as a sexual enhancer, does not increase the desire to initiate sex"
(Buffum, J. et al. 1986)

Henderson's own research presented at a symposium in Leeds in 1992 was based on findings from 6 interviews taken from 30 in-depth semi-structured interviews, a lifestyle questionnaire and 47 ecstasy questionnaires among other sources. The interviews formed part of a two-year project aimed at investigating gender differences in ways of accessing and participating within recreational drug use. Henderson's findings indicated that in most cases sexual activity was not a primary factor associated with ecstasy use and the rave scene, rather it was empathy, friendship and group bonding that were cited as the main factors.

" what makes the 'rave' scene attractive to many young women is this emphasis upon dancing/music and upon group feeling, in a social setting which lacks emphasis upon sex and sexual pressure from men"
(Henderson, 1992)

This was particularly the case with young women, although some did comment on the heightened emotional impact of using ecstasy which they regarded as much more of a problem than any physical impact.

“We do fancy blokes at raves and enjoy flirting with them ... but it’s like going back to when you were younger, you don’t want to get them into bed, you’re just friendly”
(female interviewee)

With young men the picture was more ambiguous but sexual activity still does not appear to be that prevalent. A combination of alcohol use and the often negative effect of ecstasy use on the ability of the male to achieve and maintain erection could offer explanations to this. On a cautionary note, Henderson did find that sex was much more likely to take place during the come-down period, often out of boredom while waiting to be able to sleep, and particularly where cannabis was being used to come down from the ecstasy high.

MEDICAL DANGERS

As discussed earlier the medical dangers of using ecstasy will emerge over time and any information available currently must be viewed with this in mind. However, a drug such as ecstasy that can and has resulted in the death of first time users sends its own message.

There are also a number of categories of people who are medically advised not to use ecstasy. They include those who suffer from:

- heart disease
- high blood pressure
- epilepsy
- glaucoma
- diabetes
- poor physical condition
- hypertension
- mental illness/poor mental health
- diminished liver function
- women with a history of genito-urinary tract infection

Some long-term users have reported increased susceptibility to minor ailments such as colds, flu, sore throats, back and chest pains etc
(*British Medical Journal, 1992*).

A number of young women have reported that their periods have been irregular and heavier after using ecstasy
(*ISDD, 1993*).

Heatstroke

There is also the well known risk associated with taking ecstasy of suffering heatstroke. Ecstasy affects the body’s temperature control mechanism and can push the body’s temperature to very high levels. When this is combined with the high temperature of a dance/rave setting and the dehydration caused by dancing for hours almost non-stop the risk of heatstroke is greatly increased. Hence the importance of drinking water, fruit juice or sports drinks (see Harm Reduction).

Water Toxication

The highly publicised death of Leah Betts in England highlighted the risk of drinking too much water and at least two other people in England have died in similar circumstances. Taking ecstasy releases a hormone called Anti-Diuretic Hormone (ADH) which prevents the production of dilute urine. Drinking too much water will cause a build-up of water inside the body cells (particularly the brain) which will not be excreted as normal in the form of urine because of the release of ADH. The brain soaks up the fluid until it is crushed as the water swells against the inside the skull. All the brain functions are damaged irreparably and coma and/or death is the result (ISDD, 1996).

ADDICTION RISK

Ecstasy is not regarded as physically addictive. There is no evidence in existence to support any level of physical addiction even with long-term use. However, when usage is stopped it can leave the ex-user in a weakened physical and/or mental condition for a period of time. This period can last for a number of weeks.

The addiction risk of ecstasy is at a psychological level. Long-term use of ecstasy can lead to a psychological dependence on the drug with the user believing that he/she can only feel good by using the drug. Like most drugs with long-term use tolerance levels build thus requiring higher doses of the drug to achieve the same effect. It is when this stage begins to develop that the risk of psychological addiction comes into play. There is also the increased likelihood of suffering from some of the negative medium term effects mentioned earlier as the level of usage increases. Most experts would feel that psychological dependence/addiction is the most difficult addiction to cure.

HARM REDUCTION

There are a number of measures that those using ecstasy can take to minimise some of the side effects and the risk of heatstroke. The most obvious step one could take would be not to take ecstasy in the first place but the following steps are recommended if one is using ecstasy:

- sip one pint of water per hour or drink fruit juice or preferably an isotonic sports drink
- doctors recommend adding salt to water being drunk
- avoid wearing tight and/or heavy clothing to cut down on sweating
- take regular breaks from dancing to cool down and re-hydrate
- avoid drinking alcohol as it further dehydrates the body
- avoid wearing headgear as it keeps body heat in
- avoid mixing drugs
- limit the number of ecstasy tablets taken. One should be enough to keep the user going for the night

(ISDD, 1993)

OTHER 'DANCE' DRUGS

As illustrated in Chapter 1 the majority of ecstasy tablets are cut and mixed with a variety of stimulant or hallucinogenic substances or other drugs. Considering the above it is useful to know exactly what these other substances are and the effects they can have which people may confuse as effects that occur from using ecstasy. Below is a list of most of these substances, what they are, and the effects they produce when taken. It is taken primarily from *Ecstasy and the Dance Culture* by Nicholas Saunders and *The Facts About Drug Abuse in Ireland* by Dr. Des Corrigan. Also included are drugs which are not passed off as or mixed/cut with ecstasy but are common to the dance/rave scene.

Amphetamine (amphetamine sulphate, speed, whizz)

This is the most widely used dance drug and is generally felt to be more reliable than ecstasy i.e. there is a greater likelihood that the user will know what s/he is using. It is a little bit cheaper than ecstasy and is usually sold in wraps (packs of silver foil usually). It is normally cut with filler or sometimes other drugs. It provides energy and is often used for dancing. It carries the same physical dangers as ecstasy but is regarded as having a high potential for psychological addiction with the tendency to cause binge and crash behaviour and may result in amphetamine psychosis or paranoia. Overdose results in feeling irritable and even violent. It can be taken in a variety of ways; snorted; dabbed with a finger onto the gums; added to a drink; or injected. Its effects usually last for approximately eight hours, depending on the initial amount taken.

Cannabis, marijuana (hash, blow, smoke, draw, weed)

Normally smoked either as dried leaves (grass) or the resin (hash) from a cannabis plant mixed with tobacco and rolled into a 'joint/spliff/reefer'. It can also be eaten but the effect is not as immediate. The effects are well known and include amusement, mellowness, enhanced sound and colour, hunger pangs. However, it can also produce paranoia and hallucinations when taken in large quantities. It is widely regarded as harmless, but scientific medical research has shown that consistent use can lead to a deterioration of brain cells (although this is still a matter of dispute within the medical profession). Research has also shown that long-term chronic use of cannabis can increase the risk of: developing cancers of the aero-digestive tract; leukaemia in offspring;

respiratory diseases; birth defects in children of pregnant women who use cannabis; and cognitive impairment. Cannabis has been prescribed medically in certain cases as a pain reliever and relaxant.

It is also available in the form of cannabis oil although this is rare. It is a liquid extracted from the plant and then concentrated into a black oily substance with the consistency of liquid tar. Skunk has come on the scene in the last couple of years and is a particularly potent variety of marijuana developed originally in Holland.

Cocaine (cocaine hydrochloride, coke, snow)

Cocaine is similar to amphetamine in the effect it creates but with a stronger tendency to binge and crash behaviour. It sometimes causes numbness where it touches the mouth or throat. It comes in the form of white powder and is usually snorted up a nostril using a rolled up piece of paper. It is more expensive and less long lasting than amphetamine, with the effects happening quickly but only lasting about half an hour. It became more popular as a dance drug in 1993 when poor quality ecstasy flooded the market. Consistent use may dissolve the division between nostrils.

Crack cocaine (rocks, freebase)

Derived from cocaine, 'crack' as it is commonly known is smoked and gives a shorter, bigger burst of energy but is more addictive with stronger tendencies to binge and crash than conventional cocaine. The high is almost instant, but quickly diminishes and it is over in about 10 minutes.

Dexedrine (dexys)

Comes in the form of a 5mg white scored tablet marked EVANS.DBS which consists of dexamphetamine sulphate. The effect when taken is similar to speed and causes high blood pressure.

Ephedrine

Ephedrine and the related Pseudoephedrine are found in prescription cough and cold remedies. About 3 tablets (60mg each) have a similar effect to caffeine or speed. Physical effects last 3-4 hours with gentle comedown, but the general high can last for several days. It is a prescription drug with a maximum dose of 60mg. The recreational dose is several times the prescription dose and is potentially dangerous for people with weak hearts. An overdose produces restlessness, muscle spasms, racing heart, dry throat and cold extremities.

Heroin

Heroin was originally developed as a safer form of painkiller than morphine whose use was limited by its addictive qualities. However, heroin was ultimately found to be four times as addictive and potent than morphine. It is made from the opium poppy and usually comes in powder form (white or brown) and is usually heavily diluted with substances like flour, talcum powder, glucose, caffeine etc. It is sniffed, smoked or injected and its immediate effects are an intense rush lasting less than a minute which involves a flushing of the skin and a burst of sexual excitement. After the initial rush the feelings are pleasant, peaceful and content. Pain, aggressive tendencies and sexual drives are often reduced. On the negative side it can cause nausea and vomiting. The side effects of regular use include constipation, palpitations, reduced sex drive, rashes and itching. Tolerance to the effects develop quickly making it a high-risk drug for addiction.

Iso-butyl nitrate (poppers, Liquid Gold)

Legal in most countries it comes in liquid form in small bottles. It is sniffed or breathed into the mouth. It gives strong rushes of euphoria for a minute or two, especially while on ecstasy. It can cause blackout, headache, nausea and even heart attacks. A less common form of poppers is amyl nitrate. It is traditionally popular among gay men for sex as it acts as a muscle relaxant for the anus.

Ketamine

Sometimes sold as ecstasy but usually cut with other drugs such as ephedrine and caffeine or ecstasy itself. Ketamine is medically prescribed as an anti-depressant. Low doses produce a relaxed feeling but higher doses produce dissociation (feeling separate from your body), near death experiences and insights. Higher doses may cause hallucinations of a different type to those experienced on LSD that can be confused with reality and are harder to relate. Since it is used as an anaesthetic in far higher doses, Ketamine is not widely regarded as physically dangerous but it can result in coma. If the dosage used is high enough, the mental effects may be disturbing and it can become psychologically addictive.

LSD (acid, A, trips and type names such as Microdots or Strawberries)

LSD (lysergic acid diethylamide) is an illegally manufactured drug that usually comes in the form of small squares of blotting paper which are then dissolved on the tongue. A square contains about 75 micrograms of LSD. In low doses it can enhance vision and sound, but in higher doses it can produce strong visual and emotional effects (often negative) and psychedelic/ hallucinogenic effects, the strength of which will depend on the amount taken. Bad trips can lead to depression, dizziness and panic.

Magic mushrooms (psilocybin, Liberty Caps, mushies, shrooms)

Similar to LSD with the added attraction of being natural, free and legal in some countries (not the Republic of Ireland) if eaten fresh from the field, although if processed which could include handling and drying it becomes a Class A drug. The mushrooms are dried and are usually thin and dark brown in appearance, but may be powdered. They are found in pasture in the autumn, but tend to be hidden in the grass. They are among the smallest mushrooms, and are distinguished by being an uneven grey colour with pointed caps and wiggly stems. The whole stem is active and they can either be eaten or stewed/strained and then drunk as tea.

Methamphetamine (ice or crystal meth)

A very pure form of amphetamine which comes in the form of a white crystalline solid. It can be smoked, snorted or injected and its effects lasts up to 24 hours. When heated it gives off a vapour which is inhaled. The major risk associated with taking methamphetamine is cardiotoxicity and a magnification of all the effects one would associate with taking amphetamines (speed).

Temazepam (jellies or wobbly eggs)

Sold in 10-30mg capsules or 10-20mg tablets. Medically it is used as a muscle relaxant and sleeping pill. Popular in Scotland when coming down after E, and its use is spreading. Normally swallowed, but when melted and injected can solidify and cause circulation problems. In 1994, 50 deaths were linked to Temazepam in the Glasgow area alone. It has a high potential for dependence and for resulting in irrational behaviour.

LINKS TO OTHER DRUG USE

Another common preconception that surrounds ecstasy is that it is strongly linked to the use of other drugs. The evidence in Ireland to date is primarily anecdotal but indicates that there is some evidence to support this. The use of cannabis and heroin to come down after using ecstasy is widely reported.

A study was undertaken in Sydney, Australia in 1992 which profiled 100 ecstasy users and their experiences of the drug. One of the questions they were asked was to indicate what other drugs they had tried and whether they were currently using them. The results are outlined in the table below:

Table 1: Other Drug Use by % (N=100)

TYPE OF DRUG	HAVE TRIED (%)	CURRENTLY USE (%)
Marijuana	99	77
Amphetamines	83	47
Hallucinogens	84	38
Amyl Nitrate	75	28
Cocaine	77	26
Barbiturates	52	11
Tranquillisers	51	5
Heroin	16	5
Other opiates	31	3
Inhalants	4	0

(Solowij, N. et al, 1992)

As one can see the incidence of other drug use *Have tried* is extremely high in most of the categories and would appear to support the assertion of the link between ecstasy and other drug use. However, when one looks at the second column *Currently use* which gives the level of current usage the percentages of use drop considerably in all categories. There is a particularly strong decrease in the use of drugs that would generally be regarded as the most dangerous and/or addictive: Cocaine 77% to 26%, Barbiturates 52% to 11%, Tranquillisers 51% to 5%, and Heroin 16% to 5%.

This would appear to indicate that a high proportion of those using ecstasy become involved in the drug culture and have a greater propensity to try other drugs but it does not necessarily lead to the majority of them or even a significant minority in some cases becoming consistent users and/or addicted to these drugs. Although one cannot formulate global results based on a survey of 100 people this study certainly does not support the widely made assertion that ecstasy is becoming the gateway drug to heroin use/addiction, with only 5% of those surveyed using heroin consistently. However, if one considers the thousands (possibly hundreds of thousands) of ecstasy tablets being sold in Ireland every week, the figure of 5% would represent a significant number if replicated.

In Britain the 'party-pack' of drugs similar to the following is commonly used at raves: amphetamine/speed to kick of the night, ecstasy to maintain the 'buzz' and cannabis to come down before going home (Heart of the Matter, BBC, March, 1996).

At a conference in Dublin in January, 1996 an outreach worker with the Eastern Health Board spoke of the developing trend whereby pushers were selling ecstasy and heroin as a twin-pack so teenagers using ecstasy would take heroin to come down after taking ecstasy. The worker further stated that these same young people were beginning to turn up in increasing numbers at needle exchange and health care services throughout the city exhibiting signs of heroin dependency. ("*Rave drug 'new road to heroin'*", Evening Herald, January, 1996).

The tendency to use other drugs in combination with ecstasy is further supported by a survey undertaken by O'Keeffe as part of a journalism Masters in 1996. The survey undertaken in two schools, one middle-class and one working-class found 86 ecstasy users in total. Of the 86 users, almost one in two also used cannabis, 45% also used amphetamines and a quarter also used alcohol ("*Legacy of a Love Buzz*", Irish Independent, November, 1996).

LIMITATIONS OF AVAILABLE DATA

It is difficult to accurately record figures on ecstasy use in Ireland due to the absence of reliable data. What figures are available have been sourced from the Central Statistics Office, Annual Reports of the Garda Síochána and the National Drug Treatment Centre.

The statistics are limited by the manner in which the information is compiled by some agencies who do not compile their figures by drug type. For example, the Central Statistics Office in its compilation of statistics of drug related deaths uses the category *Psychostimulant Drugs*, which includes ecstasy but also includes drugs such as caffeine and amphetamine-based substances, thus making it difficult to accurately calculate the number of ecstasy related deaths. Most medical and drug treatment agencies use broad categories such as opiates and hallucinogens (which includes ecstasy) in the compilation of their statistics rather than individual drugs.

The Gardai until relatively recently used classifications of drugs rather than drug type in the compilation of their statistics, as the penalties and sentences at the disposal of the courts are based on these classifications (see Chapter 4). The Garda Síochána Annual Report for 1995 was the first in which drug prosecutions were broken down by drug and by garda division, thus giving an accurate picture of the detection of individual drugs at regional level for the first time.

Finally, there has yet to be undertaken a national study on the level of ecstasy use among young people, so estimates on its usage tend to rely on either anecdotal evidence or using a multiplier effect based on ecstasy seizures by the Gardai (international experts regard that seizures of a particular drug account for approximately one tenth of the total quantity of the drug in circulation). (O'Keeffe, 1996)

ECSTASY SEIZURES

The figures which follow provide the most up-to-date information on officially recorded ecstasy seizures and drug related offences and are sourced from the Garda Síochána Annual Reports for 1993, 1994 and 1995. They point to the significant increase in both the availability and use of ecstasy in recent years.

Table 1: No. of Recorded Ecstasy Tablet Seizures for 1993 -1995

Year	No. of Ecstasy Tablets Seized
1993	*1,994
1994	*28,671
1995	*123,699
TOTAL	*154,364

* These figures include MDA (parent drug) and MDEA ('Eve') which come from the same *'family'* of drugs as ecstasy and are often sold as ecstasy.

The level of official seizures provides a reliable indicator to the overall trend in ecstasy use. Table 1, which provides the most recent figures available, indicates quite clearly the upward trend with the considerable increase in seizures in the period from 1993 to 1995.

Table 2: Ecstasy Drug Seizures by Value, Various Months, 1995

Date of Seizure	Value of Seizure
21/01/95	£3,000
05/02/95	£100,000
12/02/95	£12,000
02/04/95	£500,000
23/04/95	* £750,000
30/06/95	** £20,000,000
11/07/95	£800,000
15/07/95	£50,000
20/07/95	£2,000
05/08/95	£200,000
TOTAL	£22,417,000

* Joint seizure of cannabis and ecstasy
(Irish Independent, 1995)

** This figure of £20 million may seem incongruous in comparison to the figures quoted or seizures in 1995 in Table 1. However, this particular seizure refers to the discovery of two ecstasy manufacturing operations in the Dublin area. The figure is an estimation to the capacity of the two operations and is not included in the figure in Table 1 which refers to the number of ecstasy tablets seized in 1995.

Table 2 provides provisional figures up to mid-November, 1995 of major seizures of ecstasy by the National Drugs Squad. The monetary value (street value i.e. £10-£15 per tablet) of each seizure is given rather than the amount of tablets seized.

From the table it is evident that there has been a significant increase in the level of ecstasy seizures by the authorities. Some of the increase in seizures may be explained by increased co-operation and co-ordination between the National Drug Squad, National Drug Team, Customs and the Naval Service as seizures of cannabis and heroin have gone up considerably in the same period.

Notwithstanding this an increase in seizures from under 2,000 tablets in 1993 to over 120,000 in 1995 clearly points to an explosion in the amount of ecstasy coming into the country. It is generally regarded by international experts that drug seizures account for approximately one-tenth of the amount that is in circulation (O'Keeffe, 1996). If one applied this benchmark to Ireland, it would indicate that there were over 1.2 million ecstasy tablets in circulation in Ireland in 1995.

The falling prices would also support the view that ecstasy is in plentiful supply. The price has dropped from approximately £20-£25 to £10-£15 per tablet over the last two years ("Undercover story", Irish Independent, 1995).

REGIONAL VARIATIONS

Table 3 Ecstasy Drug Seizures by Location 1995

Location of Seizures	Value of Seizures
Dublin	£21,415,000
Cork	£202,000
Limerick	£50,000
Rosslare	*£750,000
TOTAL	£22,417,000

* Joint seizure of cannabis and ecstasy
(Irish Independent, 1995)

Table 3 provides a breakdown, by location of seizures, for 1995. With the rave scene being concentrated in the larger cities, particularly Dublin and Cork, it is generally believed that the bulk of ecstasy being sold is concentrated in these two cities and the locations of ecstasy seizures illustrated in Table 3 supports this. Cork in particular is showing a rapid increase in ecstasy usage. Furthermore, local police intelligence indicates that Cork supplies the Galway and Limerick regions (*“Chilling extent of drug plague is laid bare”*, Irish Independent, October 1995). Further evidence of this can be seen in Table 5 of this chapter.

There is much anecdotal evidence and media reporting that the use of ecstasy in rural parts of Ireland is widespread and on the increase. The figures given in Table 5 of this chapter, which gives a breakdown of ecstasy related prosecutions by Garda division, does not support this view. However, this can be explained by the fact that detection of ecstasy is much easier in the cities where it is being sold in large quantities. When the supply of ecstasy filters down to those using it for personal use or in small groups as would be the case, it naturally becomes more difficult to detect.

ECSTASY RELATED DRUG OFFENCES

Information on drug related offences is sourced through the Gardai. The figures that are compiled by the number of prosecutions which includes drug offences for possession, pushing/dealing, illegal production and allowing production or sale on one’s premises. These terms are explained in detail in Chapter 4 which looks at current legislation regarding the availability and usage of drugs in Ireland.

Table 4: No. of Ecstasy Related Prosecutions by Garda Division for 1995

Garda Division	Number of Ecstasy Related Prosecutions	All Drug Related Prosecutions
Carlow/Kildare	02	61
Cavan/Monaghan	07	40
Cork East	326	1,239
Cork West	04	57
Clare	00	32
Donegal	20	99
DMA North	52	349
DMA North Central	49	378
DMA South	32	166
DMA South Central	21	211
DMA East	10	78
Galway	13	163
Kerry	00	37
Leix/Offaly	08	48
Limerick	41	313
Longford/Westmeath	06	26
Louth/Meath	25	162
Mayo	00	28
Roscommon	00	00
Sligo/Leitrim	01	14
Tipperary	00	39
Waterford/Kilkenny	23	229
Wexford	05	90
TOTAL	645	3,859

(Garda Siochana, 1996)

Table 4 provides the total number of prosecutions by the Gardai for ecstasy related offences in 1995 broken down on a Garda division by division basis. 1995 was the first year in which the Gardai presented the figures this way and they allow one to make a comparison with the overall number of drug related prosecutions for 1995. Ecstasy related prosecutions accounted for 17% of all drug related prosecution for the year. Only cannabis resin (57%) accounted for a higher percentage of the overall total and supports the general view of the Gardai of the increasing availability of ecstasy (Garda Siochana, 1996).

Table 4 also highlights the fact that 77% of the total figure for people charged with ecstasy related offences in 1995 came from the Dublin and Cork area. Limerick, Galway, Donegal, Louth/Meath and Waterford/Kilkenny are the other regions which are showing significant increases in both ecstasy and other drug related arrests.

Table 5: No. of Ecstasy Related Prosecutions for 1994 and 1995

Date	No. of Ecstasy Related Prosecutions
1994	261
1995	645
TOTAL	906

(Garda Siochana, 1995 & 1996)

Table 5 provides the total number of ecstasy related prosecutions nationally for the years 1994 and 1995. In line with the previous tables we have further evidence of the upward trend in the availability and distribution of ecstasy with an increase of 250% in ecstasy related prosecutions in a single year from 1994 to 1995.

A report in October, 1995 prepared by senior Garda officers working in the national drugs administration office and shown to members of two Dail committees showed that both arrests and prosecutions for drug offences had quadrupled in the period from 1987 to 1994 (*“Chilling extent of drug plague is laid bare”*, Irish Independent, October 1995). As highlighted earlier Table 5 supports this showing that ecstasy related prosecutions increased by 250% from 1994 to 1995 and illustrates that this upward trend identified by the Gardai is continuing.

TREATMENT

The National Drug Treatment Centre’s annual figures for 1994 showed that 11.8% of the cases they dealt with were misusing amphetamine-based ecstasy tablets. However, this is based on the small catchment of drug users who present themselves for treatment (under 3,000). It had been generally accepted until recently that few people who used ecstasy would present themselves for treatment unless they were using other drugs as well. However, as the rave/dance culture becomes more mainstream this pattern is beginning to change.

In the first national report on *Treated Drug Misuse in Ireland* for 1995, it was shown that ecstasy was the second most commonly used primary drug after cannabis of those who presented for treatment to Health Board services. 22.2% (178 cases) of those at a national level presenting for treatment cited ecstasy as their primary drug of misuse as distinct from 3% (107 cases) in the Greater Dublin area. This gives some indication as to the prevalence of ecstasy use outside of Dublin. Of these 178 cases, 54% were in the 15 to 19 year old age bracket and a further 35% in the 20-24 year old age bracket (O’Higgins & Duff, 1997). The gender breakdown for these figures was 73% male and 27% female. The figure for females was 5% higher than that for all drugs. As this was the first such report no significant conclusions can be drawn. However, there was an overall 21% increase in those presenting for treatment in the period from 1994 to 1995.

In 1995 Trinity Court, Dublin’s primary drug treatment centre, treated 414 people as a result of ecstasy use, 309 for the first time. In 1991 the centre treated no ecstasy related cases (*“Legacy of a Love Buzz”*, Irish Independent, November, 1996). The National Poisons Information Centre in Beaumont Hospital recorded over 300 cases admitted to casualty departments in Irish hospitals in 1995 as a result of ecstasy use. These figures clearly illustrate the upward trend in those presenting for treatment as a result of ecstasy use.

ECSTASY RELATED DEATHS

The Central Statistics Office which compiles statistics on drug related deaths does not have a category devoted to ecstasy. Deaths related to ecstasy use come under the category *Psycho-Stimulant Drugs*, a category which includes amphetamine based substances and caffeine. In this category there was one recorded death in 1994 in the 15-19 age group. It is not clear from the figures whether this death was ecstasy related or not.

Tracing the number of deaths related to ecstasy use is further complicated due to the fact that deaths which appear to be drug related often lead to a coroner’s inquest where an official cause of death is not immediately registered but referred to the coroner for determination. In such cases it can be up to two years after the death has occurred before the official cause of death is recorded via the issuing of the coroner’s certificate, so the

figures for any given year may not accurately reflect the number of drug related deaths which have occurred in that year.

The method of recording death highlights a further difficulty in accurately assessing the number of ecstasy related deaths. Where the use of ecstasy has induced water toxification, a brain haemorrhage, organ failure, or some other condition that results in death, it is more than likely that the cause of death will be recorded as water toxification, a brain haemorrhage, organ failure etc. In such cases there will be no mention of ecstasy as being a contributory factor in the death certificate.

Because of the absence of official data on the subject and the complications highlighted above, the number of deaths can only be estimated by using informal and anecdotal sources. In *The Agony of Ecstasy*, a figure of ten ecstasy related deaths to date in Ireland is stated. The most recent cited figure in the media for ecstasy related deaths is 20, although it is unclear exactly where this figure is sourced. In addition it is reported that most of these deaths resulted from dehydration/water toxification or causal effects related to them such as a brain haemorrhage or liver failure (Madigan, 1996). Provisional figures from the Gardai have attributed ecstasy as the cause of five deaths in Dublin alone in 1995 (*"Undercover story"*, Irish Independent, November, 1995).

However, the figures from the National Poisons Information Centre of ecstasy related admittances to casualty departments (over 300 in 1995), mentioned previously, illustrates that the low number of recorded ecstasy related deaths does not give an accurate picture of the medical implications of using ecstasy.

INTRODUCTION

In examining the issue of young people and ecstasy it is important to consider the legal position with regard to ecstasy use. This is particularly important as those who work with young people will find themselves in the position of needing such knowledge should ecstasy arise as an issue or if they wish to introduce drug education to a programme/curriculum.

They may also require such knowledge in the form of information for the young people they work with, information to educate and inform themselves, or for use in an advocacy capacity. This chapter outlines the existing legislation that covers drug use in the Republic of Ireland from the point of view of use, possession, storage and dealing. The chapter will also outline the powers of the Gardai and the range of penalties and sentences available to the courts .

CURRENT LEGISLATION

There are a number of statutes which regulate the availability of medicinal products and drugs in the Republic of Ireland. These are listed below.

1947 Health Act

It permits the Minister for Health to make regulations to control the sale of medical preparations. Several such regulations exist. For example, the *Medical Preparations (Control of Sale) Regulations* restrict the sale of a wide range of drugs to pharmacists only. The drugs are divided into two schedules. Drugs listed in either part of the first schedule may only be made available by retail sale on medical, dental or veterinary prescription. This schedule includes amphetamine-type stimulants and barbiturate sedatives, both of which are also subjected to other far more stringent controls. Also included are various minor tranquillisers of the diazepam type. The second schedule lists substances which can be sold without a prescription, but which are restricted to pharmacies. The schedule includes various anti-histamine drugs used to combat hay fever and prevent travel sickness, and which may cause drowsiness. Accordingly, the latter type of product must bear a warning that “this may cause drowsiness”.

The 1961 Poisons Act

The *1961 Poisons Act* controls the sale of poisons by confining their sale to authorised sellers (mainly pharmacists). Most recognised drugs of abuse are controlled in this way and are also subject to further legal controls.

Medical Preparations (Control of Amphetamines) Regulations 1970

The *Medical Preparations (Control of Amphetamines) Regulations 1970* prohibit the manufacture, preparation, importation, sale or distribution of seven scheduled amphetamine (‘speed’) type drugs. However, the Minister for Health may grant licences for the manufacture, importation or sale of a specified quantity of a controlled preparation when it is needed for certain medical conditions.

Misuse of Drugs Acts 1977 & 1984

The *Misuse of Drugs Acts* (1977 & 1984) are intended to prevent the non-medical use of drugs. For this reason, they control not just medicinal drugs but also drugs with no current medical use. Offences involving the general public are covered under these Acts. The drugs to which the Acts apply are specified in the Schedules to the Act and are known as controlled drugs. The list includes, in addition to narcotics such as heroin, other substances such as sedatives which are open to abuse.

The Acts define a series of offences including unlawful supply, intent to supply, the import or export, and the unlawful production of controlled drugs. Other offences include the growing of opium poppies, cannabis and coca plants, forging of prescriptions, occupiers of premises knowingly allowing illicit traffic in drugs or permitting the use of controlled drugs on their premises. The Acts also prohibit the unlawful possession of drugs, but make a distinction between possessing for one’s own personal use and possession for illegal supply to another person (‘pushing’). This latter offence carries much heavier penalties. To enforce this law, the Gardai have special powers to stop, detain and search people and vehicles without a warrant if they have ‘reasonable cause’ to believe that someone is in possession of a controlled drug.

Possession

The basic offence under the Act is that of possession, and save for one exception, at Section 16 concerning the use of opium, the use of a controlled drug is not generally prohibited under the Act. The offence of possession is also a constituent of other offences under the Act such as that of possession for the purpose of supply, and of course a person cannot import or traffic in a drug unless it is in their possession, neither can they use a drug unless it is in their possession.

The legislation naturally contains exemptions for certain classes of person legally to possess controlled drugs. The Gardai or Customs and Excise officers may legitimately possess controlled drugs if acting in the course of their duty. There are similar provisions for doctors and chemists, etc.

Virtually all crimes require proof of a mental element known as mens rea. This is a requirement of all but the most minor offences under the Act, and is a component of the offence of possession.

As far as the criminal law is concerned possession can mean more than simply physical possession. If a person asks someone to hold a bag for him/her it remains in their possession. Possession in law requires custody or control and denotes the right and power to deal with the thing in question. Two or more persons may have possession of the one object or substance if both have control over it, and the right to deal with the object or substance in question.

However, before one has the right or power to deal with something one must have knowledge of its existence. Thus in addition to custody or control possession in the criminal law requires also knowledge - a person cannot be said to be in possession or control of something of whose existence he has no knowledge.

Supply of Controlled Drugs

Section 5 of the Act provides, inter alia,:

- (1) *For the purpose of preventing the misuse of controlled drugs, the Minister may make regulations -*
 - (a) *Prohibiting absolutely, or permitting subject to such conditions or exceptions as may be specified in the regulations, or subject to any licence, permit or other form of authority as may be specified -*
 - (i) *The supply, the offering to supply or the distribution of controlled drugs.*

Article 4 of the Misuse of Drugs Regulations, 1979 states simply:

- (1) *Subject to the provisions of these Regulations a person shall not*
 - (b) *Supply or offer to supply a controlled drug.*

This section refers to the actual supply of drugs and is rarely used. As one will see Section 15 of the Misuse of Drugs Act 1977 is the more widely used section and is easier to prove. It should be noted that in relation to Section 5 and Article 4 mentioned above, it is irrelevant if the offer is not genuine as long as the offeror intends that the offeree should think he is receiving a controlled drug. Thus if a person offers to supply someone with ecstasy, when the person knows that the tablets are in fact harmless vitamins, the person is nonetheless guilty of offering to supply a controlled drug.

The offence of possession for the purposes of supply is much easier to prove and is the more generally prosecuted offence. It is also dependent upon the regulations. The Minister is empowered by **Section 5(1)** of the Act to make regulations prohibiting the supply of controlled drugs, and **Article 4(1)(b)**, as previously quoted, does so.

The prohibition is absolute and the burden of proving an exception lies on the Defence, but is discharged on the balance of probabilities, rather than beyond reasonable doubt.

Section 15 of the Act creates the offence of “drug pushing”. It provides:

- (1) *A person who has in his possession, whether lawfully or not, a controlled drug for the purpose of selling or otherwise supplying it to another in contravention of the regulations under Section 5 of this Act shall be guilty of an offence.*

The Act goes on to provide that supply includes giving without payment. It should be noted that possession is a constituent element of this offence.

The Act does not include a technical definition of the word supply and it should therefore be given its ordinary meaning. In all cases the accused may also be successfully prosecuted for the offence of possession of a controlled drug, and in almost all circumstances the offence of offering to supply will have occurred before such supply.

Section 15 is the more usual charge preferred as it is not necessary to prove that supply actually took place and, therefore, will not require evidence of observation of an actual 'drug deal' taking place.

Because of the existence of the presumption at **Section 15 (2)** i.e. that the person is in possession of the controlled drug for the purposes of supplying them to another, the prosecution need only establish the possession of the drugs to secure a conviction.

It is worth noting that the burden of proof then shifts to the defence to establish that the drugs were for personal use.

There is no statutory provision for amounts of controlled drugs necessary to take a charge from simple possession to possession for the purposes of supply. The section simply refers to '*other than immediate personal use*'. Hence possession of five or six ecstasy tablets could warrant a charge of possession for the purposes of supply.

In the course of a trial for possession for the purposes of supply a forensic scientist will give the total weight or quantity of the substance. The scientist will also describe the usual quantities that the drugs are made up into for sale and the percentage purity of the drug usually found in the tablet as sold on the street.

To buy drugs on behalf of other persons, or to buy to give to one's friends, also constitutes the offence of possession for the purpose of supply. A person who takes possession of a controlled drug for the purpose of delivering it to another is also guilty of the offence.

Allowing on Premises

Generally to allow a crime to happen is not in itself a crime, nor does the mere presence at the scene of a crime constitute a crime. However **Section 19** of the Act provides that any person who is the occupier, or is in control or is concerned in the management of any land, vessel or vehicle who knowingly permits or suffers any of a number of things to take place shall be guilty of an offence.

There are several different offences created by the section and it is therefore not proper to charge them in the alternative on the same count. The elements of the offence comprise knowledge of the prohibited activity and authority to prevent its commission.

Section 29(4) provides:

*"In any proceedings for an offence under **Section 19** of the Act it shall be a Defence to show that the Defendant took steps to prevent the occurrence of the continuance of the activity or contravention to which the alleged offence relates and that, in the particular circumstances, the steps were taken as soon as practicable and were reasonable"*

At the very least **Section 19** requires that the accused have some authority in relation to the premises. It need not be absolute but must exist to the extent that the accused was capable of doing some act whereby others would be obliged to desist from their criminal activities.

If the person has no right to take steps to prevent the prohibited activity he cannot be said to fall into the category of persons the Act seeks to penalise. The section covers even transient use of the premises once those charged can fairly be said to have control over what occurs within the premises.

The phrase "*concerned in the management of*" refers more to the activity carried on in the place and the degree of participation in that activity of the accused.

Once it has been proved that the requisite activity took place and the accused is proved to have been in control of the place where the activity took place, the burden shifts to the defence to prove, on the balance of probability, that the accused was unaware of the activity. **Section 19(2)** provides that:

"it shall be presumed until the court is satisfied to the contrary that the activity or contravention took place with the knowledge of the Defendant".

GARDA POWERS

Under the Act members of the Gardai are given powers to stop, search and arrest persons whom they reasonably suspect to be committing an offence under the Act.

Section 23 of the Act deals with the power of members of the Gardai to search persons whom they reasonably suspect are in possession of a controlled drug.

Pre arrest searches will involve an infringement of the constitutional right to liberty, and where a thorough search is required, a possible violation of the constitutional right to bodily integrity. Because of the substantial inroads into the liberty of the citizen, the Gardai should inform the party to be searched of their reasons for so doing.

The member may search the person, and if he considers it necessary for that purpose, detain the person for such time as is reasonably necessary for the making of the search. Where he decides to search a person he may require that person to accompany him to the Garda Station for the purpose of the search. If such a requirement is made and the person refuses to comply with the said requirement, the member of the Gardai may arrest without warrant the person of whom the requirement was made.

There is no power to arrest a person who merely refuses to be searched. However, he may then be lawfully requested to accompany the member of the Gardai to the Station and if he refuses he may then be lawfully arrested. It is an offence to contravene a lawful direction under **Section 23** and such an offence carries a fine of up to £200.

The search of premises will involve the violation of a constitutional right where the premises are the dwelling of the accused. Where the Gardai propose to search a premises for the purposes of finding evidence, then they must first obtain a warrant. Reasonable force may be used, but doors may not be broken down unless entry has been demanded and refused. The Gardai may search only the premises specified on the warrant and no others. Persons found on the premises may also be searched as this power is contained by the Act. The face of the warrant must also specify the search of persons found on the premises if such is to be lawful.

A warrant may be issued by a District Judge or by a Peace Commissioner if he or she is satisfied on oath that the member of the Garda Síochána has reasonable grounds for suspicion. The standard of the information must go beyond a mere averment by the member of the Garda Síochána that he has reasonable grounds for suspecting any of the matters contained in the sub section.

A clear power of arrest is created by **Section 25(1)** in relation to drug pushing. The section provides that a member of the Gardai may arrest without warrant a person whom he suspects, with reasonable cause, has committed an offence. As we have seen, three separate offences exist in relation to drug pushing, supply, offer to supply and possession for the purpose of supply which is the only offence contrary to **Section 15**. However, every person who supplies a controlled drug will, at the moment of supply or attempt to supply have had the controlled drug in his possession for the purpose of supply. The power of arrest will usually, therefore, cover all three situations.

All other offences under the Act are arrestable only on specified conditions set out in **Section 25(2)**. Thus the Act differentiates, for the purpose of arrest, between drug pushing and all other offences.

In order to have a reasonable suspicion, the Gardai need not have a prima facie case, or be sure of a conviction, but the suspicion must be reasonable and must not be based on guesswork, or on a hunch or on instinct. It must be founded on some ground which if challenged will show that if at the moment of arrest the Gardai acts on a hunch, **but has no reasonable suspicion**, the factual correctness of the hunch will not render the arrested person's detention lawful, in consequence any confession made by that person will not be admissible in evidence.

As the arrest of a person constitutes an interference with his constitutional right to liberty the powers granted to the Gardai under the Act must be strictly adhered to and all the conditions precedent to their exercise complied with stringently.

The question of reasonable suspicion does not have any strict legal definition and each case will depend on its own facts. In founding a reasonable suspicion the Gardai may rely on hearsay which must be reliable, which will depend on its source. The Gardai should exercise great care in arresting a person on the information of an accomplice. An anonymous communication will not be sufficient. Information given by one Garda to another can be said to come from a reliable source. The Gardai, in practice, invariably claim privilege as to the source of their information, which claim is invariably upheld.

While the behaviour of a suspect may justify an arrest, his refusal to co-operate with Garda enquiries will not, as this is the right of every citizen. In effecting an arrest the Gardai may use no more force than is reasonably necessary. The purpose of the arrest is to have a person charged with a criminal offence. The powers of arrest under **Section 25** should not be used for the purpose of questioning.

A person arrested is now invariably given a form outlining his rights whilst in custody, which includes the right of access to a legal advisor, although this does not include the right to have a solicitor present during interrogation. Where a person is arrested or subjected to any power which involves a deprivation of his liberty he should be informed of the reasons for the exercise of that power. This is because no citizen is obliged to submit to a deprivation of his liberty until such time as he knows that such deprivation is lawful. An arrest will not be lawful if the suspect is unaware of the reason for his arrest. The burden of disproving the existence of such knowledge lies on the accused. However, an arrest which is bad, for the failure to inform the accused for its reason, may be cured by that information being given to the accused later (Malone, 1996).

Other Provisions

The *Misuse of Drugs Act 1984* also prohibits the printing, or sale of books or magazines which encourage the use of drugs prescribed in the Act, or which contain advertisements for drug equipment, pipes or cocaine kits.

Customs and Excise officers have similar powers under the *Customs and Excise (Miscellaneous Provisions) (No.2) Act 1988* which also permits intimate body searches by a medical practitioner acting at the request of a Customs officer, in order to detect smuggling of drugs in body cavities by so-called “*Stuffers and Swallowers*”.

Irresponsible Prescribing

The Acts give the Minister for Health the power to give a direction prohibiting the prescribing of controlled drugs by a doctor, dentist or veterinary surgeon, who has been found, after investigation by a committee of inquiry, to have been prescribing, administering or supplying such drugs in an irresponsible manner. There is a special procedure which allows the Minister to give a temporary direction which lasts for four weeks but may be extended for periods of 28 days at a time while the case is being investigated by a committee of inquiry. The committee having investigated the case can make a recommendation to the Minister for Health that a special (or permanent) direction be put in place. A doctor, dentist or veterinary surgeon with such a direction against him/her also has the right of appeal to the Courts. Since 1979 when the *Misuse of Drugs Act* became law, seven doctors have been served with such directions by the Minister for Health.

Precursors of Illicit Drugs

The processing of drugs from plants such as the Opium poppy and the Cocoa plant, as well as the synthesis of L.S.D., Ecstasy, Amphetamines and the so-called “designer Drugs” requires the availability of various chemicals needed in different stages of their production. **Article 12** of the *1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* attempts to limit the supply of precursor and processing chemicals to illegal drugs producers.

Within the E.U. a number of Council Regulations have been introduced to give force to the provisions in **Article 12**, and they are implemented by means of the *European Committees (Monitoring of External Trade in Scheduled Substances) Regulations 1993*. The principal effect of these Regulations is to designate the relevant national competent authorities for the various purposes of **Council Regulation (EEC) No 3677/90** to discourage the diversion of certain scheduled substances to the illicit manufacture of narcotic drugs and psychotropic substances. The Regulations also establish penalties for breaches of the Council Regulation and for giving of false or misleading information or documentation. These EU Regulations lay down the measures necessary to implement **Article 12** of the *1988 Vienna Convention* insofar as the Convention relates to trade with countries outside the European Union. (Department of Health, 1994)

The Commission of the EU has produced a publication entitled “*A Practical Guide for Operators*” which explains the operation of these EU Regulations in the various member states of the EU. By ‘operator’, the EU means “*natural or legal persons engaged in the manufacture, production, trade or distribution of scheduled substances in the EU or involved in other related activities such as import, export, transit, broking and processing of scheduled substances. This definition includes, in particular, persons pursuing the activity of making customs declarations on a self-employed basis, either as their principal occupation or as a secondary activity related to another occupation*”.

A copy of this publication can be obtained from: **Department of Health,(Drugs Section), Hawkins House, Hawkins Street, Dublin 2. Tel: 01/6714711 Fax: 01/6711947**

PENALTIES AND SENTENCES UNDER THE MISUSE OF DRUGS ACTS

Maximum sentences differ according to the nature of the offence. Sentences are greater for pushing, illegal production or for allowing premises to be used for producing or supplying drugs, but are less for possession. For the more serious offences, maximum penalties include an open-ended fine or life imprisonment. In the case of cannabis,

on the other hand, the maximum penalty for possession for personal use is restricted to a £300 fine for a first offence tried in the District Court, or £500 fine on indictment, a £400 fine for a second offence with no option of imprisonment. If this second offence is tried before a judge and jury, the maximum fine is £1000. For third and subsequent offences the fine is £1000 or 12 months in jail or both. The penalty for a third offence tried by judge and jury is an open ended fine or three years in jail, or both fine and imprisonment. There is no distinction made between drugs under these provisions with the exception of cannabis as stated.

The penalties for possession of all other drugs depend on the type of court. In the District Court, the penalty is a maximum fine of £1000 or 12 months in jail, or both. In the case of a person found guilty before a judge and jury, the maximum fine for possession is left to the discretion of the court, which may also impose a seven year jail sentence, or a fine and jail sentence.

Court Provision for the Treatment of Convicted Drug Offenders

When a person is convicted of an offence under these Acts, the Court may decide to obtain a written medical report on the convicted person, with recommendations about medical treatment which the person might require arising from his or her dependency on drugs, and also a report on the person's social background, vocational and educational circumstances. On the basis of these reports the Court may decide not to impose the appropriate penalty. It can decide to have the person detained in a custodial treatment centre or require him or her to undergo a course of medical treatment and/or a course of education and training to improve his/her social and educational background with a view to facilitating social rehabilitation.

REGULATIONS

Regulations made under the *Misuse of Drugs Acts* divide the controlled drugs up in different ways to take account of medical practice. They allow exceptions to the general prohibitions on possession, supply, etc.

Schedule 1 lists mainly hallucinogenic drugs which are not used at present in medicine in Ireland and cannot be prescribed by doctors or sold in pharmacies. The use of these drugs is limited to scientific research or forensic analysis. Production, supply, import and possession are subject to special licensing.

Schedule 2 lists those drugs which may be used for medical purposes but which are regarded as particularly dangerous if abused. They consist mainly of the naturally occurring (e.g. morphine) and synthetic (e.g. pethidine) narcotics, but also include amphetamines and related stimulants and methaqualone. Any of these drugs can only be legally obtained if they have been prescribed by a doctor, dentist or veterinary surgeon, and supplied by a pharmacist. All aspects of the production and supply of Schedule 2 drugs are strictly controlled and licensed, and they are subject to stringent record keeping requirements.

Schedule 3 to which less stringent controls and no record keeping requirements apply, contains certain dependence producing sedatives such as barbiturates.

Schedule 4 includes various minor tranquillisers and preparations of phenobarbitone containing less than 100 milligrammes. There are minimal *Misuse of Drugs Act* controls applied, since these medicines are already controlled under the *Medical Products (Prescriptions and Control of Supply) Regulations, 1996*.

Schedule 5 lists certain preparations of controlled drugs to which the restrictions on possession do not apply. These are usually very dilute non-injectable products some of which can be bought over-the-counter without a prescription, but only from a pharmacy (e.g. some cough bottles and anti-diarrhoea products containing opiates).

(sections reproduced from "The Facts About Drug Abuse in Ireland", Health Promotion Unit, 1994).

INTRODUCTION

This chapter will outline a range of international, national and local responses to drug use. With the exception of a harm reduction response to ecstasy use in the Netherlands, the responses are not ecstasy specific. However, they all include specific responses to ecstasy use as part of their overall programme/activities. No one approach or response is being recommended over another. They have been selected on the basis that they incorporate the wide range of strategies being used to respond to drug use from control strategies through to harm reduction.

INTERNATIONAL RESPONSES

Britain

On 19 October, 1994 the British Government launched drug strategy reports for England and Scotland, the most important drug policy documents in the Conservative Party's 15 years in office. Drafted by a task force chaired by Scottish Office Minister Lord Fraser, Drugs in Scotland is now government policy and being implemented. The English version, Tackling Drugs Together, was put together by the government's Central Drugs Coordination Unit as a consultation paper.

The English report took a high-level strategic approach, setting objectives measured by performance indicators for the main agencies, but rarely detailed how these should be achieved. The Scottish report was more practical with a hands-on approach and was less specific about strategic objectives but detailed what should be happening on the ground. Outlined below are the main proposals contained in the English report.

England

The focus of the new strategy was on:

- (i) crime
- (ii) young people
- (iii) public health

The strategy was driven by the following Statement of Purpose.

“To take action by vigorous law enforcement and a new emphasis on education and prevention to: increase the safety of communities from drug-related crime; reduce the acceptability and availability of drugs to young people; reduce the health risks and other damage caused by drug misuse”. The main objectives in these areas were:

Crime

- To see that the law is effectively enforced, especially against those involved in the supply and trafficking of illegal drugs;
- To reduce drug-related crime;
- To reduce the public's fear of drug-related crime;
- To reduce drug misuse in prisons.

Young people

- To discourage young people from taking drugs;
- To develop effective public education strategies focusing on young people.
- To ensure schools offer effective programmes of drug education, giving education, giving pupils the facts and warning them of the risks;
- To raise awareness among school staff, governors and parents.

Public health

- To protect communities from the health risks and other damage associated with drug misuse, including spread of communicable diseases;
- To discourage people from misusing drugs and to enable those who do so to stop;
- To ensure drug misusers have access to a range of advice, counselling, treatment, rehabilitation and aftercare services.

The main proposals for action in support of these objectives were the following, some of which have already been put in place:

Drug-related crime

- Police, Customs, probation and prison services were asked to consider what changes they wished to make in the light of the Statement of Purpose and report by June 1995.
- The police, probation and prison services were asked to develop explicit strategies for tackling drug misuse, including appropriate training and participation in local multi-agency partnerships, by March 1996.
- The Home Secretary to include drugs in the five key objectives for policing. MM Inspectorate of Constabulary will examine all police force drugs strategies by the end of June, 1996 to ensure that they are consistent with the key objectives.
- HM Prison Service will include the reduction of drug misuse in prisons as a key performance indicator. Compulsory drug testing, improved security and effective treatment services will be introduced.
- The Home Office to develop ways of measuring progress in reducing drug-related crime.
- No new legalisation on any currently banned drugs.

Helping young people resist drugs

- Additional resources were made available to schools from April 1995 to train teachers and support innovative projects in drug education and drug prevention.
- Schools were asked to develop their policies on managing drug-related incidents and drug education by spring 1996 in the light of guidance from the Dept. for Education.
- The Office for Standards in Education will inspect the quality and effectiveness of these policies.
- New publicity campaigns coordinated by the Department of Health will be aimed at motivating young people to resist drug misuse.
- Services addressing the needs of young people experimenting with drugs will be made available in the light of the current review of effective treatment services;
- The Home Office Drugs Prevention Initiative was expanded in 1995 to cover a wider area.

Reducing health risks

- Treatment policies will reflect the national strategy. Their principal objective will be to assist drug misusers to achieve and maintain a drug free state.
- Steps will continue to be taken to reduce the spread of HIV and other diseases by drug misusers.
- The Department of Health will ensure that drug misusers have easy access to cost-effective and appropriate services.
- A national [drugs] helpline was established in 1995 by the Department of Health.
- Special consideration to be given by the Home Office and the Department of Health to (a) the adequacy and effectiveness of drug services in prison and (b) appropriate local arrangements for purchasing drug services in the community for people diverted from the criminal justice system.

Local Strategy

- Drug Action Teams of senior representatives of police, probation, health, education, prison and local authorities were established in 1995 to tackle problems locally.
- Teams will select their own Chair, who will report to government with the Government calling upon district health authorities to set up one Team in each district.
- The Teams' role will be to make progress in line with the priorities of the national drugs strategy and in the light of local needs.

- Each Team will be advised by a wider community group (e.g. voluntary organisations, doctors and school governors).
- Development funds will be made available to support each Team. Each service on the Team will be accountable through its own management line for deploying its resources and cooperating with other agencies.

Monitoring progress

The overall strategy will be monitored at three levels:

- Through performance indicators related to the Statement of Purpose;
- Through a system of detailed performance indicators related to the objectives and tasks which flow from the Statement of Purpose;
- Through the periodic review of local action against drugs undertaken by Drug Action Teams.

Scotland

Outlined below are the areas where the Scottish strategy differed from the English strategy. The main differences in the Scottish strategy stemmed from the overall focus of the strategy which was that drug misuse tended to flourish in conditions of deprivation, alienation and poverty of aspiration. Therefore, in demand reduction measures, priority should be given to young people vulnerable to drug misuse.

- Pilot community drug action schemes should be set up with a focus on alternative activities which engage young people at a time in their lives when they are attracted by excitement and risk.
- New drug prevention packages should be developed for the under 10s and over 14s.
- Health education campaigns should explain how needles can be sterilised or how rave goers can minimise the risks of ecstasy use.
- If successful, peer-led education should be developed.
- Additional crisis intervention centres should be developed quickly.
- The community drug problem service model should be developed to achieve more referrals from and to social services.
- Agencies with outreach workers should establish clear objectives and standards and ensure workers are well supported.
- The Scottish Office should issue guidance for rave organisers on stewarding, paramedic staff, 'chill out' areas and water supplies, and information on sensible behaviour and harm minimisation.
- Earmarked funding to health boards for drug services should continue. Contracts with the non-statutory sector should cover three to four years.
- Local drug action teams should be funded by the Scottish Office to employ a drugs development officer and should seek the assistance of broadly-based drugs forums/drug reference groups in England. Their main purpose would be to express the views of service providers and users and those who need services.
- A pragmatic approach for prisoners where short-term detoxification prescribing is unlikely to succeed.
- Prisons should continue to make sterilising tablets widely and discreetly available.

Britain has traditionally had a hard line position on drug use with campaigns focusing on the anti-drug/just say 'no' approach. However, their most recent campaign represents a significant shift in attitude. The focus of the latest campaign launched in August, 1995 and costing £14 million is on providing young people with as much information as is possible to at least equip them with the knowledge to make an informed choice. It is based on the two drug strategy reports for England and Scotland outlined above. The Health Education Authority which drew up the campaign for the Department of Health stated that it believed that an open and honest campaign was the best way to make young people aware of the dangers (Sunday Times, October, 1995).

The differences in content to previous campaigns and strategies would have been inconceivable until recently. The Scottish report focused heavily on reducing harm from drug misuse, whereas the English report focused on the "community" affected by drug use. The policy switch is clear in the chapters on prevention. The English report proposed a "strong emphasis on preventing young people from misusing drugs" but acknowledged that some would nevertheless "chose to experiment". It was therefore important "to give them the information and skills to minimise risk".

The Scottish report took the controversial step of endorsing safer drug use advice for the young with the radical statement that "in the prevention and education fields, harm minimisation is a legitimate approach". While not condoning drugtaking it acknowledged that it takes place. Therefore, the pragmatic response should be to provide information and advice about minimising risks. Both strategies signalled a new emphasis on demand reduction

through prevention and education, concern over drug-related crime, while emphasising the importance of continued law enforcement. (*extracts from Druglink magazine, ISDD, Nov/Dec, 1994*)

The Netherlands

The Netherlands has what most people would regard as a liberal approach to drug use and their legislation reflects this. Cannabis is legal and the free needle exchange and heroin supply programmes are well known and a source of ongoing controversy. The focus tends to be on dealing with the reality of the situation and thus making drug use as safe as possible. The approach to ecstasy is no different. For example the Dutch (and Spanish) authorities have called for ecstasy to be re-classified to a Class B drug similar to cannabis and amphetamines.

The Netherlands is widely regarded as the main manufacturer of ecstasy in Europe and its impact on the rave culture has been as strong as anywhere else. The response has been to provide as much information as possible in order that young people can make informed choices and know exactly what is ahead of them and the potential risks should they decide to use ecstasy. Drug campaigns in the Netherlands therefore, have concentrated on providing accurate and reliable information on drug use and harm reduction.

As illustrated in Chapter 2 one of the biggest risks involved in using ecstasy is the fact that it may not be ecstasy at all and/or could be mixed with almost anything. In response to this the Dutch have developed a screening system at rave/dance settings. They are called *Safe Houses* which are mobile units where people can take ecstasy that they have purchased and have it tested on the spot by licensed professionals to find out exactly what it contains.

The following project is an example of a harm reduction educational strategy for responding to ecstasy use in the Netherlands. It clearly illustrates the information and harm reduction approach that has become official Dutch drug policy.

Background

In 1988, ecstasy was brought under the Dutch Narcotic Law on list 1, alongside heroin, cocaine, etc. This caused many small producers to cease production of ecstasy. However, at the same time the popularity of ecstasy was increasing dramatically. This discrepancy between supply and demand resulted in the production of a number of other drugs such as LSD (acid), MDA (the parent drug of ecstasy), and amphetamine. The increasing popularity of this 'new' drug and the widespread presence of imposter-drugs necessitated the development of an educational strategy to reduce harm as well as prevent use.

The Target Group

The target group for the educational intervention was ecstasy users because there existed a lack of information among them. It was also hoped to reach those who were considering whether or not to use ecstasy. This expectation was based on the properties of ecstasy, the structure of the market and the local character of the market.

Relevant sociological factors

- *the reinforcement of feelings of togetherness;*
- *the 'light' trend i.e. ecstasy becoming preferred above 'hard' drugs such as LSD, and more importantly amphetamine or cocaine; old drugs being rejected or being used more pragmatically;*
- *the 'varia' trend in consumption patterns of legal as well as illegal drugs;*
- *the revival of the 'sixties';*
- *the feeling of personal stardom: with your head in the clouds, but with your feet solid on the ground.*

Project Goals

The goal of the education was harm reduction, by giving factual information offered in a normative frame, without moralizing, taking into account the responsibility of individuals and their existing knowledge on drugs. The focus of the educational intervention was on three levels: primary, secondary and tertiary.

Primary prevention

- *Emphasizing the considerable chance that what one uses may not be ecstasy but a more dangerous drug, because what is offered as ecstasy is often adulterated or contains other drugs (i.e. amphetamine or LSD).*
- *Giving the aspirant consumer more tools for decision-making about whether or not to use the drug.*
- *Prevention of over-identification by avoiding scene-words.*

Secondary prevention

- *The building of knowledge and experience among user groups.*
- *Reinforcing the self-correcting capacity of user groups and the market. Even on the 'black market', standardization is possible as can be seen with LSD.*

Tertiary prevention

- *Stimulation of self-help, teaching people what to do when they are confronted with problems in others.*

Service Delivery

Public Awareness Campaign

The initial problem with the project was how to reach different groups, especially while the differences between the groups are so large that media specifically directed at these groups do not exist, in contrast to the underground press in the 1960s. So two approaches were used:

High key: *a board campaign directed at the general public, but having the risk that such a campaign evokes interest in the drug that did not exist beforehand.*

Low key: *communicating by many different channels, directed to all special groups.*

The approaches were handled in the following way:

High key: *a publicity campaign focused on a conference on ecstasy in which the drug itself was not the central theme, but the 'market pollution', i.e. the general risk of all black market products not being what they are supposed to be, due to lack of control of the products. This is information that is that is relevant to all people, consumers as well as potential consumers of nearly all illegal drugs, and is supposed to have a demand reduction effect.*

Low key: *aimed at the different groups of (potential) users with specific information on ecstasy, contiguous with the high key approach. The chosen media were a leaflet, an information pack and, as an experiment, a public service telephone number.*

Information Pack

The style of the pack was modelled on the insert often enclosed with medical drugs which outlines its effects and potential dangers. With regard to the contents the following items were included:

- *The effects of the drug: aimed at reducing the influence of 'mala fide' suppliers.*
- *The market pollution: appealing to the responsibility of the potential user and connecting to the high key campaign - the risks of the use, acute poisoning and long-term effects.*
- *Combinations with other drugs: answered the question of whether specific combinations should be discussed by only mentioning them in general terms. Combinations that are used only in small circles (e.g. ecstasy with poppers) were not mentioned. It was considered the risk involved in drawing attention to such combinations to be heavier than the lack of information.*
- *Contra-indications*

The Public Service Phone Number

The project prepared a tape recording with the same information included in the pack for use on a public service telephone. The number was advertised in several national newspapers (Fromberg, 1991).

The Dutch Government also funds an organisation called *Jellinek* who test street drugs in laboratories and publish the results thus providing the public with an accurate scientific overview of current trends in drug use (Saunders, 1995).

Ireland

The Government Strategy to Prevent Drug Misuse was published in 1991 and was based on the recommendations of the National Co-ordinating Committee on Drug Abuse which was established to advise the Government on general issues regarding the prevention and treatment of drug misuse. The Strategy recognised that the problem of drug misuse is a complex and difficult one to which there are no easy or instant solutions and proposed 'a *multi-disciplinary approach requiring action in the areas of supply reduction, demand reduction and increased access to treatment and rehabilitation programmes, together with a comprehensive coordinated structure geared towards their effective implementation*'. Since 1991, the Department of Health, in co-operation with other Departments and state agencies has been implementing the recommendations contained in the Strategy.

In February, 1996 the Minister for Health Michael Noonan at the launch of new Government Demand Reduction Measures to prevent drug misuse announced a number of measures under the broad heading of Education and Prevention. This included a public media campaign launched by the Department of Health in 1996 to provide information to young people and parents on the danger of drug misuse. The campaign focused heavily on ecstasy. The Minister announced a range of initiatives undertaken in conjunction with the Department of Education on education and health promotion in schools. The Minister also announced a number of planned initiatives aimed at responding on a community level including the following:

- greater coordination of services among statutory, voluntary and community agencies at local level.
- the establishment by each health board of a contact service to provide assistance, information and advice to the public.
- improved liaison arrangements between the prison service and community treatment services.
- the coordination of detoxification facilities in Dublin will be improved.
- special attention will be given to the problems of those smoking heroin.
- rehabilitation and support services for those misusing drugs will be further developed.

Other measures currently under consideration include: the provision of a mobile treatment unit; expanding the methadone maintenance programme; and using health centres as an adjunct to community drug centres in order to respond to the increased demand.

As is evident from the above the government strategy on drug use has been focused primarily on heroin/IV drug use and existing initiatives and their expansion such as; the Methadone Maintenance Programme; Community Drug Teams; and Detoxification and Rehabilitation Centres have been developed with this in mind as were most of the measures being proposed in the recent launch by the Minister for Health highlighted above.

Recommendations of Ministerial Committee on Measures to Reduce the Demand for Drugs

The Ministerial Committee was established by the Government on 9 July, 1996. It was chaired by Pat Rabbitte, T.D., Minister of State to the Government and comprised of seven Ministers of State. The Committee publicly advertised for submissions and received 123 submissions in total.

At the launch of the recommendations arising from the submissions received, Minister Rabbitte said that of the £14m allocated to implement the recommendations, £10m was earmarked for service development in priority drugs area, £3m would go on local estate improvement and £1m for specific anti-drug projects in Health Boards outside the priority areas. He highlighted the recommendation that current drug treatment waiting lists be eliminated during 1997.

In this first report, the Ministers concentrated on the heroin problem. The Report identified eleven priority areas on which many of the recommended measures are focused. The eleven areas are: parts of Ballyfermot, Ballymun, Blanchardstown, Coolock, Clondalkin, Crumlin, Finglas/Cabra, Tallaght, North and South Dublin Inner City, and North Cork City.

The Committee recommendations, approved by Government, include:

- the establishment of a Cabinet Drugs Committee, chaired by the Taoiseach and comprising relevant Ministers, to give overall political leadership in the fight against drugs.
- the establishment of a National Drugs Strategy Team, comprising key personnel seconded from relevant Departments and agencies, as well as persons with a background in the voluntary and community sectors dealing with drugs, and mandated to implement the Government's overall drugs strategy.
- the establishment of Local Drugs Task Forces in each of the eleven areas identified as having the most acute drugs problem and requiring priority action. The local Task Forces will comprise personnel from relevant agencies along with community representatives and a chairperson proposed by the local Partnership.
- speedy establishment of information databases by the Health Boards, in order to establish the extent of addiction,
- Health Boards to move to eliminate drug treatment waiting lists, with the Eastern Health Board waiting list to be eliminated in 1997,
- particular attention to be given to the needs of young drug misusers in the priority areas,
- priority status for Community Employment (CE) applications offering integrated services for recovering addicts,
- a series of education and prevention steps, including enhanced truancy measures and an anti-drug programme for all primary schools in priority areas,

- an Estate Improvement Programme (£3m in 1997-'98) for severely run-down urban housing estates,
- Local Authorities to develop sports and recreation activities in the priority areas, within the national sports strategy framework.

The Ministers emphasised that this Report was the second part of a two-pronged Government strategy on drugs, complementing the supply side, in the form of law and order measures introduced by the Government. A second report for which the Task Force also sought public submissions was initiated to concentrate on:

- the effectiveness of the current response to drugs, such as cannabis and ecstasy,
- measures to deal with the demand for drugs in our prisons,
- the establishment of State-run rehabilitation centres, and
- the development of facilities in therapeutic communities.

This second report of the Task Force reported back in May, 1997 and the key recommendations arising from the report are summarised below.

Summary of Key Recommendations

- the establishment of a Youth Services Development Fund - with contributions from the Exchequer and the corporate sector - to develop youth services in disadvantaged areas where there is a significant drugs problem. The contribution from the Exchequer will be of the order of £20 million;
- the preparation of development proposals by relevant bodies to meet the prioritised needs of young people in disadvantaged areas where there is a significant drugs problem;
- the according of a high priority in the allocation of the "demographic dividend" in education to the provision of staff to lead the development of the youth services in disadvantaged areas;
- the training and employment of youth leaders from disadvantaged communities under Community Employment and other social economy measures;
- the development and implementation of a substance abuse prevention programme specifically for the non-formal education (youth work) sector, to be introduced with an accredited "Training for Trainees" programme;
- the employment of a training to develop, co-ordinate and implement this education strategy throughout the Youth Service;
- the development of specialised outreach programmes to reach those not in contact with any services or organisations, i.e. those who are often most at risk;
- the development and implementation of information designed specifically to target young people with low literacy skills;
- the establishment of pilot projects in urban areas, where locally-appointed Sports Development Officers will work in partnership with Local Authorities, Vocational Education Committees, Health Boards, sports clubs, sports centres and community groups to attract isolated young people into sport and physical recreation;
- the establishment of Local Sports Development Forums to co-ordinate local activities and bring local clubs and groups together;
- the continued development of education/awareness initiatives, including the expansion of the programmes of substance misuse prevention/education in primary and second level schools;
- the development of information/media campaigns in relation to drugs such as ecstasy, which replicate the approach being taken in some other countries, like Britain;
- the establishment of an independent Expert Group - containing international expertise - to assess how treatment services inside and outside prison interact and to make recommendations for the improved co-ordination/integration of those services for drug misusers coming into contact with the criminal justice system;
- the development of properly supervised treatment programmes for "low risk" offenders who misuse drugs are convicted of petty crimes, as an alternative to prison;
- the continued development of security measures in Mountjoy to prevent the smuggling of drugs into the prison.
- the establishment of an Advisory Body to conduct research into the causes, effects, trends, etc. of drug misuse and to evaluate the effectiveness of different models of treatment.

NATIONAL DRUG MISUSE PREVENTION INITIATIVES

There are a number of primary education and prevention programmes in place, broadly coming under the heading of National Drug Misuse Prevention Initiatives which are outlined below. It is within these programmes that the issues of education and prevention in relation to ecstasy is being responded to.

ON MY OWN TWO FEET

This Programme was developed by the Health Promotion Unit of the Department of Health and the Psychological Service of the Department of Education with assistance from the Mater Dei Counselling Centre. It is a comprehensive drug education programme which involves the whole school staff of participating schools.

This Programme had an extremely successful two-year pilot phase and is now available to all second level schools. It has been introduced to about sixty per cent of schools and in-service training and wider dissemination are continuing. The programme consists of modules on Identity and Self Esteem; Assertive Communication; Feelings; Influences on Young People; and Decision Making. It is a participative programme, the aim of which is to enable students to develop their ability to take charge of their mental health and to make informed decisions about the use of drugs in their lives. Programme materials include information on ecstasy and its effects.

PARENT EDUCATION ON ALCOHOL, DRUGS AND FAMILY COMMUNICATION

This Programme has been developed by the Health Promotion Unit in conjunction with the Cork Social and Health Education Project of the Southern Health Board. This project recognises that young people and their parents must be provided with assistance to help them deal with the problems posed by both licit and illicit drugs. To this end, a course has been developed which focuses, not only on drugs themselves, but also on the skills and personal attributes that help people deal with drug situations. These skills relate to such areas as listening; communication; self-esteem; conflict resolution; discipline and similar issues.

“PARENTING FOR PREVENTION” PARENTING PROGRAMME

This Programme was developed by Community Awareness of Drugs - a voluntary organisation - with financial and practical assistance from the Health Promotion Unit. It aims to assist parents in exploring attitudes, beliefs and decisions about the issue of drug misuse.

NATIONAL YOUTH HEALTH PROGRAMME

The National Youth Health Programme is a partnership between the National Youth Council of Ireland, the Health Promotion Unit and the Youth Affairs Section of the Department of Education. The aim of the Programme is to develop Health Education resources and provide training in health issues specific to young people. This includes drug education and prevention. The Programme employs a Health Education Officer.

In 1995 the Programme organised a national one day seminar on Drugs Issues for the Irish Youth Service with the aim of highlighting the problem of drug misuse among young people and discussing a strategy for dealing with the problem in youth work settings. The seminar identified (i) the need for a drugs education programme specifically for the non-formal education sector (ii) the need for appropriate guidelines on dealing with drug misuse situations in youth organisations and (iii) the need for a National Trainers Forum to enable youth workers to avail of specialised training in different approaches in their work. A response to all these issues has been developed by the National Youth Health programme.

SOLVENT ABUSE RESOURCE MATERIALS

The National Youth Health Programme developed Solvent Abuse Materials in 1992. These materials were designed for use by such people as youth leaders, instructors of Community Training Workshops, Youthreach projects as well as the formal education sector. The contents of the package are also flexible enough for use in special schools, residential centres and as an aid to the Juvenile Liaison Scheme of an Garda Síochána.

The underlying philosophy is that drug and alcohol education is not only about drugs but also about people. Thus, while young people need accurate information about drugs, this alone is not sufficient to ensure responsible behaviour. Information must be backed up by assistance in the development of skills in relation to the use of drugs. This incorporates, among other things, the enhancement of self-esteem and decision making skills. Young people also need to examine attitudes to drug use - both their own as individuals and the attitude of the community in which they live. This resource affords the educator the opportunity to do all these things.

DRUG QUESTIONS - LOCAL ANSWERS?

This is a community-based training programme for health/education professionals, Gardai, youth workers and others interested in drug-related problems which they meet in their own work. The Health Promotion Unit runs convenor

training programmes for this pack in conjunction with the eight regional health boards. As a result of these courses a large number of convenors have been trained to use this pack.

LEADERSHIP TRAINING PROGRAMME FOR PRIMARY PREVENTION OF DRUG MISUSE

This programme which is a CROSSCARE (Catholic Social Service Conference) initiative, is being partially funded by the Health Promotion Unit, the European Commission and CROSSCARE.

It is a pilot project which aims:

- to develop and implement a flexible process to facilitate the people in the target communities in tackling their own drug prevention issues, and
- to enable the local people to develop their own skills and resources so that they may address these issues more effectively.

MY BEST FRIEND: A DRUG EDUCATION STORY

Video and booklet produced by the Health Promotion Unit of the Department of Health to assist educators in schools, youth organisations and other educational environments. It is primarily aimed at 13-17 year olds but can be used with a variety of groups in formal and informal educational settings. The package is designed to be used as part of an ongoing drug education programme. (*Health Promotion Unit, 1996*)

COMMUNITY BASED PROJECT PROFILES

Community based drug projects in general do not deal exclusively with ecstasy. This would be impractical and would not make sense as ecstasy use, as illustrated in Chapter 1, fits into a particular youth sub-culture that is inextricably linked to a number of other drugs.

The use of ecstasy needs to be responded to with these issues in mind as well as the particular dynamics of the community in question and thus can not be responded to in isolation. The projects outlined here all deal with ecstasy as part of their work but they use a variety of methods and approaches that should be of interest to anyone involved in or considering setting up a drug awareness/education programme.

PROFILE NO. 1: COMMUNITY RESPONSE, DUBLIN.

Background

Community Response is an organisation consisting of Statutory, Voluntary and Community people who either live or work in the South Inner City area of Dublin and are concerned with the drug problem. The project employs one full-time Co-ordinator, a part-time resource worker as well as a part-time administrator.

The project's aims are to develop and devise practical and effective ways of tackling the drug problem and its effects in Dublin's South Inner City. Central to its aims is the involvement of the local community in seeking solutions to the problem.

The project works to ensure that local communities are resourced to work along with service providers to ensure that:

- the treatment needs of drug users are met
- effective responses to the issues of drug supply and drug related crime are addressed
- family members of drug users receive support, information and training
- drug awareness programmes are delivered in all schools, community training workshops and youth clubs in the South Inner City area
- education and training be provided to community and youth groups, agencies and services in the area of drug awareness
- proper and effective community policing is developed

Service Delivery

- Information & Education
- Newsletter: The project publishes a regular newsletter, *Community Response News & Views* which provides the community with up to date information regarding the local drug situation and related topics.

- Drop-in-Service: The project is presently involved in providing a Drop-in-Service for drug users and their families in the Donore Avenue area of the city. This is run in conjunction with the local youth club there; The Small Club.
- Education: Community Response proposes in the next two years to target all 22 schools in the area along with all youth clubs, training workshops, parents groups, teachers and community groups with drug awareness programmes. To do this adequately and successfully the project has been operating a Training for Trainers Course for local people who in turn provide these awareness programmes as part of a Community Response education team.
- Schools Competition: The project has held two very successful competitions for all the schools and training workshops in the South Inner City area. The competitions were broken down into three categories; short story, poster and poetry and were aimed at raising awareness of the issue of drugs and helped in raising a consciousness around the dangers of drugs both for the pupils and teachers alike. A booklet entitled *Drugs, HIV Is It for Me?* which featured a selection of poems, stories and posters from the competition was produced and is available from the Community Response office.

Support Services

- Family Support Group: The aim of this group is to allow families of drug users to come to terms with the problems they face and to look at ways by which to address them. The Family Support Group, which meets once a week and is open to any family member of a drug user in the South Inner City, provides ongoing support through stress reduction, relaxation and counselling as well as information and training. Some of the group members are presently working with Inside Out Theatre Group on a drama production which reflects their real life situation.
- Research: The project is nearing completion of a research project entitled Drug Use and Intervention Strategies in Dublin's South Inner City. As well as giving us vital statistical data and providing information on what intervention strategies need to take place, it will provide the project and other community groups in the area with a valuable tool for action and change. Community Response were also involved in the development of the Dublin South West Inner City Area Action Plan 1995, produced by the South West Inner City Network. Included in this plan is a substantial proposal on the drug issue and the project is represented on the Network's Steering Committee.
- Treatment: The project facilitates an ongoing debate on the issue of treatment within the community. This is done through open forum meetings, meetings with local groups and through the newsletter News & Views. The project's position is that treatment facilities should be backed up by Community Drug Teams and that such facilities should include:
 - Methadone Maintenance
 - Methadone De-toxification
 - Drug free elements
 - Rehabilitation programmes
 - Residential treatment

For further information contact: ***Fearghal Connolly, Community Response, 29 Blackpitts, Off Clanbrassil Street, Dublin 8.***

Tel: (01) 4549772 Fax: (01) 4547378

PROFILE NO. 2: THE BREAKTHRU PROJECT, DUNGANNON, NORTHERN IRELAND

Background

Drug seizures in the Dungannon area are on the increase. During the 1994-95 period seizures in the Dungannon area amounted to over £14,000, of which over £11,000 were Ecstasy. Cannabis, LSD and Amphetamines were also present in large amounts. The Breakthru Project is a community drugs awareness, education & information project. It is an initiative of the Dungannon Development Association Initiative. The project was officially launched in June 1995 to respond to the increase in drug use in the locality. The project aims to prevent drug misuse in an innovative and effective way.

Service Delivery

- Information & Education
- Parents' information evenings.
- Information phoneline for parents (Tel 01868 753228).
- Resource library (free for all community members to use).

- Currently working towards having a comprehensive drugs education programme in every school in the Dungannon area.
- Monthly youth newsletter.

Support Services

- Drama project which works with young people in the Dungannon area (10-13 year olds) tackling the issue of drugs misuse through drama, dance and mime.
- Referral agency to other services including drug counselling if required.

For further information contact: ***Carol McGill, The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.***
Tel: (01868)753228 Fax: (01868)753229

PROFILE NO. 3: BALLYMUN YOUTH ACTION PROJECT, DUBLIN.

Background

The Ballymun Youth Action Project was established in 1981 after three young people from the area died from drug related causes. The project sets out to develop a community response to drug abuse, thereby taking responsibilities for problems and seeing themselves as crucial to the solutions. The project has a full-time staff of eight people.

Service Delivery

- Information & Education
- Drop-in Facilities
- Home Visits
- Prison Visits
- School Visits

Support Services

- Family Counselling
- Individual Counselling
- Street Work
- Group Work
- **URRUS - Ireland's Community Addiction Studies Training Centre**

URRUS is an initiative of the Ballymun Youth Action Project which has been established to provide training in the areas of drug abuse and addiction. The aim is to develop a centre of learning and excellence where people can access a range of training options aimed at increasing their effectiveness in the area of responses to drug abuse and increase participants personal skills, effectiveness and employment potential for the future. The centre will develop a range of training modules on drug abuse, addiction and community responses which can be adapted and used in other communities in Ireland and in other European countries.

For further information contact: ***Mary Ellen McCann, Ballymun Youth Action Project, 1A Balcurris Road, Ballymun, Dublin 11.***
Tel: (01) 8428071 Fax: (01) 8621025 E-mail: byap@iol.ie

PROFILE NO. 4: LIFELINE PROJECT, MANCHESTER, ENGLAND.

Background

The Lifeline Project, based in Manchester, has been in existence for 25 years and is one of the oldest non-statutory, non-residential drugs agencies in Britain. In the early days Lifeline was heavily influenced by the Therapeutic Community movement. In the middle years Lifeline was just as heavily influenced by the statutory Community Drugs Teams. Lifeline really came of age with a truly unique identity around the time of its 21st birthday in 1992. By then Lifeline was confident that it had a model of working that was different from all other drugs services. The key to this model was that Lifeline is a client-led service and is happy to work in partnerships with any professions, groups or individuals that can benefit its client groups and enable it to fulfil its commitment to drug users, their families and their friends. It is their needs that dictate and direct the work of Lifeline.

Methodology

Lifeline recognises that there is a fundamental difference between two groups of people. Those who are ‘addicted’ to drugs (group A) and those who use drugs in a more ‘recreational’ or discriminating fashion (group B). However, Lifeline also refutes any idea that recreational drug use is synonymous with non-problematic drug use. Recreational drug users do have problems and therefore they do have needs. They may not be the same as the needs of the addict but they are there and Lifeline is committed to responding to all kinds of drug user and drug problem.

Lifeline’s methods of service delivery stem from the philosophy of the project. This philosophy is morally neutral in relation to the use of drugs. Lifeline’s view of drug use is ‘agnostic’ i.e. not adopting the belief that the use of drugs is an intrinsically bad or good thing to do. The project sees no point in adopting a strong moral position in relation to the use of drugs. Many of Lifeline’s staff and customers hold very strong views about drugs legislation but this remains a matter for their personal moral philosophical outlook. The only belief that Lifeline holds as a corporate moral philosophy is a commitment to tell the truth about drugs and drug users.

Lifeline are in regular contact with hundreds of young drug users at any one time. We regularly ‘take the temperature’ of drug using trends and monitor the price and quality of drugs that are being used by young people. Lifeline regularly produce a list of up-to-date prices of illegal drugs in Greater Manchester. Besides informing Lifeline’s training work this regular monitoring of young people’s drug use also makes a major contribution to Lifeline’s health promotion materials.

Many agencies are involved in researching trends in drug use. Lifeline’s research is designed to be as contemporaneous as possible and to report in the shortest possible time scale. This does mean however that although Lifeline research is regularly featured in the trade press it has rarely appeared in the academic press. This is due to the fact that most refereed journals require exclusive rights on research material and work can take years to appear in print. Lifeline, believes that it is much more important that its research satisfies the practical needs of practitioners and planners than the esoteric requirements of the academy.

Service Delivery

Lifeline recognises that in the current context there is a need to engage young people who are at various stages of drug use and its services are geared to respond to these various stages:

- for those who have made a decision not to use drugs, Lifeline will seek to reinforce this decision through its prevention efforts.
- for those who are thinking about using drugs, or have already started to experiment. Lifeline will provide access to health promotion materials that provide them with the necessary information to avoid drug related problems.
- for those that have started to use drugs on a regular basis, Lifeline offer easy access to confidential advice, information and counselling that is designed to intervene as early as possible in a drug using career, with the aim of preventing the escalation from recreational (Group B) use to dependent styles of drug use (Group A).
- the project also produces an extensive range of publications, posters, card sets, cartoons and comics on all aspects of illicit drug use, particularly dance drugs, specifically aimed at young people currently engaged in drug use (much of the information is written with young people in mind and thus some of the material/language is explicit in content and should only be used with an appropriate adult).
- the project also undertakes research projects.

For further information contact: *Lifeline, 101 - 103 Oldham Street, Manchester M4 1LW, England.*

Tel: (0044) 161 8392054 Fax: (0044) 0161 8345903

PROFILE NO. 5: THE MERCHANT’S QUAY PROJECT, DUBLIN

Background

The Merchant’s Quay Project was established in 1989 as a response to the growing issues of drugs and HIV/AIDS, and provides non judgemental care and support service for drug users and their families. The model which underpins the Project is described by McKeown (1993) who undertook an evaluation of the Project as a “medico-psychosocial-model”. The model is designed to reflect the multifaceted nature of drug users’ needs. In addition to having medical problems such as abscesses, under nourishment, and HIV/AIDS related symptoms, drug users often have psycho-social problems such as marital difficulties, and difficulties in the area of housing, money, the law and

unemployment. The Project attempts to address these needs directly or indirectly by referring clients to the appropriate agency and acting as an advocate on their behalf.

Charter of Rights

The project operates a Charter of Rights in order to create a safe and respectful environment for all those using its services:

1. While in the Project you have the right to be spoken to and addressed respectfully at all times.
2. While in the Project you have the right to be free from threatening and violent behaviour (both verbal and physical).
3. You have the right to use the Project without being subjected to dealing, supplying, trading or drug use on the premises.
4. You have the right to use the Project without being subjected to other peoples affected behaviour, i.e. goofing, drunkenness etc.
5. You have the right, while in the Project, to be free from prejudice, i.e. sexism, racism, ageism, etc.
6. While in the Project, children have the right to be supervised and kept safe at all times.
7. You have the right to have your complaints investigated and responded to within seven working days.

This is a charter for all people within the Project including clients, workers, visitors and children.

Service Delivery

- Assessing clients' needs and working out a treatment plan to suit the needs of each individual;
- Advice on the safer use of drugs, particularly in terms of reducing the risk of HIV infection;
- Advice on safer sex including general health promotion materials;
- A needle exchange programme;
- Helping clients to access drug treatment and medical services;
- Supporting General Practitioners who are providing treatment for drug users in the local area;
- Helping clients with welfare and housing problems:
- Supporting persons who are detoxifying;
- Preparing constant reports for clients and appearing in court to speak on their behalf;
- Prison support programme;
- Stabilisation programmes incorporating art therapy, drama therapy, acupuncture, personal development, relaxation and literacy;
- Provision of information and support to parents, spouses, relatives and friends of drug users. There are currently three parents support groups in operation.

The Project also operates a twelve week residential detoxification programme at a centre in North County Dublin utilising a group based therapy approach.

Intervention Programmes

Crisis Intervention

At the contact centre there are trained drug workers, who provide crisis interventions and assessments for clients. These workers assist with housing problems, welfare issues and will help with accessing clients to drug treatment and medical services. They provide a complete range of support that promotes safer drug use and safer sex. Treatment plans and goals are worked out with each client. Court reports can be prepared for clients who have completed assessments.

Stabilising Programmes

The stabilising programme engages the prescribing doctor, family members and the project worker in an agreed schedule designed to reduce the disorder in the clients life. The project employs a Medico Psycho Social approach to stabilising. This includes art therapy, acupuncture, relaxation and literacy training. Psychological assessments are provided to assist clients in making decisions about adult education courses and finding jobs. Family therapy is provided to support the family members in understanding the stabilising process.

Detoxification Supports

For those clients who are attending the contact centre while detoxifying there is provision for a daily programme with counselling, family support, and a daily routine to reduce the likelihood of relapse.

Detoxification support is also provided via residential respite facility for those who feel too vulnerable to cope with the “streets”.

During this respite phase the staff will examine future treatment options with clients. Information is provided on Coolmine, Aiseiri, Rutland, NA and other treatment options. Clients are encouraged to make their own choices that promote ongoing recovery.

Drug Free Programmes

The project provides ongoing support to people who are drug free. These include relapse prevention, gym fitness training, HIV counselling and general health promotion advice. For those experiencing stress the respite care acts as a means of providing a rest and a chance to review their situation.

For further information contact: ***Tony Geoghegan, Drugs/HIV Service, 4 Merchants Quay, Dublin 8.***
Tel: (01) 6790044/6771123 Fax: (01) 6771000

This chapter on resources is divided into four sections: Education and Information sources (agencies); Counselling and Treatment Services; Research and information Resources; Education and Training Resources. It is not an exhaustive list under any of the sections. Each section provides a range of agencies or materials which can be used by people to assist them in sourcing information on treatment provision, resources for drug education & prevention and general information on drug related issues.

EDUCATION & INFORMATION SOURCES

Addiction Information Service.

9 B Farmhill Road, Goatstown, Dublin 14.

Tel: 01 988983

Services include client-centred counselling, individual therapy, cognitive behaviour model, gestalt and reality therapy, analysis.

Community Awareness of Drugs (C.A.D.)

31a Central Hotel Chambers, Dame Court, Dublin 2.

Tel: 01 6792681 Monday to Friday 10am - 4pm.

C.A.D. is a network of voluntary community workers engaged, through education, in the prevention of drug misuse. C.A.D. assists communities to develop their own preventative strategies. Services include support and advice for parents, training for voluntary community workers and a Parenting For Prevention Programme.

Regional Branches

Gorey: Tel 055 21561

Leixlip: Tel 01 6245631

Middleton: Tel 021 632449

CROSSCARE Drug Awareness Group

The Red House, Clonliffe House, Dublin 3

Tel: 01 8360011

Aims to provide a range community development initiatives including programmes to increase the awareness of drugs. Services include HIV/AIDS initiatives and programmes for drug awareness

EURAD

Kilcullen House, 1 Haigh Terrace, Dun Laoighaire, Co. Dublin

Tel: 01 2841164 Fax: 01 2841577

Irish headquarters of the Europe Against Drugs campaign.

Hazelden Educational Services International, Ltd.

25D Southside Industrial Estate, Pouladuff, Cork

Tel: 021 314318/961269

Distributes by post and through bookshops, of books, pamphlets, audiotapes and videos on a wide range of addictions and related problems.

Health Promotion Unit

Department of Health, Hawkins House, Hawkins Street, Dublin 2.

Tel: 016714711

Engaged in programmes dealing with health promotion issues, such as immunisation, drugs, smoking, alcohol, hygiene, cancer and AIDS. Public office is on ground floor of Hawkins House from which a wide range of promotional material is available.

Institute for the Study of Drug Dependence

Waterbridge House, 32-36 Loman Street, London SE1 OEE.

Tel: 0044 171 9281211

Contains what is widely regarded as the best reference section on ecstasy in Britain in its public library. Also undertakes research, publishes articles & leaflets, and produces its own magazine (Druglink).

Irish Association of Alcohol and Addiction Counsellors (IAAAC)
Secretary, c/o C.A.D.S., Bishopsgate Street, Mullingar, Co. Westmeath.
Tel: 044 48289/41630

National professional body whose aims include: to promote high ethical and professional standards in the field of addiction counselling; to provide ongoing support, education and training for members; to represent the views and interests of members; and to establish a communications network. IAAAC also produce a quarterly newsletter.

Lifeline

Manchester, 101-103 Oldham Street, Manchester MW 1LW.
Tel: 0044 161 8392054

Produces an extensive range of publications, posters, card sets, cartoons and comics on all aspects of illicit drug use, particularly dance drugs. The publications are specifically aimed at young people currently engaged in drug use. Much of the information is written with young people in mind and thus some of the material/language is explicit in content and should only be used with an appropriate adult. They also provide an advice service and undertake research projects.

National Coordinating Committee on Drug Abuse

Room 927, Department of Health, Hawkins House, Dublin 2.

Established by the Minister for Health to advise the Government on general issues relating to the prevention and treatment of drug abuse; to monitor the effectiveness and efficiency of measures in force to prevent and treat drug abuse; to facilitate communication between the various agencies involved in the prevention and treatment of drug abuse.

National Drugs Advisory Board

Charles Lucas House, 63/64 Adelaide Road, Dublin 2.

Tel: 01 6764971 Fax: 01 6767836

Established by the Minister for Health in 1966 under the Health (Corporate Bodies) Act 1961. Assesses the safety, quality and efficacy of marketed drugs for human and veterinary use. Inspection of pharmaceutical manufacturers and wholesalers and advising the Minister on the issue of manufacturing and wholesale licences. Organising and administering a system for the recording and assessing of side-effects to drugs. Advises the Minister for Health on precautions, restrictions, testing, manufacture, etc. Disseminates information on drugs and produces publications primarily for medical practitioners and pharmacists.

National Drug Squad

Harcourt Square, Harcourt Street, Dublin 2.

Tel: 01 8751356/8732222

Aims to protect the community from the illegal distribution of drugs. Will supply speakers on its work to groups on request.

National Drugs Team

14 Lord Edward Street, Dublin 2.

Tel: 01 6792777

National enforcement agency for the detection and prevention of drugs being smuggled in or out of the country.

National Youth Health Programme

National Youth Council of Ireland, 3 Montague Street, Dublin 2

Tel: 01 4784122

The National Youth Health Programme is a partnership between the National Youth Council of Ireland, the Health Promotion Unit and the Youth Affairs Section of the Department of Education. The aim of the Programme is to develop Health Education resources and provide training in health issues specific to young people. This includes drug education and prevention. The Programme employs a Health Education Officer.

Waterford Drug Abuse Resource Group

52 Upper Yellow Road, Waterford

Tel: 051 73333

Provides support, information and advice to people directly and indirectly affected by drugs.

COUNSELLING AND TREATMENT SERVICES

Aiseiri.

Townpark, Cahir, Co. Tipperary.

Tel: 052 41166

Roxborough, Wexford.

Tel: 053 41818

Services provided include professional 12-Step/abstinence-based programme, group and individual therapy, counselling, peer & relapse groups, out-patient family support programme, and bibliotherapy.

Alcohol and Drug Abuse Treatment Centre

Arbour House, Douglas Road, Cork.

Tel: 021 968933

Provides support and medical care for drug users.

Alcohol & Drug Counselling Services.

1 Coote Terrace, Portlaoise, Co. Laois

Tel: 0502 21364 Ext 409

Catchment Area: Laois/Offaly.

Services provided include holistic methods, one-to-one assessment, family counselling & referral where appropriate.

Ana Liffey Drug Project

13 Lower Abbey Street, Dublin 1.

Tel: 01 8786899

Open: Monday to Friday 9.30 to 1pm; 2 to 5.30pm.

The Ana Liffey Drug Project is a voluntary organisation staffed by professionals. The service provides counselling, and has a drop-in centre at the above address. An appointment is needed for counselling. The organisation provides practical help and information for those with drug addictions and their families. There is also a support group called Cheile for parents who have lost children through HIV and AIDS. There are no fees for the services provided.

Centre Care

1A Cathedral St., Dublin 1

Tel: 01 6792681

Provides a referral service in relation to alcohol, drugs, smoking and eating disorders.

Clanwilliam Institute.

18 Clanwilliam Terrace., Grand Canal Quay, Dublin 2.

Tel: 01 761363.

Services include individual, family & group therapy, utilising rational and emotive Therapy Principals and emotive therapy principles and Minnesota model tasks. Detox can be arranged.

Cluain Mhuire Family Psychiatric Services

Newtownpark Ave, Blackrock, Co. Dublin.

Tel: 01 2833766 Fax: 01 2833886

Services provided include detox, day hospital group-orientated programme, out-patient assessment and follow-up.

Community Addiction Counselling

37 Castle Street, Dublin 2.

Tel: 01 4757837

Catchment Area: Community Care Area 3

Services provided include individual counselling (out-patient), advice, referral, and group work.

Community Addiction Counselling

Edenmore Health Centre, Edenmore Park, Raheny, Dublin 5.

Tel: 01 8480666

Catchment Area: Community Care Area 8

Services provided include individual counselling (out-patient), assessment, family counselling.

Community Addiction Counselling

Glen Abbey Centre, Belgard Road, Tallaght, Dublin 24.

Tel: 01 4516589/4516754 Fax: 01 4621283

Catchment Area: Community Care Area 4,5,9.

Services provided include individual counselling (out-patient), abstinence group, aftercare group, family members group.

Community Addiction Counselling

Health Centre, Shopping Centre, Ballymun, Dublin 11.

Tel: 01 8420011 Fax: 01 8420187

Catchment Area: Ballymun, Community Care Area 7

Services provided include individual counselling (out-patient), advice, referral, and group work.

Community Addiction Counselling

Health Centre, Patrick Street, Dun Laoghaire, Co. Dublin.

Tel: 01 2808471

Catchment Area: Merrion Gates to Bray.

Services provided include individual counselling (out-patient), advice, referral, and group work.

Community Addiction Counselling

EHB Poplar House, Naas, Co.Kildare.

Tel: 045 876001 Fax: 045 879225

Catchment Area: Co.Kildare, West Wicklow

Services provided include individual counselling (out-patient), advice, education and referral, if necessary.

Community Addiction Counselling

Tallaght Community Drug Team, 515 Main Street, Tallaght, Dublin 24.

Tel: 01 4513894 Fax: 01 4520501

Catchment Area: Community Care Area 4

Services provided include individual and family counselling (out-patient), advice, information, community networking and referral, if necessary.

Coolemine Therapeutic Community

19 Lord Edward Street, Dublin 2.

Tel: 01 6793765/6794822. Fax: 01 6793430.

The Coolemine Therapeutic Community is a voluntary organisation which receives some funding from the Eastern Health Board, and from the Department of Justice. It is run by a combination of professionals (with backgrounds in psychiatry, medicine and reality therapy) and trained volunteer 'graduates' of the programme. Coolemine provides separate residential programmes for men and women, and a day programme for people with less serious addictions. There is also a family association which allows parents to help in a patient's recovery, and a parents' support group. Social Welfare allowance is used as payment for the residential programme. The Coolemine Community Residential Programme is a very intense programme designed for people with serious addiction to drugs. There is a waiting list for this service with referrals usually coming from the Drug Treatment Centre, the Courts, or Garda Stations.

Cuan Dara Detoxification Unit

E.H.B. Cherry Orchard Hospital, Ballyfermot, Dublin 10.

Tel: 01 6235817 Fax: 01 6235835

Catchment Area: E.H.B. Region

Provides two week detoxification followed by one month of counselling/group and family therapy on an in-patient basis.

Cuan Mhuire Rehabilitation Centre

Athy, Co Kildare; Newry, Co Down; and Bruree, Co Limerick.

Tel: 0507 31493/31564

Provides rehabilitation services for alcoholics and drug users.

Drug Treatment Centre Board

Trinity Court, 30/31 Pearse Street, Dublin 2.

Tel: 01 6771122.

Open: Monday to Friday 9.30am to 1pm, 2.15 to 5.30pm; Saturday and Sunday 10am to 12.30pm (only for those being treated).

The Drug Treatment Centre Board is a state organisation with a fully trained professional staff. The centre provides confidential treatment and counselling for all drug dependencies including cannabis and ecstasy. The centre gives advice and information and also provides group therapy and support groups. A methadone programme is available

for opiate addicts. Family group meetings are held every Wednesday at 11am. There are no fees for the services of the centre.

Eastern Health Board Drug and Alcohol Addiction Counselling Service

There is at least one drug and alcohol addiction counsellor in each of the Eastern Health Board areas. The Eastern Health Board addiction counsellors do not charge for their services. Below is the contact list for counsellors in the Dublin area.

Area 1: Dun Laoghaire

Area 2: Dublin South East

Area 3: Dublin South Central

Contact: **Lesley Proudfoot at Baggot Street Clinic, Dublin 4.**

Tel: 01 6602149.

Area 4: Dublin South West

Area 5: Dublin West

Contact: **Marian Packard in the Health Centre, Main Street, Tallaght.**

Tel: 01 4515486.

Area 6: Dublin North West

Area 7: Dublin North Central

Area 8: Dublin North

Contact: **The Stanhope Street Centre.**

Tel 01 6779447.

E.H.B. Satellite Clinic, Aisling

Cherry Orchard, Dublin 10

Tel: 01 6262476 Fax: 01 6262486

Catchment Area: Community Care Area 5

Services provided: include opiate detoxification (in-patient and out-patient); methadone maintenance; medical treatment and psychiatric assessment; H.I.V. testing; counselling and outreach.

E.H.B. Satellite Clinic, Baggot Street

19 Haddington Road, Dublin 4

Tel: 01 6602149/6602227

Catchment Area: Community Care Area 2

Services provided: include opiate detoxification (in-patient and out-patient); methadone maintenance; medical treatment and psychiatric assessment; H.I.V. testing; counselling and outreach.

E.H.B. Satellite Clinic, City Clinic

108-109 Amiens Street, Dublin 1

Tel: 01 8749360 Fax: 01 8749373

Catchment Area: Dublin 1

Services provided: include opiate detoxification (in-patient and out-patient); methadone maintenance; medical treatment and psychiatric assessment; H.I.V. testing; counselling and outreach.

E.H.B. Specialist Addiction Service

3rd Floor, Trinity Court, 30-31 Pearse Street, Dublin 2

Tel: 01 6717659

Catchment Area: Community Care Areas 1,3,4,5,7,8,9,10.

Services provided: include opiate detoxification (in-patient and out-patient); methadone maintenance; medical treatment and psychiatric assessment; H.I.V. testing; counselling and outreach.

Mater Dei Counselling Centre.

Mater Dei Institute, Clonliffe Rd., Dublin 3.

Tel: 01 371892.

Services cover a wide range of adolescent problems with special emphasis on the treatment of substance abuse which is dealt with in a family context.

Merchants Quay Project

Franciscan Friary, 4 Merchants Quay, Dublin 8

Tel: 01 6790044

Open: Monday to Friday 10am to 4.30pm; opens Thursday at 2pm.

The Merchants Quay Project is a charity, staffed by trained volunteers, professionally trained social workers and reality therapists. The Project provides a contact centre for drug users, and works with every level of addiction from harm reduction to detoxification and recovery. Counselling is available, and people are assigned to a particular counsellor. The families of drug users can also attend and a creche is available. The centre encourages creative enterprises, such as painting and drama, and clients may also receive acupuncture and massage. There is a Residence Facility which can cater for up to six people for four weeks. There are no fees for the services provided by the Project and you do not have to be drug free to attend.

Nar-Anon

c/o 38 Gardiner Street, Dublin 1.

Tel: 01 8748431 Answering machine service.

Nar-Anon is a voluntary organisation run by the families of people with narcotic users in the family for families in similar situations. There are open meetings on the first Monday of every month at 11am in the Drug Treatment Rehabilitation Board Centre, at Trinity Court, 30/31 Pearse Street, Dublin 2. The meetings are aimed at helping families accept that the addiction is a disease, reducing family tension, and encouraging the user to seek help. Nar-Anon can make referrals but it is primarily a support group. There are no fees for Nar-Anon.

Narcotics Anonymous

PO Box 1368, Sheriff Street, Dublin 1.

Tel: 01 8300944(ext486)

Aims to help drug users recover from addiction. Services include regular support meeting and a telephone answering service.

Saoirse Addiction Treatment Centre.

Brankhill, Belturbert, Co. Cavan.

Tel: 049 22515

Services include the "Whole Person" approach, family involvement, group/individual counselling, and a referral service where appropriate.

The Hanly Centre

The Mews, Eblana Ave., Dun Laoghaire, Co. Dublin.

Tel: 01 2807269/2809795

Services provided include Minnesota Model, A.C.O.A., courses, feeling & awareness, therapeutic group for spouses & concerned persons.

Talbot Centre

29 Upper Buckingham St., Dublin 1.

Tel: 01 363434.

Services include one to one counselling for adolescents, group work, compensatory education, and self development.

The Rutland Centre Ltd

Knocklyon House, Knocklyon Road, Templeogue, Dublin 16.

Tel: 01 4946358/4946761/4946972

The Rutland Centre is a private centre run by qualified professional staff. The centre specialises in the treatment of addiction, namely alcohol, drug, and gambling addictions, and provides educational information on the nature and effects of addiction. The centre offers a drug free programme, counselling, and support groups for clients and their families. The fees for the centre are calculated on a sliding scale.

RESEARCH AND INFORMATION RESOURCES

Drug Misuse in Britain 1994

by ISDD.1993

Gives reliable and factual information on the drugs situation in Britain, it lists all the major studies and projects. The main drawback of this book is that Ireland is not included. Published by: *Institute for the Study of Drug Dependence, Waterbridge House, 32-36 Loman Street, London SE1 OEE.*

E Ecstasy and the Dance Culture

by Nicholas Saunders, 1995

Probably the most comprehensive source of information about ecstasy and the dance culture ever produced. It provides a detailed background to the history of ecstasy, the dance culture, the effects of ecstasy (positive and negative), its possible uses, personal experiences, other dance drugs etc.

Published by: *Self published, London.*

E For Ecstasy

by Nicholas Saunders, 1993

Thorough review of the medical, social and legal history of MDMA is presented, in a well documented analysis of this highly controversial drug, at the height of its popularity. The rave scene is described, as is the beginning acceptance of MDMA as a valuable therapeutic tool. An annotated bibliography by Alexander Shulgin is attached.

Published by: *Self published, London.*

ECSTASY, The MDMA Story

by Bruce Eisner, 1989

Complete review of much of the background and history of the origin and entry of MDMA into youth culture in America.

Published by: *Ronin Press, PO Box 1035, Berkeley, California, CA 94701, USA.*

If it Weren't for the Alligators: A History of Drugs, Music and Popular Culture in Manchester

by Rowdy Yates

Funny and moving book which provides a personal account from Lifeline's ex-director of the history of Lifeline from the Barbiturate haze of the early 70s to the rave generation of the 90s.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW 1LW.*

Recreational MDMA use in Sydney: a profile of 'Ecstasy users and their experiences with the drug'

by Nadai Solowij, Wayne Hall & Nicole Lee, 1992

Detailed case study of 100 ecstasy users in Sydney, Australia. Looks at ecstasy and other drug use, frequency of use, effects (positive and negative), dosage, tolerance and consistent use.

Available from: *National Drug and Alcohol Research Centre, University of South Wales, P.O. Box 1, Kensington, New South Wales 2033, Australia.*

Smack in the Eye: An Evaluation of a Harm Reduction Comic for Drug Users

by Michael Linnell, 1993

Report that explains the rationale and theoretical basis for Lifelines publications approach. Data from over 400 drug users who responded to a questionnaire is used to evaluate what effect the comic has on its audience, does it do any good?

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW 1LW.*

Street Drugs

by Andrew Tyler, 1995

Excellent introduction to the whole range of drugs issues. It deals chapter by chapter with the different drug groups including tobacco and alcohol. It also includes histories of each drug group and self-help tips and advice for coming off. The author presents all sides to each debate covered but is not afraid to give his own opinions and also addresses the substantial shifts in culture, policy, treatment and services. This is a very readable book where complex issues are dealt with in an in-depth manner but without the scientific jargon. Available on loan from: *The Breakthru' Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

The Agony of Ecstasy

by Julian Madigan, 1996

Insightful book written by a young man from Dublin who has been through the ecstasy experience and the rave scene and come out the other side. It provides a compelling account of his experience and a number of chapters are written by his father outlining his perspective and feelings as events were occurring. Published by: *Poolbeg Press Ltd, 123 Baldoyle Industrial Estate, Dublin 13.*

The Ecstasy Papers

by ISDD, 1993

Collection of articles taken from Druglink Magazine produced by the ISDD. It gives an excellent rundown on the 'dance culture' and the drugs scene that goes with it. The articles are extremely readable, accompanied by cartoons and quotations from young users and ravers.

Published by: *Institute for the Study of Drug Dependence, Waterbridge House, 32-36 Loman Street, London SE1 0EE.*

The Pursuit of Ecstasy - the MDMA Experience

by Gerome Beck and Marsha Rosenbaum, 1994

Comprehensive examination of ecstasy by two sociologists who started their work less than two years after ecstasy was banned.

Published by: *State University of New York Press, New York, U.S.A.*

Young Women, Sexuality and Recreational Drug Use

by Sheila Henderson, 1993.

Report focused on the use of 'dance drugs' among young women, their sexual behaviour, attitude to sex and HIV/AIDS and their leisure and wider lifestyles.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

EDUCATION AND TRAINING RESOURCES

Cocaine to Crack

by Educational Media International

Dramatic film relating a chilling tale of how two teenagers develop a severe addiction to cocaine and eventually crack.

Available from: *Educational Media International, 235 Imperial drive, Rayners Lane, Harrow, Middlesex. HA2 7HE.*

Drug Education for Young Offenders

by TACADE

Specialist resource containing a compendium of learning activities for drug education with young offenders who are drug users. The manual is made up of five units with detailed guidelines. Can be used for group work or one to one work. There are also handouts, reference materials and a reading list. Available from: *TACADE, 1 Hulme Place, The Crescent, Salford, Greater Manchester, M5 4QA.*

Drug Education : A Handbook for Teachers and Youth Leaders

by Graham T. and Linda Davies

Designed to provide support materials for teachers and youth workers involved in drug education. It contains a record of training, easy reference to drug related facts and the primary considerations involved in implementing a drug education programme.

Available from: *Health Promotion and Education Centre, Carville House, Rookwood Hospital, Llandaff, Cardiff, Wales.*

Drug Myths: A parents guide

by Lifeline

Guide for parents to the common myths around drug use, that can lead to fear and misunderstanding.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

Drug Questions - Local Answers?

Health Promotion Unit, Department of Health

Community-based training programme for health/education professionals, Gardai, youth workers and others interested in drug-related problems which they meet in their own work. The Health Promotion Unit runs convenor training programmes for this pack in conjunction with the eight regional health boards. As a result of these courses a large number of convenors have been trained to use this pack.

Available from: *Health Promotion, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

Drug Warning

by David Stockley

Practical guide to identifying and recognising various illicit drugs such as analgesics, heroin/opium, hallucinogens, tranquillisers, cannabis and solvents. It is easy to use with colour coding to help you find the chapter on drugs which you require. It also provides pictures of drugs and information about everything you need to know about them. It is very comprehensive and easy to understand.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

Drugs

Covers some of the most important issues surrounding young people's use of drugs including information on trends, the dangers, drug education, drug-related crime and what can be done about drug use. Each chapter tackles a different issue and focuses on key questions which young people can discuss with other young people, teachers and

even parents. It also gives a list of publications on drug use for further reading as well as a list of National and Local organisations who could be contacted for help and information.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

**Drugs Issues for Schools
by Colin Chapman, 1992**

Complete guide to drugs and the issues surrounding them which directly affect schools. It includes a section on drug education which evaluates the different approaches from deterrence to peer-led education. It also offers sound practical advice on how to cope with drugs problems within schools including how to develop a coherent drugs policy. The final section contains useful background information on why young people use drugs, trends in drug use and information on drugs and their effects.

Published by: *Institute for the Study of Drug Dependence, Waterbridge House, 32-36 Loman Street, London SE1 OEE.*

**Drugs: Your Questions Answered
by ISDD**

Provides a selection of short chapters from other longer works. It deals with illegal drugs and is a very good introduction to a wide range of drugs issues. Topics covered include effects of drugs on the family, drugs and crime, the legalisation debate, existing drugs strategy for the UK. This book also includes a very good final chapter exploding myths which have developed about drugs.

Published by: *Institute for the Study of Drug Dependence, Waterbridge House, 32-36 Loman Street, London SE1 OEE.*

**Drugwise Drug Free - A Drug Education Programme for 14-18 Year Olds
by Scottish Office**

Video and training manual which is aimed at 14-18 year olds. It is complete with photocopiable activity sheets which aid the students to be more aware that the substances which are sold on the streets are often of unknown purity, that dealers are only interested in making money. It also explores the legal difference between possessing and supplying drugs and the legal penalties which accompany. These issues are explored through group activities and group discussion in order to enable the young person to develop a clearer understanding of the implications for them.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

**Drugwise First - A Drug Education Programme for 5 to 10 year olds
by Scottish Office**

First in the series of drug education programmes which have been specially written for use in schools. It is aimed at 5-10 year olds. The package contains a training manual and photocopiable activity sheets. The package aims to make children aware of drugs as medicines, that there are simple safety rules regarding drugs and other substances. It highlights the fact that although some people require medicines to live a normal life, drugs may have side effects and are harmful if not used properly. The package also introduces to children the basic techniques for resisting pressure from friends and others in order to be safe in situations where they may be at risk.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

**Drugwise Too - a Drug Education Programme for 10-14 year olds
by Scottish Office**

Video and training manual which is aimed at the 10-14 age bracket. It is complete with photocopiable activity worksheets which aid the students to be more aware of the risks in taking drugs (physical and social) through group discussions and enabling them to make more informed decisions if ever placed in a drug offer situation. There are two sections, one aimed at 10-12 age bracket and the other at the 12-14 age bracket. The training manual is flexible in that it realises that attitudes constantly change within our culture and especially throughout adolescence making it harder to resist peer pressure.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

**'E' By Gum: With Peanut Pete
by Lifeline**

Pete has no money to go to the Rave until his "Fairy Godfather" appears, grants his wishes and gives him some sound advice on safer ways of using Ecstasy.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW 1LW.*

Ecstasy and Eve: The Rainbow Series

by Lifeline

Looks at the story of ecstasy to date, the latest information on ecstasy, what's bought as ecstasy can often be Eve, and what is actually in some of the more common tablets and capsules bought in Britain?

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

Facts about Drug Abuse in Ireland

by Health Promotion Unit, Department of Health

Third updated addition of this book aimed at providing people in a non-technical way with background information on legal, medical, social and historical facts about drugs used for non-medical purposes in Ireland.

Available from: *Health Promotion Unit, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

Go Ask Alice

by Anonymous

Diary of a drug addict who didn't quite make it which has become a landmark publication. Essential reading!

Available from: *Corgi Books, Century House, 61 - 63 Onbridge Road, Baling, London, W5 5SA.*

Guidelines for Good Practice at Dance Events

by Scottish Drugs Forum, 1995

Guide to all aspects of running a safe dance venue. This is essential reading for all club owners. All aspects are covered including availability of free water, air conditioning and the reduction of heat levels inside venues, staff training, medical/first aid provision and guidelines on stewarding and security.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT70 1DX.*

Lets Act

by YCI/HEB

Training and resource pack for youth leaders to help them in tackling the issue of drug and substance abuse among young people.

Available from: *NYCI, 3 Montague Street, Dublin 2 (OR) HPU, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

Locating Drug Education

by Health Education Council

Resource pack aimed at youth and community groups in both club and detached work environments. It is not intended as a ready made drug pack but rather as a guide encouraging groups to assess the starting point of young people on this issue and to plan their own programme as a result.

Available from: *TACADE, 1 Hulme Place, The Crescent, Salford, Greater Manchester, M54QA.*

MDA (Snowballs): The Rainbow Series

by Lifeline

MDA is the parent of the family that has Ecstasy and Eve as two of its children. What is it? What experiences have users, many of whom bought it as Ecstasy, described? MDA is not a dance drug - it has a far darker side.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

My Best Friend: A Drug Education Story

by Health Promotion Unit, 1996

Video and booklet produced by the Health Promotion Unit of the Department of Health to assist educators in schools, youth organisations and other educational environments. It is primarily aimed at 13-17 year olds but can be used with a variety of groups in formal and informal educational settings. The package is designed to be used as part of an ongoing drug education programme.

Available from: *Health Promotion Unit, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

On My Own Two Feet

Health Promotion Unit, Department of Health

Programme developed by the Health Promotion Unit of the Department of Health and the Psychological Service of the Department of Education with assistance from the Mater Dei Counselling Centre. It is a comprehensive drug education programme which involves the whole school staff of participating schools. The programme consists of modules on *Identity and Self Esteem; Assertive Communication; Feelings; Influences on Young People; and Decision Making.* It is a participative programme, the aim of which is to enable students to develop their ability to take charge of their mental health and to make informed decisions about the use of drugs in their lives. Programme materials include information on ecstasy and its effects.

Available from: *Health Promotion Unit, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

Safer Dancing Guidelines

by Dr. Russell Newcombe

Written for Lifeline and Manchester City Council, the Safer Dancing Guidelines are intended to promote good practice in nightclubs and raves. Covers temperature regulation, provision of cold water, training of security staff, etc.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

Snidey 'E'

by Lifeline

Cartoon bases booklet which answer questions on safe dosage, Ketamine - what is it? What does it do?, ecstasy mixed with Barbiturates, liver problems, epileptic fits, diabetes, asthma.

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

Snowdrops, Snowballs and Blue Bananas

by Contact Youth and N.I. Youth Forum

Excellent, locally produced resource contains a training manual and video. The pack concentrated on 'dance drugs'. The 30 minute video was scripted by Martin Lynch, one of Northern Ireland's best known playwrights. The story line is set in Belfast and tells the story of a teenager who enjoys the rave scene. He succumbs to peer pressure and gets into recreational drugs. The training manual describes what the drugs are and their side effects. It also gives guide lines as to how the video can be used in a group setting.

Available on loan from: *The Breakthru Project, 21 William Street, Dungannon, Co. Tyrone, Northern Ireland BT701DX.*

Solvent Abuse : A Guide for professionals and parents

by Health Promotion Unit, Department of Health

Resource handbook offering background information, recognition and prevention of solvent abuse and guidelines on helping the abuser for parents, youth leaders, teachers, social workers, probation and juvenile liaison officers, gardai and community and voluntary groups.

Available from: *HPU, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

Solvent Abuse Programme

by NYCI/HPU/Youth Affairs Section (Department of Education)

Programme designed to provide youth leaders with specially designed materials and information to enable them to plan and implement a solvent abuse programme with young people.

Available from: *NYCI, 3 Montague Street, Dublin 2 (OR) HPU, Department of Health, Hawkins House, Hawkins Street, Dublin 2.*

The Big Blue Book of Dance Drugs

by Lifeline

Provides detailed coverage of Cannabis, LSD, Ecstasy, Amphetamine, The Law, Drug Set and Setting and Drugs and Sex, (suitable for use in schools).

Published by: *Lifeline Manchester, 101-103 Oldham Street, Manchester MW1LW.*

Working with Solvent Sniffers

by Richard Ives

This booklet outlines some possible danger signs and details the legal position. It suggests a number of practical approaches for dealing with people who are using drugs or solvents.

Available from: *ISOD Publications, 1 Hatton Place, London EC1N 8ND.*

Youth Work Support For Dealing With the Drugs Issue

National Youth Health Programme, NYCI, 1996

Resource pack aimed at supporting youth organisations and workers dealing with the drugs issue and/or involved in drug education and prevention work. It is divided into four sections: Youth Work in a Drug Using Society; Youth Work Responses to Drug Use; Policy Development; and Supporting Information.

Available from: *National Youth Health Programme, NYCI, 3 Montague Street, Dublin 2.*

ECSTASY USE

As shown there is clear evidence from the current level of ecstasy seizures and the reduction in cost of ecstasy on the streets that there has been a significant increase in the availability of ecstasy in Ireland. Furthermore, recent reporting would seem to indicate that the number of ecstasy related deaths is on the increase. Taking these factors into account, it is reasonable to assume that the level of ecstasy use by young people in Ireland is on the increase and the upward trend is accelerating.

Verifying this trend and the undertaking of more in-depth research will be greatly assisted if and when the absence of reliable data on the level of ecstasy use in Ireland and the availability of ecstasy is addressed via a national study on ecstasy/drug use among young people. Such a study should assess:

- a) *the level of ecstasy use by young people;*
- b) *the frequency of use;*
- c) *the profile of the user i.e. age, gender, class, socio-economic background, location, living circumstances, etc;*
- d) *the links to other drug use;*
- e) *the attitude of users to media reporting of ecstasy use*
- f) *the attitude of users to and the scope of existing preventive and educational programmes aimed at responding to ecstasy use.*

ECSTASY RELATED CRIME

As illustrated in Chapter 3, 1995 was the first year in which the Gardai presented drug related prosecutions on a drug by drug basis. These figures allow one to make a comparison with the overall number of drug related prosecutions for 1995. Ecstasy related prosecutions accounted for 17% of all drug related prosecution for the year.

As an extension to this it would be valuable if drug seizures by the Gardai were broken down on a Gardai division by division basis and be included in the Garda Annual Crime Report in order to be able to analyse regional trends.

Also, it would be helpful to have drug related prosecutions broken down by age and gender and be included in the Garda Annual Crime Report. This would enable a more accurate profile of the user to be gleaned which in turn will assist those involved in the development of drug education and prevention programmes.

ECSTASY RELATED DEATHS

Chapter 3 illustrated the difficulties involved in accurately assessing the number of ecstasy related deaths that occur. The situation will be greatly improved when:

- (i) drug related deaths are categorised on a drug by drug basis by the Central Statistics Office and these figures are included in the quarterly and annual Vital Statistics publications.
- (ii) if a death has been ecstasy induced but the officially recorded cause of death is a brain haemorrhage, water toxification, organ failure etc, it should be officially recorded that ecstasy was a contributory factor to the cause of death. This should also be the case where any drug has been a contributory factor in the cause of death.

RESPONSES

The focus of most drug education initiatives/programmes and responses to drug use in Ireland to date has been on the use of hard drugs such as heroin and/or the socially accepted drugs such as alcohol and tobacco.

Any educational and prevention campaigns on ecstasy should take into account international experiences of initiatives/projects in countries such as England, Scotland and Netherlands as outlined in Chapter 5 who have implemented successful awareness campaigns on ecstasy specifically.

There should also be a particular focus on raves and nightclubs emphasising harm reduction measures for ecstasy users as highlighted in Chapter 2. Such a campaign in Scotland focusing on harm reduction has resulted in no reported ecstasy related deaths in the last eighteen months to two years.

TREATMENT

There is also a question with regard to specific treatment provision for ecstasy users in Ireland, with drug treatment/addiction centres primarily geared to respond to heroin and other hard drugs, alcohol, prescribed drugs etc. What research exists clearly illustrates that medium and long term use of ecstasy results in physical and psychological '*side effects*' for many users. As highlighted in Chapter 3 increasing numbers of ecstasy users are presenting for treatment at recognised drug treatment centres. Appropriate treatment provision should either be sourced within existing treatment provision or a new service should be initiated.

GENERAL

Finally, the situation with regard to ecstasy use is confused and at times contradictory. Depending on the source of information, one could categorise ecstasy as a drug with minimal risks involved, providing precautions are adhered to when using it, or, at the other end of the spectrum that it is a highly dangerous toxic substance with potentially serious medical and/or fatal consequences if used. The current debate has unfortunately been polarised into these two camps with little or no room for a middle ground. It is not helped by the majority of media coverage which tends to be sensationalistic portraying ecstasy as a '*death*' drug without the evidence to support this claim.

At this stage the bulk of information available on the potential effects of ecstasy, particularly medical, must be regarded as provisional and not conclusive. One will have to wait until large-scale longitudinal medical research has taken place on the effects of ecstasy before a definitive position will be able to be formulated. This will probably take 10 years or more as the only reliable way to evaluate the long term effects of ecstasy will be to look at long term consistent users.

However, it is self-evident, even at this stage that ecstasy is a dangerous illegal drug, the reaction to it will be very idiosyncratic to the user, and its use can cause negative short and medium-term effects that can result in death in certain cases.

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Appendix A: ECSTASY AND YOUNG PEOPLE SEMINAR PROGRAMME

SATURDAY 8 JUNE, 1996

- 10.30** **Registration/Tea & Coffee**
- 11.00** **Welcome & Introductions**
Fran Bissett, National Youth Federation
- 11.15** **ECSTASY USE IN IRELAND : AN OVERVIEW**
Speaker: John Mooney, Freelance Journalist (Input and Qs. & Ans. Format)
- 12.30** **Lunch**
- 13.30** **THE EFFECTS OF ECSTASY USE**
Speaker: Dr. Des Corrigan, School of Pharmacy, T.C.D. (Input and Qs & Ans. Format)
- 14.45** **Tea/Coffee**
- 15.00** **ECSTASY: THE LEGAL POSITION**
Speaker: Grainne Malone, Solicitor (Input and Qs.& Ans. Format)
- 15.50** **POLICE RESPONSE**
Speaker: Jim Keegan, Garda (Input and Qs.& Ans. Format)
- 16.45** **Review and Close**

SUNDAY 9 JUNE, 1996

- 10.00** **A PERSONAL PERSPECTIVE**
Speaker: Julian and Gerry Madigan, father and son, co-authors of The Agony of Ecstasy'
- 11.15** **Tea/Coffee**
- 11.30** **PROFILES OF PRACTICE**
Speaker: Carol McGill, Breakthru' Project, Dungannon
- 12.45** **Lunch**
- 13.45** **Profiles of Practice (Contd...)**
Speaker: Fearghal Connolly, Community Response, Dublin
- 15.00** **Profiles of Practice (Contd...)**
Speaker: Mary Ellen McCann, Ballymun Youth Action Project, Dublin
- 16.15** **Review and Follow-up**
Louise Hurley, National Youth Federation

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