

A Report
Prepared For The
Franciscan Friars
At Merchants' Quay
Dublin 8.

By
Kieran McKeown,
Grace Fitzgerald,
Ann Deehan

The Merchants' Quay Project



A Drugs / HIV Service in the
Inner City of Dublin,
1989 - 1992

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**The Merchants' Quay Project:
A Drugs/HIV Service In The Inner City of Dublin,
1989-1992**

by

Kieran Mc Keown, B.Soc.Sc., M.A.(Econ.), Ph.D.

Grace Fitzgerald, B.A.(Acc.)

Ann Deehan, B.Soc.Sc., M.Soc.Sc.

*Kieran Mc Keown Limited,
Social and Economic Research Consultants,
16 Holly bank Road,
Drumcondra,
Dublin 9.*

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Foreword

by

*Fr. Gerard Raftery, OFM,
Guardian, Franciscan Friary, Merchants' Quay, Dublin 8.*

The Franciscans have lived and worked on the south side of Dublin's Liffey since 1232. A presence of seven hundred and sixty years has seen many changes. The Friars live among the people and they have been affected by social, religious and political upheavals through the centuries.

In 1348 the Black Death swept through Dublin and among the thousands who died there were twenty four Franciscans. During the Reformation in 1540 the Friary at Francis Street was confiscated and the community dispersed. In the following century the Friars worked secretly in the Cook Street area. At that time they said Mass in Adam and Eve tavern, hence the popular name of the present day Church. Following Catholic Emancipation the Friars were able to build a new Church; its foundation stone was laid in 1843.

For over a century the main work of the Friars was in the Church services offered to the people of Dublin. Merchants' Quay was a popular place for Confessions, Mass was readily and frequently available, a thriving Third Order developed, devotion to Saint Anthony was cultivated. Until the 1960s Merchants' Quay was one of the most popular and well-attended churches in Dublin city.

The 1960s saw profound changes in central Dublin and in the Church. People began to move out of the city centre, tenements were torn down and communities dispersed to the new estates in the suburbs. Following the Second Vatican Council, the Church took an interest in matters of social justice. The Franciscans could not ignore the poverty and the social problems on their own doorstep and, as a result, some Friars became engaged in justice activities. The first Simon Community Shelter was set up on the Friars' property in Winetavern Street in 1969. Tea Rooms for the poor were opened by the Friars in the same year.

Side by side with Church and religious services the Franciscans in Merchants' Quay have found themselves engaged in a number of justice initiatives. The 1990 Provincial Chapter of the Franciscan Order in Ireland designated Merchants' Quay as a house for justice and peace activities. This gave a new impetus to the social justice agenda of the Friars in Adam and Eve's.

In recent years social disadvantage has expressed itself in new and more alienated forms within the inner city of Dublin. Drug use and its associated problems of HIV infection, crime, family problems, unemployment and poverty have affected the inner city area. The Friars at Merchants' Quay became conscious of the problem in 1989 and a project for people affected by drug use and HIV was established. Apart from the specialised work of the Merchants' Quay Project, the community continues to care for people who call to the Friary on a casual basis seeking food, accommodation and other help. Space is also offered to various self-help groups, religious groups and organisations engaged in justice activities.

The primary task of the Franciscans in Merchants' Quay is Evangelization. That means living and proclaiming the Gospel. The Gospel must be lived and proclaimed in the world in which we find ourselves. We are trying to read the signs of the times, to be in touch with the reality around us. We have invited a

social researcher. Dr. Kieran Mc Keown, to evaluate our work and help us to draw up action plans for the future. He and his colleagues have produced three reports* which are thorough, penetrating and challenging.

The Franciscans have been noted for their historical research; the work of the Four Masters is unrivalled as a document of history. The Kieran Mc Keown reports offer us another way of writing history; the present is history in the making. The Reports give us a comprehensive picture of some of the work of the Franciscans in Merchants' Quay in the 1990s, but they also tell us a great deal about the social realities of Dublin's inner city.

These reports are offered to all who are interested in the struggles of a religious community to be faithful to their founding charism and to the reality of today's world. These reports will have relevance to voluntary and statutory bodies engaged in work with the homeless, the socially disadvantaged, with drug users and those who are affected by HIV. We offer these reports to all who are concerned with social justice in Dublin and Ireland today.

Gerard Raftery, OFM
Guardian of the Franciscan Friary,
Merchants' Quay, Dublin 8.

* **Mc Keown, K., Deehan, A., Fitzgerald, G., 1993, *The Tea Rooms: An Overview of Saint Francis' Food Centre, Cook Street, Dublin 8, 1970-1992, A Report Prepared for the Franciscan Friars, Merchants' Quay, Dublin 8*, Dublin: Franciscan Friary, Merchants' Quay.**

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This Report was compiled with considerable assistance from all the people associated with Merchants' Quay Project.

Father Sean Cassin, OFM, founder and director of the Project, provided detailed information on its origin and development and assisted in the design of questionnaires. In addition to facilitating the research process, he made incisive and constructive comments on the interpretation of data throughout the report.

The volunteers in the Project, both current and former, completed 35 detailed questionnaires and facilitated our interviews with clients. We are extremely grateful to them and to the Coordinator of the Project, Tony Geoghegan, for the time and support they gave to the research, notwithstanding their heavy workload.

Deirdre Foran, Senior Health Promotion Counsellor with the AIDS Resource Centre, Baggot Street, Dublin 2 and Vice-Chairperson of the Board of Management of the Project, was extremely generous with her time and expertise in helping to design the questionnaire used to interview clients of the Project.

At an early stage of the research, discussions with Barry Cullen, former Director of the Ana Liffey Drug Project, and Anne Marie Jones, Coordinator of Cairde and former Member of the Board of Management of the Project, proved to be extremely valuable in drawing attention to some of the key issues for policy and practice in the area of drug use, HIV and AIDS.

Dr. James Walsh, National AIDS Adviser, Department of Health, was very helpful in supplying data on HIV and AIDS and in clarifying issues affecting its interpretation.

The interviews with 120 clients were carried out by current and former volunteers: Karen Flynn, Patrick Robinson, Tommy Larkin, Bobby Flynn, Marie Dillon, Jackie Blanchfield, Emily Reaper, Ita Kirwin, Brendan Murphy and Shey Pegley. One interview was carried out by Tony Geoghegan. Each interview lasted approximately one hour and entailed the collection of extremely detailed and sensitive information about clients. All of the interviews were carried out very competently and according to procedures which guaranteed the confidentiality of clients. Only one client refused to be interviewed.

In this context, it is important to record our gratitude to the clients who shared their life experiences with the interviewers. Many of their stories are extremely harrowing and distressing. This report tries to reflect, as far as possible within the limits of this medium, the truthfulness of their stories, so that their voices may be heard.

A number of discussions with Karen Flynn, formerly a volunteer in Merchants' Quay Project and currently an Outreach Counsellor with the AIDS Resource Centre, Baggot Street, Dublin 2, were extremely helpful in terms of interpreting the data on clients of the project.

The research was commissioned and funded by the Franciscan Friars in Merchants' Quay. Within the Friary, specific responsibility for overseeing the research rested with Father Gerard Raftery, OFM, Guardian of the Friary and member of the Board of Management of the Project, Father Donal O'Shea, OFM, Director of Initiatives for Justice and Peace in the Franciscan Province in Ireland, and Father Michael Martin, OFM, Chairperson of the Board of Management of the Project. The researchers are extremely grateful to these and all the Friars in Merchants' Quay for the support - including the provision of office space and access to other facilities - which they received in the course of the research.

Chapter One

Background and Context

1.1 Introduction

The Merchants' Quay Project: Drugs/HIV Service was set up to help prevent the spread of HIV through drug-use and related behaviour and to provide non-judgmental care and support to drug users with HIV and their families. Thus the twin problems of drug use and HIV provide the background and context to the project. This chapter summarises some general information on HIV, ADDS and drug use in Ireland. Section 1.2 summarises statistical information on the characteristics of known HIV+ cases in Ireland while section 1.3 analyses statistical trends in the characteristics of cases and deaths from AIDS in Ireland between 1982 and 1992. Section 1.4 provides a brief overview of the data on drug use in Ireland. The problems associated with HIV and drug use are partly related and the policy response has tended to treat them jointly. This policy response is examined in section 1.5. Finally in section 1.6 there is a brief summary of the key findings to emerge in the chapter.

1.2 HIV+ Cases in Ireland

Human Immunodeficiency Virus (HIV) is responsible for Acquired Immune Deficiency Syndrome (AIDS). AIDS is a breaking down of the body's immune system to the point where it increasingly fails to fight infections. It was first noticed as a new condition in the United States in 1981. In Britain the first case was also reported in 1981 while the first case in Ireland was reported in 1982. HIV is transmitted in four ways: (i) by sharing HIV-infected needles; (ii) by penetrative sexual intercourse with an infected partner; (iii) from an infected mother to her unborn child; (iv) through transfusion of infected blood/blood products.

Information on the number of HIV cases in Ireland to date is based on tests undertaken at the behest, or on behalf, of individuals. These tests are extremely accurate scientifically since each blood sample is tested three times before the outcome is confirmed by the Virus Reference Laboratory at University College Dublin. Table 1.1 gives a breakdown of the cumulative total number of tests undertaken between September 1982 (when the first HIV antibody tests were undertaken in Ireland) and August 1992 (the latest date for which statistics were available).

The data in Table 1.1 is based on "linked tests", that is, it is linked to named individuals. It differs from "unlinked tests" which are undertaken on anonymous blood samples and are also being undertaken in Ireland since October 1992 (see section 1.5 below). The significance of linked tests from a statistical point of view is that the persons who have been tested for HIV antibodies are not necessarily representative of the population in general. As a result, it is not possible from the data in Table 1.1 to extrapolate an estimate of the number HIV+ cases in Ireland generally.

The data in Table 1.1 indicates that, as of December 1992, a total of 65,823 tests for HIV antibodies have been carried out in Ireland. (These are not necessarily 65,823 separate individuals since some persons may have been tested more than once, although the extent of double counting is probably rather slight). Of these, 1,313 (2%) have been diagnosed as HIV+.

Nearly three quarters (73%) of all tests have been undertaken on persons in three categories: heterosexuals with an unspecified risk, insurance requests and visa requests. The overall likelihood of a test producing a HIV+ result is 2% although this varies substantially between each category and behaviour. The behaviour with the highest proportion of HIV+ results is injecting drug use; 11.4% (686) of those tested in this category have proved positive. Haemophiliacs have the second highest likelihood of being diagnosed as HIV+ (10.5%, 113) essentially because the virus was transmitted through infected blood transfusions, a risk that has since been eliminated. Homosexual behaviour has the third highest probability of producing a HIV+ diagnosis (7.7%, 231). So far, only two persons tested at the request of insurance and visa card companies have been diagnosed as HIV+.

Table 1.1 Cumulative Total Number of Cases Tested for HIV Antibody by Category of Person and by Outcome, 1982 -1992

Category of Persons Tested	Total Tests N	Total Tests %	HIV+ N	% HIV+ in Each Category	HIV+ as % of All HIV+
Injecting drug users	6,012	9.1	686	11.4	52.2
<i>Men</i>	4,156	6.3	507	73.9	38.6
<i>Women</i>	1,776	2.7	266	24.2	12.6
<i>Unknown</i>	80	0.1	13	1.9	1.0
Homosexuals	3,014	4.6	231	7.7	17.6
Heterosexual/risk unspecified	22,873	34.7	166	0.7	12.6
Haemophiliacs	1,074	1.6	113	10.5	8.9
Children at risk	1,033	1.6	85	8.2	6.5
Blood donors	1,657	2.5	17	1.0	1.3
Prisoners	393	0.6	13	3.3	1.0
Insurance	17,842	27.1	0	0.0	0.0
Visa requests	7,344	11.2	2	0.0	0.2
Organ donors	3,070	4.7	0	0.0	0.0
Hospital staff/occupational hazard	1,177	1.8	0	0.0	0.0
Transfusion	265	0.4	0	0.0	0.0
Haemophiliac contact	69	0.1	0	0.0	0.0
Total	65,823	100.0	1,313	2.0	100.0

Source: Based on data supplied by the Department of Health.

Notwithstanding the statistical limitations of the data in Table 1.1, it is not unreasonable to extrapolate that injecting drug use is the behaviour which has the highest risk of producing a HIV+ diagnosis. More than half (52%) of known HIV+ cases are associated with this behaviour. More significantly, the large number of injecting drug users who have been tested (6,012) relative to the estimated total number of drug users in the Greater Dublin Area (7,000) suggests that these test results are, other things being equal, probably a reasonably reliable indicator of the overall prevalence of HIV (11%) within this group. Other studies, however, have indicated an even higher prevalence of HIV among drug users in Dublin. In their study of heroin users attending the Drug Treatment Centre, Dean, et al, (1987, p.141) found that 27% of heroin users were HIV positive while another study of drug users in the south inner city of Dublin found that 35% were HIV positive (Bury, O'Kelly, 1988, p.102). It is noteworthy in this context that up to 90% of persons who are known to be HIV+ are estimated to be from the Greater Dublin Area (National AIDS Strategy Committee, 1992, p.9)

It is not possible from the data in Table 1.1 to draw any definitive conclusions about the prevalence of HIV in any of the other groups tested. This will have to wait for the results of more widespread unlinked testing of blood samples which started in Dublin in October 1992.

1.3 AIDS Cases and AIDS Deaths in Ireland

Statistics on AIDS cases and deaths is compiled by the Department of Health. The Department of Health, in turn, supplies quarterly statistics on AIDS to the WHO-EC sponsored European Centre for the Epidemiological Monitoring of AIDS in France. In June 1992, the cumulative total number of recorded AIDS cases in Ireland was 276. In other words, approximately one fifth of persons with HIV have developed AIDS.

Figure 1.1 shows how the number of AIDS cases has increased systematically in each year since the first cases were recorded in 1982. However between 1988 and 1992 the growth in the number of new AIDS cases has fallen precipitously: in 1988 the growth rate was 85%; in 1989 the growth rate was 35%; in 1990 the growth rate was 10%; in 1991 the growth rate was 13%; and in 1992 the growth rate was 8%. These growth rates need to be interpreted carefully however in view of small number of new cases of AIDS recorded each year.

Figure 1.1 New AIDS Cases Recorded in Ireland Each Year, 1982 - 1992

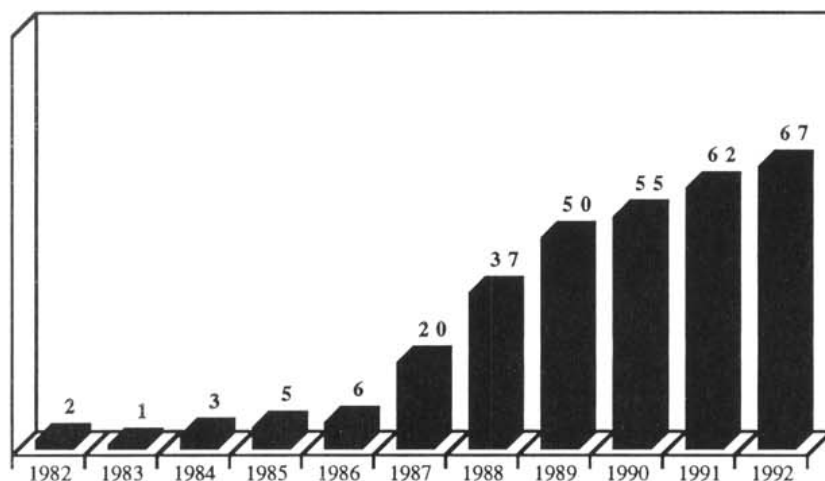


Figure 1.2 Gender of Recorded AIDS Cases in Ireland, 1982 - 1992

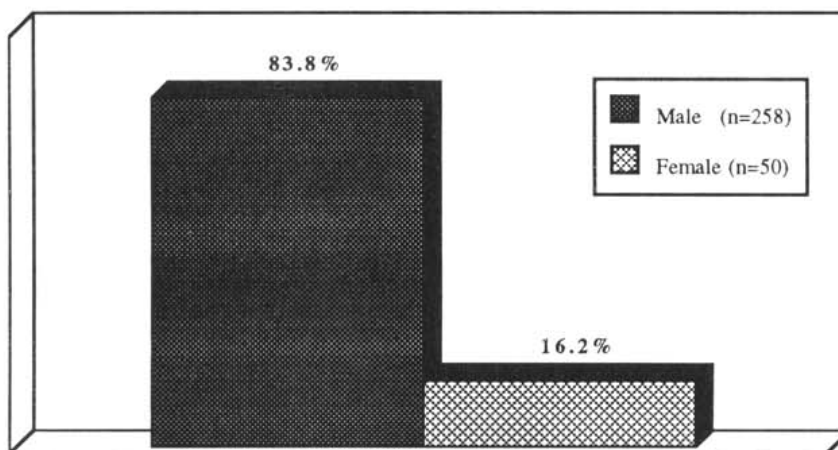
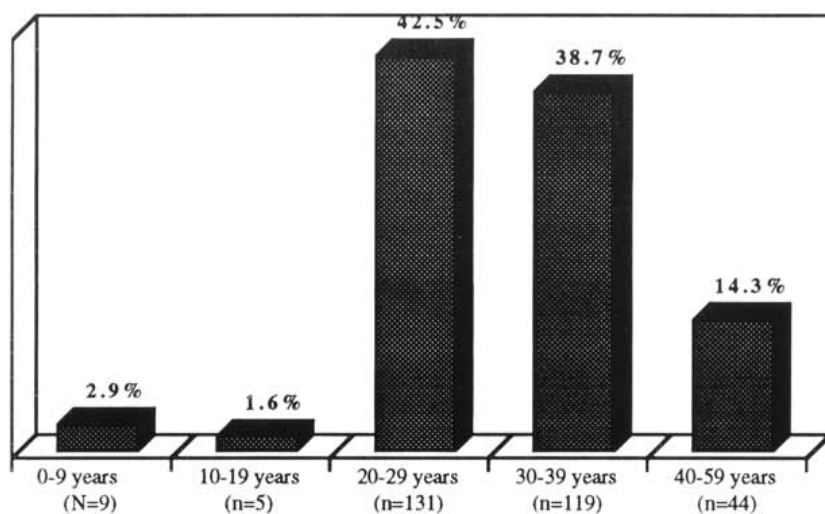


Figure 1.3 Age of Recorded AIDS Cases in Ireland, 1982 - 1992



Source: Based on statistics supplied by the Department of Health.

The majority of AIDS cases (258, 84%) are male, as Figure 1.2 indicates.

Figure 1.3 reveals that more than four fifths (250, 81%) of all AIDS cases are aged between 20 and 39 years.

The distribution of AIDS cases by transmission category is summarised in Figure 1.4. This indicates that just under half (142, 46%) of all recorded AIDS cases in Ireland are related to injecting drug use. Eight of these are babies born to mothers who inject drugs. The second largest group is male homosexuals/bisexuals who constitute over one third (109, 35%) of all recorded AIDS cases. One tenth (10%, 31) of AIDS cases arose through heterosexual contact, one of them a baby born to a heterosexual mother.

AIDS cases have led to AIDS deaths because that there is no vaccine against HIV nor is there a cure. Many AIDS-related illnesses can be treated, however. The incubation period between the time of HIV infection and the time of serious AIDS illness can vary from four to fourteen years. Figure 1.5 summarises data on the number of recorded AIDS deaths in Ireland up to December 1992. A total of 137 deaths have been recorded, equivalent to just under half of all AIDS cases.

The distribution of AIDS deaths by transmission category is similar to that for AIDS cases with just under half (61, 45%) of all deaths related to drug use, six of them involving babies born to mothers who inject drugs. One third (45, 33%) of all deaths have been among male homosexuals/bisexuals. Fifteen persons who contacted the disease through heterosexual contact have died while 12 haemophiliacs who contacted the disease through an infected blood transfusion have also died.

The most salient finding to emerge from the data in this section is that the largest number of AIDS cases and AIDS deaths are to be found among those who inject drugs. The largest number of persons who have tested HIV+ are also to be found in this group, as the previous section indicated. Thus injecting drug use is the highest risk behaviour in terms of the transmission of HIV. Persons engaging in this behaviour are typically in great need of care because of the multiple problems associated with both HIV and injecting drug use.

The prevalence of HIV and AIDS in the other groups is still unknown and will not be known until more widespread HIV testing of blood samples is undertaken on the population at large. Accordingly there is a risk that the existing data may seriously underestimate the true extent of HIV in the population .

1.4 Drug Use in Ireland

Information on the nature and extent of drug use in Ireland is largely confined to the Greater Dublin Area and refers primarily to the “drug *treated population*” . This is not the same as the total population using drugs however since it is likely that a significant proportion of persons using drugs are not be in receipt of any form of treatment. Moreover it would be extremely difficult to quantify precisely the total number of persons using drugs given that this is an illegal activity and those engaged in it are difficult to contact. Notwithstanding these difficulties, one estimate suggested that there were 4,000 heroin users in Dublin in 1988 (Catholic Social Service Conference, 1988, p.21) while another estimate placed the number of intravenous drug users in the Greater Dublin Area in 1990 at 7,000 (O’KeUy, 1990, p.13; O’Kelly, Bury, Carey, 1990, p.1). According to O’Hare and O’Brien (1992, p.54), an estimated 1,752 persons received treatment for drug use in Dublin in 1990, about a quarter of the estimated number of drug users.

The lack of data on drug use outside the Greater Dublin Area was indicated in the report. Government Strategy To Prevent Drug Misuse (Department of Health, 1991, p. 5). Impressionistic data on drug use outside the Greater Dublin Area was collected from key agencies and professionals for that report and their overall conclusion was that “*the problem of serious drug misuse seems to be confined to the Dublin area*” (Ibid., p.6).

In 1989 a comprehensive Dublin Drug Misuse Reporting System was set up in the Health Research Board to collate information on drug users in 22 different treatment centres throughout the Greater Dublin Area. This, in turn, is part of a much larger Drug Misuse Reporting System set up in 10 European cities by the Pompidou Group of the Council of Europe. In the Greater Dublin Area anonymous information on clients in treatment centres is returned to the Health Research Board on a regular basis, providing almost complete coverage of the

Figure 1.4 Recorded AIDS Cases in Ireland by Transmission Category, 1982 to June 1992

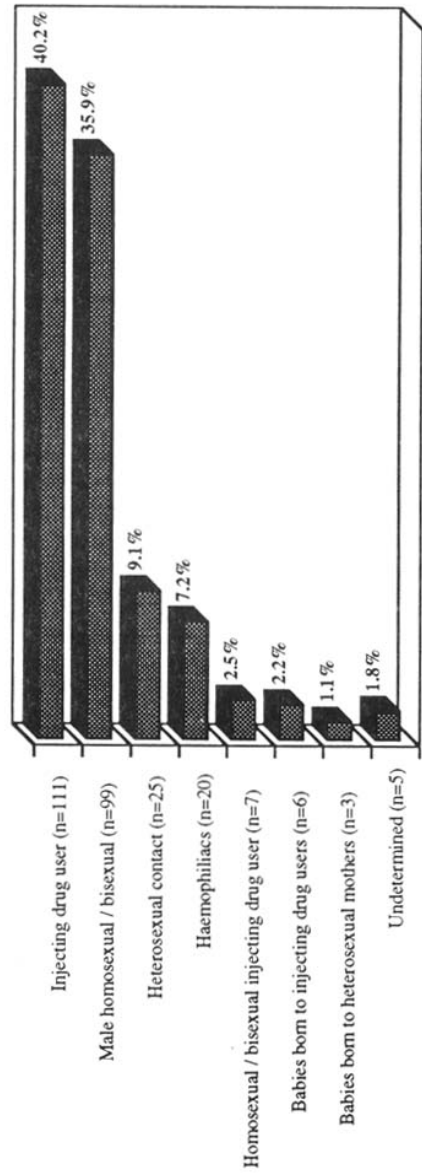
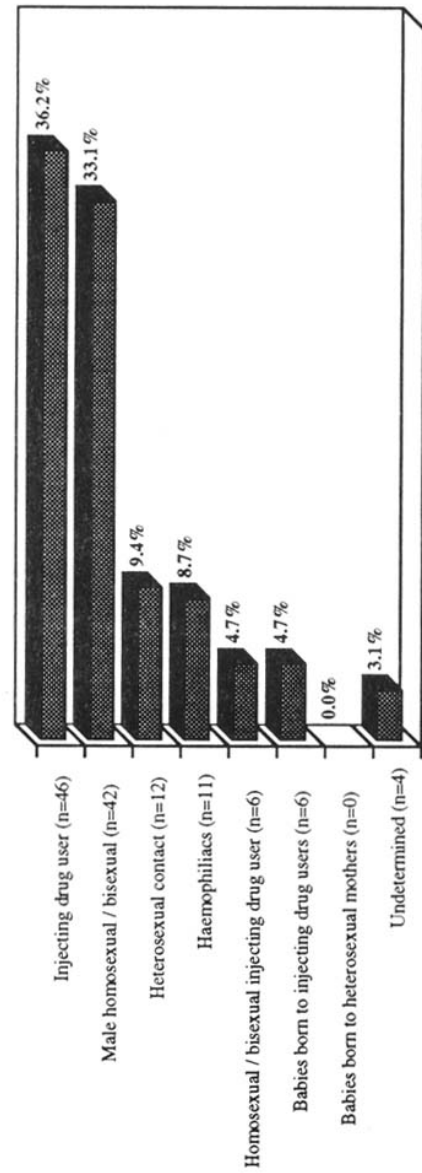


Figure 1.5 Recorded AIDS Deaths in Ireland by Transmission Category, 1982 to September 1992



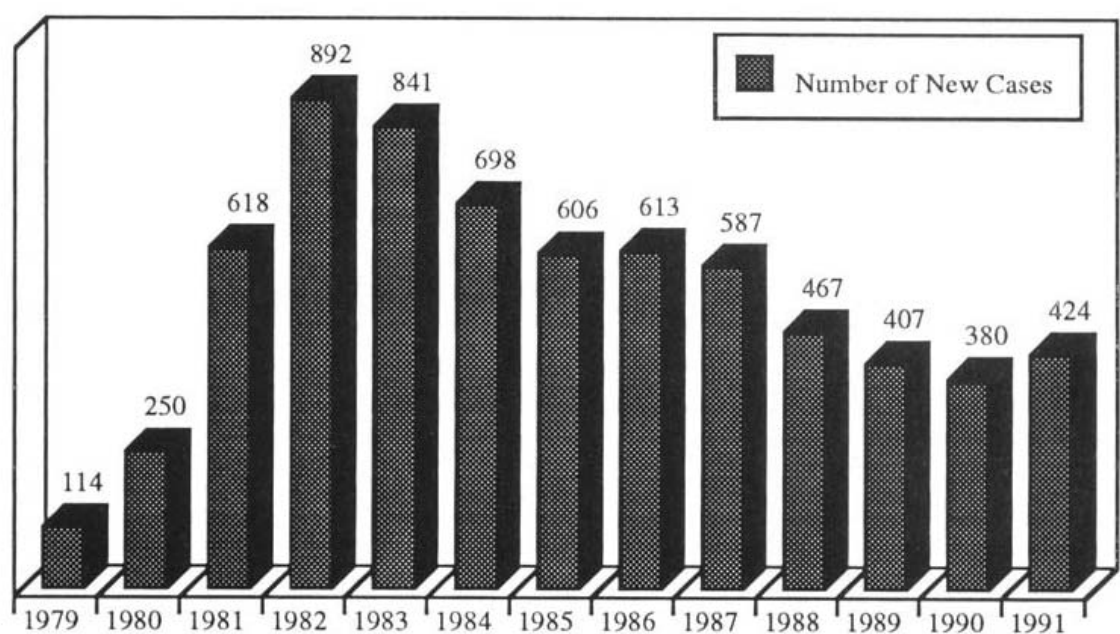
Source: Based on statistics supplied by the Department of Health.

treated drug misuse population in the Greater Dublin Area. A central proposal of the Government Strategy To Prevent Drug Misuse is to extend this system to the entire country (Department of Health, 1991, p.9). Accordingly, a National Drug Misuse Database is currently being set up by the Health Research Board (Health Research Board, 1992, p.19). The first report of the Dublin Drug Misuse Reporting System - Treated Drug Misuse in the Greater Dublin Area 1990 - covering 1990 was published in November 1992.

Prior to 1990, the most reliable indicator of general trends in the incidence of drug use in Dublin was the number of new cases seen in the Drug Treatment Centre. The Drug Treatment Centre was established in 1969 in Jervis Street Hospital, Dublin 1, with both out-patient and in-patient facilities. Since 1988 the out-patient unit is situated in Trinity Court, 30-31 Pearse Street, Dublin 2, while the in-patient, 10-bed, detoxification unit is located in Beaumont Hospital, Dublin 9. It is the main centre in Ireland which offers medical treatment to drug users along with therapy and counselling. The Drug Treatment Centre treats drug users from all parts of Ireland although 90% of their cases are from the Eastern Health Board Area and the vast majority of these in turn are from the Greater Dublin Area.

Figure 1.6 summarises data on the number of new cases seen in the Drug Treatment Centre between 1979 and 1991. The data reveals a dramatic increase in the number of new cases seen in the Drug Treatment Centre between 1979 and 1983. The majority of this increase came from opiate users, particularly heroin addicts, giving rise to an “*opiate epidemic*” in Dublin between 1979 and 1983 (Dean, et al., 1987, p. 139; see also Dean, et al., 1985).

Figure 1.6 Number of New Cases Attending the Drug Treatment Centre, 1979-1991



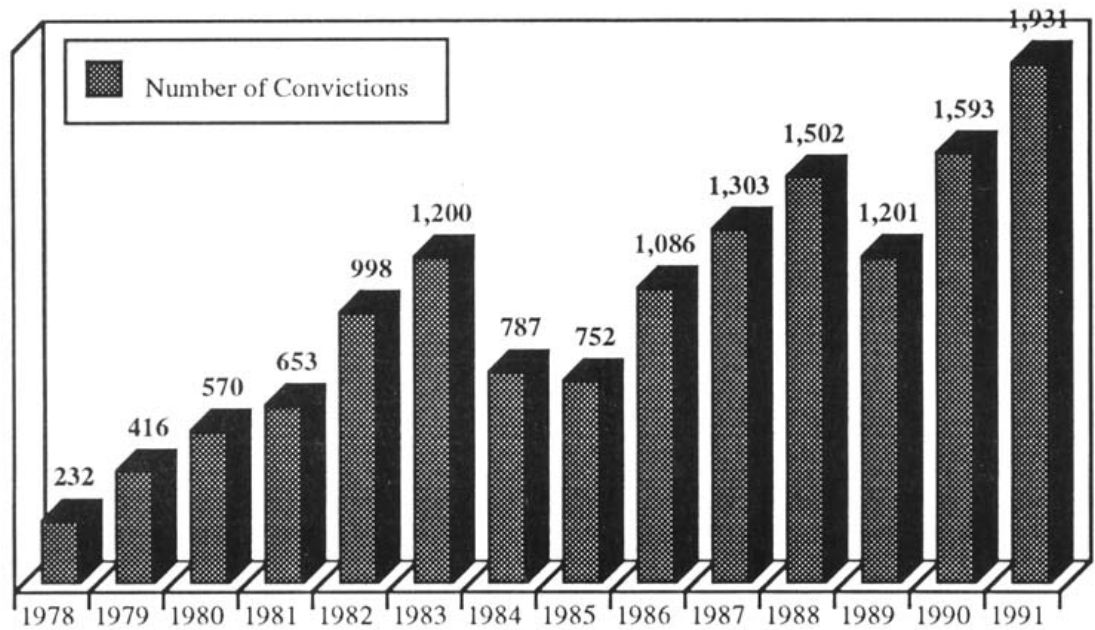
Source: Based on data supplied by the Drug Treatment Centre, 1992.

Commenting on this period, Butler (1991, p.218) writes: “*From that year [1979] onwards ... there was a dramatic upsurge in the use of opiates, particularly heroin, in the Dublin area; this new wave of drug use saw the emergence of a ‘needle culture’ for the first time in Ireland, as intravenous drug use became the norm. Another unwelcome change was the advent of organised, commercial drug pushing*”. It is noteworthy in this context that Concerned Parents Against Drugs was set up in Dublin in the summer of 1983 to “deal” directly with drug pushers (usually independently of the Garda Síochána), frequently forcing drug pushers to leave their homes (see Bennet, 1988).

Since 1982, as Figure 1.6 reveals, the number of new cases seen in the Drug Treatment Centre has fallen. Between 1988 and 1991, the average number of new cases seen per year was 420.

Figure 1.7 summarises statistics on the number of convictions for drug offences between 1978 and 1991. This reveals that the number of convictions for drug offences rose steadily up until 1983. The number of convictions fell dramatically in 1984 but has increased consistently in each subsequent year (with the exception of 1989). In 1991 it reached its highest level ever. On the basis of this indicator therefore, it would appear that the level of drug use in Ireland could have regained the levels of 1983 when the situation was described as epidemic.

Figure 1.7 Number of Convictions for Drug Offences in Ireland Under Misuse of Drugs Act, 1977/1984, Between 1978 and 1991



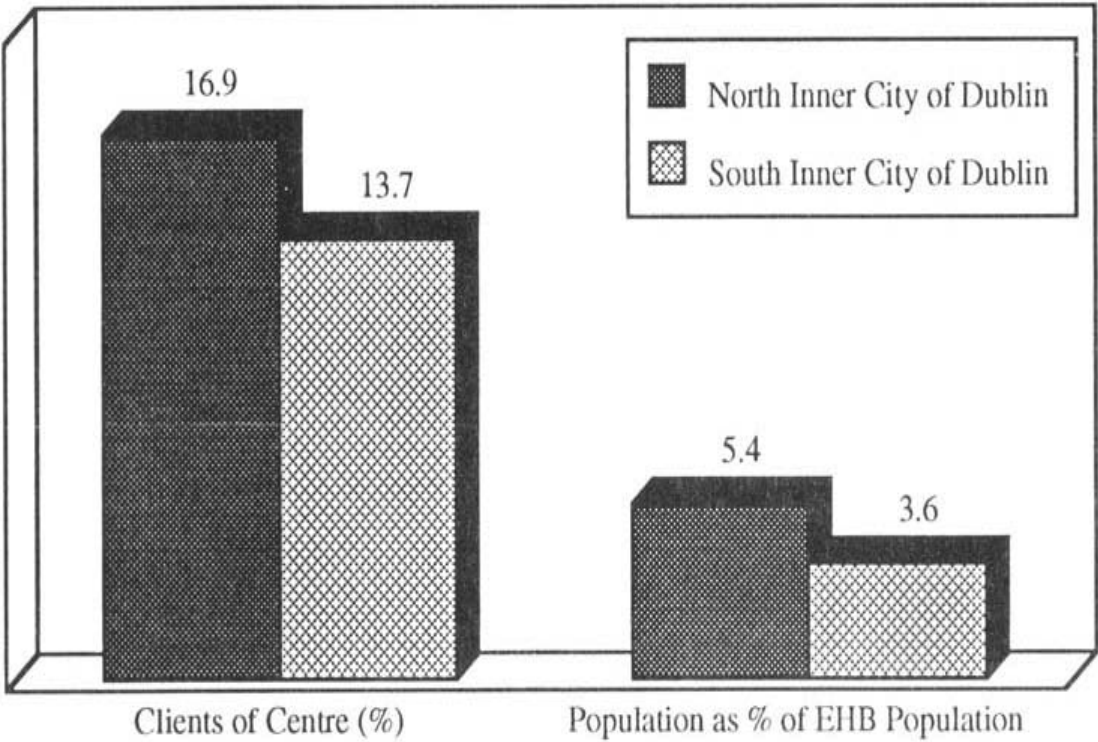
Source: Garda Siochana, Reports on Crime, 1975-1991, Dublin: Garda Siochana Headquarters.

Informed opinion on drug use in Ireland and in Europe generally suggests that, in the 1990s, drug use may be on the increase again, following the peak in 1983. According to the Government Strategy to Prevent Drug Misuse: “during 1990 there were indications (an increase in the number of drug misusers, in drug related deaths and in seizure of illicit drugs) of an upsurge of drug activity in Europe, including the United Kingdom. There is some evidence of a similar increase here. There has been an upturn in seizures and in persons charged. These, and suggestions of an increase in street availability of cannabis and heroin, need to be carefully monitored” (Department of Health, 1991, p.8).

In Dublin a disproportionately large number of drug users come from the inner city. This is confirmed by a number of studies (See Dean, Bradshaw and Lavelle, 1983; Dean, Lavelle, Butler and Bradshaw, 1984; Lavelle, 1986; O’Kelly, Bury, Cullen, Dean, 1988; Bury, O’Kelly, 1989; O’Hare and O’Brien, 1992) and is also suggested by an analysis of cases seen in the Drug Treatment Centre between 1986 and 1988. Figure 1.8 compares the proportion of cases from (the north and south inner city who were seen in the Drug Treatment Centre between 1986 and 1988 with the proportion of the population of (the Eastern Health Board (EHB) living in those areas. It reveals that an average of 16.9% of all EHB cases attending the Drug Treatment Centre came from the north inner city of Dublin even though only 5.4% of the population of the EHB area come from the north inner city. In other words, the proportion of drug users from the north inner city is three times higher than would be expected from its population size. Similarly the proportion of drug users from the south inner city attending the Drug Treatment Centre between 1986 and 1988 is also more than three times higher than would be expected from its population size (Mc Keown, 1991, pp.62-66).

Other studies have found that drug use in Dublin is associated with unemployment and poor living conditions (See Dean, Bradshaw and Lavelle, 1983; Dean, Lavelle, Butler and Bradshaw, 1984; Dean et al., 1985; Lavelle, 1986; O’Kelly, O’Doherty, Bury and O’Callaghan, 1986; Dean et al., 1987; O’Kelly, Bury, Cullen and Dean, 1988; O’Kelly, 1990; O’Hare and O’Brien, 1992). In this sense, the relatively high incidence of drug use in the inner city of Dublin can be interpreted as an indicator of other forms of deprivation in that area.

Figure 1.8 Drug Users from the North and South Inner City Attending the National Drug Treatment Centre Relative to Population Size, 1986 -1988



Source: Based on data supplied by the Drug Treatment Centre, Dublin, 1992.

Following her review of all the major studies on drug use in Dublin, O’Hare painted the following picture of the typical drug user: “... *all recent sources show heroin, administered intravenously, as the preferred drug for the majority of drug users - although it should be noted that most are polydrug users. The demographic and social characteristics of drug users are very similar. The majority are male, single, from a depressed socio-economic background, with low educational achievement and a poor employment record. Many come from problem family homes and have been in trouble with the law often before their involvement with drugs*” (O’Hare, 1987, p.86).

1.5 Policy Response to Drug Use and HIV/AIDS in the 1990s

The broad parameters of current public policy in the areas of drug use and HIV/AIDS were set down in the Government Strategy to Prevent Drug Misuse published in May 1991 (Department of Health, 1991). This strategy was produced in consultation with the National Coordinating Committee on Drug Abuse (composed mainly of senior civil servants) which was reconstituted in May 1990, and took account of submissions received from 22 statutory and voluntary organisations. A National AIDS Strategy Committee (also composed mainly of senior civil servants) was set up in December 1991 to advise the Minister for Health on specific aspects of policy on HIV/AIDS.

Before analysing the detailed measures which constitute this strategy it may be useful to examine why the same general strategy is used to address both drug use and HIV/AIDS. Drug use and HIV/AIDS are different problems in the sense that each can exist without the other. Drug use is not a necessary condition for contracting AIDS and many persons have AIDS who are not drug users. In Ireland however the two problems are closely connected since, as indicated in the previous section, 56% (582) of all known HIV+ cases are related to drug use, 44% (86) of known AIDS cases are related to drug use, and 41% (33) of known AIDS deaths are related to drug use. While closely related, it is worth emphasising however that substantial proportions of other social groups, most notably, homosexuals/bisexual, are also affected by HIV/AIDS.

The implication of the close connection between drug use and HIV/AIDS is interpreted in the Government Strategy to Prevent Drug Misuse to imply that “;*is impossible to separate policies relating to drugs from those of AIDS/HIV transmission*” (Department of Health, 1991, p.8). This (overstatement of the connection is the foundation for adopting a largely unified policy approach to drug use and HIV/AIDS: “*In Ireland it is difficult to separate policies dealing with drug use from the HIV/AIDS problem. The Government propose, therefore,*

that measures will be taken to ensure that the closest possible contact and liaison exist between agencies operating in both fields to ensure integration of policies. In this respect, the Government propose that health boards will, as far as is practicable, co-ordinate their programmes in the AIDS and Drug Misuse Areas and designate a senior officer as AIDS and Drug Misuse Regional Co-ordinator” (Department of Health, pp.17-18).

Notwithstanding the substantial overlap in public policy between drugs and HIV/AIDS, there are four elements in the policy on HIV/AIDS which are not targeted specifically on drug users. The first is a national HIV surveillance programme to determine the incidence and prevalence of HIV among the population at large and among at-risk groups in particular. This programme involves anonymous blood tests (i.e. the blood is not linked to any named individual, unlike all testing to date in this area) and is being implemented in three phases: testing of blood in ante-natal clinics; testing of blood in general hospitals; and testing of blood samples from users of drug centres and STD (sexually transmitted diseases) clinics. Phase One of this surveillance programme, based in ante-natal clinics, began in October 1992, following a pilot scheme on ante-natal mothers in the Rotunda Hospital, Dublin 1.

The second element in the HIV/AIDS policy involves setting up AIDS Resource Centres, possibly five or six, in the main centres of population which will offer HIV testing, combined with pre-and post-test counselling as well as needle exchange and methadone maintenance for drug users. Two of these “satellite clinics” (National AIDS Strategy Committee, 1992, p.12) were formally opened by the Minister for Health in Dublin in September 1992: one at Baggot Street Hospital, the other at Cherry Orchard Hospital each serving, respectively, the south and the west of Dublin.

The third element in HIV/AIDS policy involves the appointment in September 1992 of a Consultant in Infectious Diseases at the Mater and the Beaumont hospitals to facilitate in-patient care for persons with AIDS on the north side of Dublin; St. James’ Hospital on the south of the city already has a medical consultant specialising in AIDS.

The fourth element in the HIV/AIDS policy is prevention and this mainly involves the dissemination of information on HIV and AIDS through mass media, posters, leaflets, booklets, videos and outreach initiatives. These are being targeted at the general public as well as specific groups such as young people, young emigrants, drug users, homosexuals/bisexuals and prostitutes.

These elements, together with the Government Strategy to Prevent Drug Misuse, constitute the public policy response to both drugs and HIV/AIDS in Ireland in the 1990s. The measures in the Government Strategy to Prevent Drug Misuse can be classified into three broad categories:

- measures to reduce the supply of drugs
- measures to reduce the demand for drugs
- measures to increase access to treatment and rehabilitation, both for drug users and persons with HIV/AIDS.

Each set of measures will now be described briefly.

1.5a Supply Reduction

The Government Strategy to Prevent Drug Misuse identifies four actions which would help to reduce the supply of drugs in Ireland (Department of Health, 1991, Chapter Two). These are:

- a streamlining of controls contained in the Misuse of Drugs Acts 1977 - 1984 and the Misuse of Drugs Regulations 1988.
- confiscation of the proceeds of drug trafficking in accordance with the United Nations Convention.
- increased powers for Customs Authorities to combat the importation of drugs concealed in body cavities.

1.5b Demand Reduction

The demand for drugs comes from two sources: from existing drug users and from potentially new drug users. Demand reduction measures for existing drug users effectively involve treatment and rehabilitation which are dealt with in the next subsection. Demand reduction from potentially new drug users focuses specifically on dissuading young persons from starting to take drugs. The main ways for doing this are through education, both formal and informal. The Government Strategy to Prevent Drug Misuse identifies four measures to help reduce the demand for drugs among this group (Department of Health, 1991, pp.14-15). These are:

- the development of a Drug Education Programme for schools, teacher training colleges and education departments of universities.
- the extension of in-service training for teachers on drug-related matters.
- the development by the Department of Education of adequate attractive leisure activities for young people and the use of the informal education element of youth and sports programmes for dealing with drug related issues.
- the establishment of formal links between the educational, treatment and community services and the prisons.

It is perhaps significant that these preventive measures do not radically address the underlying social and economic deprivations which, as all research and experience indicates, are a major contributory factor in drug use. In this sense the “treatment” does not match the “diagnosis”.

1.5c Treatment and Rehabilitation

Until recently many of the services offering treatment and rehabilitation to drug users were based on an abstinence model. Typically this requires, usually as a precondition of receiving service, that the drug user ceases taking drugs completely, or takes only a fixed daily amount of a prescribed drug. This model, which is not suited to the needs of all drug users, has shaped two of the main and longest-established drug services in Ireland: the Drug Treatment Centre in Trinity Court (established in 1969) and the Coolmine Therapeutic Community (established in 1973). A number of projects for drug users have emerged to offer a choice of support and/or treatment options to drug users, including harm reduction treatments. These projects include the Ballymun Youth Action Project (established in 1980), the Ana Liffey Drugs Project (established in 1982), the AIDS Resource Centre (established in 1989) and the Merchants’ Quay Project (established in 1989). Since 1987 the Drug Treatment Centre has also offered methadone maintenance to drug users, albeit under very strictly controlled conditions.

The Government Strategy to Prevent Drug Misuse recognises, for the first time in Irish drug treatment policy, that the multiplicity of needs among drug users requires a multiplicity of treatment options. The *Strategy* states:

“Of its nature, the treatment, care and management of the drug misuser does not lend itself to any ‘one-solution approach’. The Government accepts that the provision of services aimed at the achievement of drug-free society only or harm reduction programmes solely are inappropriate. There is a need to make available to the drug misuser, a range of possible approaches and the means of access to the service(s) most appropriate to his/her immediate needs and capabilities. A fundamental consideration in this respect is to ensure that services available are attractive and accessible in order to encourage misusers to avail of them and to motivate them to continue with treatment” (Department of Health, p.16).

The Government Strategy to Prevent Drug Misuse places responsibility on the Health Boards to provide, coordinate and fund treatment programmes for drug users, having due regard to the important role of the voluntary sector. The three key measures on treatment and rehabilitation are:

- integrating programmes dealing with drugs and HIV/AIDS in each Health Board Area by, inter alia, designating a senior officer as the AIDS and Drug Misuse Regional Co-ordinator.
- setting up Community Drug Teams in selected areas, drawing on professionals from at least some of the following disciplines: General Practitioners, Outreach Workers, Social Workers, Public Health Nurses, representatives of statutory and voluntary agencies. Juvenile Liaison Officers/Probation Officers.
- a review of the role of the Drug Treatment Centre in Trinity Court.

1.6 Summary

The Merchants' Quay Project was set up in 1989 to help prevent the spread of HIV through drug-use and related behaviour and to provide non-judgmental care and support to drug users with HIV and their families. Most experts agree that the problem of drug use is concentrated in Dublin. The majority of persons who are HIV+ are also to be found in the capital.

In Dublin the connection between injecting drug use and HIV is quite strong given that more than half of all persons diagnosed as HIV+ have previously injected drugs. Drug use in Dublin is also concentrated in and around the inner city and is mainly associated with unemployment and poor living conditions. This is also the case with clients of Merchants' Quay project, as Chapter Four below reveals.

The broad parameters of current public policy in the areas of drug use and HIV/AIDS were set down in the Government Strategy to Prevent Drug Misuse published in May 1991 (Department of Health, 1991). Although drug use and HIV/AIDS are different problems in the sense that each can exist without the other, the position adopted in the Government Strategy to Prevent Drug Misuse is that *"it is impossible to separate policies relating to drugs from those of AIDS/HIV transmission"* (Department of Health, 1991, p.8).

The measures in the Government Strategy to Prevent Drug Misuse fall into three broad categories: measures to reduce the supply of drugs; measures to reduce the demand for drugs; measures to increase access to treatment and rehabilitation, both for drug users and persons with HIV/AIDS. It is particularly significant that none of the measures in the Government Strategy to Prevent Drug Misuse radically address the underlying social and economic deprivations which, as all research and experience indicates, are the major contributory causes of drug use.

Chapter Two

Origin and Development

2.1 Introduction

This chapter describes the origin and development of Merchants' Quay Project: Drugs/HIV Service. Some of the key events which shaped the project in its early stages are outlined in section 2.2. This is followed in section 2.3 by a description of the objectives and approach adopted by the project. The specific services offered to clients are outlined in section 2.4. These services are provided mainly by volunteers and some information on their recruitment and training is provided in section 2.5. A brief overview of the income and expenditure accounts of the project for the year ended 31 May 1992 is presented in section 2.6. Finally, a summary of some of the key themes of the chapter is presented in section 2.7.

2.2 Origins

The origins of the Merchants' Quay Project can be traced to the latter half of 1989 when the Franciscan Friars in Merchants' Quay became increasingly aware of the substantial number of persons in the locality who were drug users or HIV+, or both. This awareness came through casual callers to the Friary, an increasing proportion of whom were drug users. It also came through the research of one of the Friars in Merchants' Quay, Father Sean Cassin, OFM, who undertook in 1987, on behalf of the Catholic Social Service Conference (CSSC), a major survey of organisations working with drug users in Dublin (Cassin, 1988). Sean Cassin also had experience of working with drug users while studying in the Franciscan Seminary in Rome in 1985/86.

It became clear from these contacts with drug users that all of them experienced a sense of isolation and rejection in their own communities. Many were in poor health, dependent on social welfare and often living a "chaotic" lifestyle. All of them had been through the limited range of services for drug users and for persons with HIV and this frequently reinforced their sense of despair.

Initially, it was not clear to the Franciscan Friars how they should respond to this problem. Some of the Friars believed that the correct response required an referral of casual callers to the appropriate services. Others believed that the entire problem of drug use and HIV was entirely outside their competence and their involvement in it should be minimised. None believed that setting up a project in the Friary to act as a contact centre for drug users and for persons with HIV was possible or desirable.

Sean Cassin had previous training and experience in the area of providing services for drug users and persons with HIV and is a qualified counsellor. He adopted a leading role in shaping the Friary's response to the needs of drug users in the locality. Initially this took the form of providing information, advice and counselling to drug users who called to the Friary on a casual basis. The scale of the demand for these services grew and, as volunteer helpers were taken on, a "project" began to take shape in the first half of 1990. The emergence of the project in this way was not inspired by any overall vision or strategy; it was a practical response to the needs of local drug users as they presented themselves at the Friary. Referring retrospectively to the origins of the project, Sean Cassin summarises this period by saying "*it was local needs which created the project*".

The project was located in one of the parlours in the Friary (Parlour Three) and remained there until it moved to larger accommodation in another part of the Friary in September 1991. While in Parlour Three, drug users, often accompanied by their children, entered through the main door of the Friary and queued in the corridor to see Sean Cassin or one of the volunteers. This part of the Friary became a busy and sometimes noisy thoroughfare and was a new and sometimes distressing experience for the Franciscan Friars many of whose fears and prejudices about drug use, HIV and AIDS were no different to (those typically found in the population in general).

A vigorous debate ensued within the Franciscan community about their involvement in this work. One of the older Friars in the community asked Sean Cassin if the Friars were in danger of contracting AIDS from the presence of drug users in their midst, to which he replied: "*If you use sterilised needles and do not have*

unprotected sex you are likely to be safe!". Fears were gradually allayed and, given that the Friary had been designated by the Franciscan Province in Ireland as a house for justice activities in June 1989, it became accepted that this was an important and legitimate justice activity.

The shape and direction of the project was strongly influenced by an Advisory Team which was formed in March 1990. This Advisory Team, as Table 2. 1a reveals, comprised professionals who had considerable experience in the drugs/HIV area, both statutory and voluntary.

In July 1991, the project was registered as a limited company and was granted charitable status by the Revenue Commissioners in June 1992. The project's Advisory Team was incorporated into a larger Board of Directors. The names of the Board of Directors and their organisational affiliation are summarised in Table 2. 1b.

In addition to involving experienced professionals from other agencies in running the project, members of the project - particularly the Director and the Co-ordinator (see Figure 2.1 below) - have, in turn, become involved in the running of other organisations. The Director and/or Co-ordinator are members of the following organisations:

- National AIDS Strategy Committee (a committee appointed by the Minister of Health to oversee the implementation of the National AIDS Strategy)
- National AIDS Forum (Irish Catholic Bishops Task Force on AIDS)
- Voluntary Drug Treatment Committee (comprising Directors of the Ana Liffey Project, Ballymun Youth Action Project; Coolmine Therapeutic Community; Merchants' Quay Project)
- AIDS Liaison Forum (comprising all AIDS workers in statutory and voluntary organisations)
- Soile Project (a project cofinanced by the European Community and the Eastern Health Board to provide training for drug users)
- Irish Association of Alcohol and Addiction Counsellors (Accreditation Body for Alcohol and Addiction Counsellors in Britain)
- British Association of Counselling (Accreditation Body for Counsellors in Ireland).

2.3 Objective and Approach

The objective of Merchants' Quay Project is to help prevent the spread of HIV through drug-use and related behaviour and to provide non-judgmental care and treatment to drug users with HIV and their families. This objective was shaped by the project's initial encounter with drug users, many of whom were HIV+ or whose behaviour placed them at risk of contracting HIV. This remains the project's core client group as well as its key objective.

The model which informs the approach of the project is a medico-psycho-social model. This model is designed to reflect the multifaceted nature of drug user needs. Many drug users have medical problems associated with their drug use such as abscesses, under nourishment, AIDS symptoms, as well as psycho-social problems such as marital and other relationship problems and difficulties in the areas of housing, money, the law, unemployment, etc. The objective of the project is to address these problems directly through the Project Worker or indirectly by referring them to the appropriate agency and acting as an advocate on their behalf.

The distinctive feature of the project's approach is that it is client-led. The nature of this approach was explained by Sean Cassin in his address at the formal opening of the project on 27 April 1992: "*Client-led services are simply about having a non-judgmental respect/or drug users. We have opted strongly/or a client-led approach which encourages respect/or the individual's capacity to change their behaviour; respect/or a person's right to test or not to test/or HIV; respect/or those who are infected that they will do their utmost to avoid transmission to others. We are not claiming that the project's commitment to a client-led service was invented by us. In fact the Ana Liffey Project [established in 1982] had pioneered the idea when it was neither profitable nor popular*" (Cassin, 1992).

The approach of the project is underlined by the fact that Merchants' Quay is a *contact centre* rather than a drop-in centre. This is an important distinction in the present context because, unlike a drop-in centre where drug users can meet socially and chat, a contact centre provides a more structured environment where each client is offered a specific service tailored to his/her specific needs. This model was adopted by the project

**Table 2.1a Persons on Advisory Team Of Merchants’ Quay
Project, March 1990 - May 1991**

Name	Organisation	Previous Experience
Frank Brady	Director, Ana Liffey Project, Dublin 1.	Founder member of Ana Liffey Project.
Sean Cassin	Founder of Merchants’ Quay Project, Dublin 8	Drugs Worker and Counsellor; author of report on services for drug users.
Deirdre Foran	Senior Health Promotion Counsellor, Genito Urinary Medicine, St James’ Hospital, Dublin 8.	Project Worker with Ana Liffey Project; founder member of Cairde; author of research papers in area of HIV/AIDS.
Anne Marie Jones	Co-ordinator, Cairde, Dublin 1.	Social Worker
Fergus O’Kelly	General Practitioner, Dublin 8.	Chairperson, AIDS Subcommittee, Irish College of General Practitioners; author of research papers on drugs and HIV.

**Table 2.1b Board of Management and Governing Body
of Merchants’ Quay Project, June 1991 - December 1992**

Name	Position	Organisation
Michael Martin*	Chairperson	Chaplain to College of Technology, Bolton St., Dublin 1.
Deirdre Foran*	Vice Chairperson	Senior Health Promotion Counsellor, AIDS Resource Centre. Baggot St. Dublin 2.
Gabriel Kinahan*	Secretary	Director of Youth Formation, Co-Worker in Simon Community.
Frank Brady*	Treasurer	Former Director of Ana Liffey Drugs Project, Dublin 1.
Sean Cassin*	Member	Director, Merchants’ Quay Project, Dublin 8.
Fergus O’Kelly*	Member	General Practitioner, Dublin 8.
Gerard Raftery*	Member	Guardian, Franciscan Friary, Merchants’ Quay, Dublin 8.
Anne Marie Jones*	Member	Coordinator of Cairde, Dublin 1
Tony Geoghegan	Member	Coordinator, Merchants’ Quay Project, Dublin 8.
Mary T. Walsh	Member	Addiction Counsellor, Community Care Area 1, Eastern Health Board. Dun Laoghaire.
Rachel Curran	Member	Company Law Solicitor, Dublin 2.
Jackie Blanchfield	Member	Volunteer, Merchants’ Quay Project, Dublin 8.

* Member of Governing Body

because the needs of different drug users are not only different but may be in conflict with each other. For example the needs of persons who are stable or reducing drug users are very different to the needs of persons who are chaotic drug users and, given the frequently pressing nature of their needs, neither may benefit significantly from a casual meeting in a drop-in centre.

The organisation and physical layout of the project is strongly influenced by the fact that it is a contact centre. The project has its own entrance on Winetavern Street rather than the Friary entrance on Merchants' Quay, when the project first opened. Upon entering the project, each client is met by the Receptionist and a Welcome Worker. The Welcome Worker talks to the client over a cup of tea or coffee and, in the case of new clients, explains the type of help available within the project. The Key Worker within the project arranges for the client to meet one of the Project Workers. Repeat clients will typically have the same Project Worker on each visit, usually by an appointment made following their last visit. The project has a large reception area, four consultation rooms, a larger room for group sessions, a kitchen and a toilet.

The social organisation and layout of the project is designed to ensure that the needs of both clients and volunteers are mutually respected. Respect for clients is ensured by the fact that each is welcomed on arrival and an arrangement is made to see a Project Worker either immediately or as soon as possible by appointment. Clients who are "stoned on drugs" or are disruptive to other clients are asked respectfully to leave - but may be offered an appointment to come at another time - although no client has ever been barred from the project. This arrangement also allows the rights of volunteers to be respected and ensures that they are not overwhelmed by large numbers of clients and left unable to cope. According to the Director of the project, Sean Cassin, *"Project Workers are always in control and clear boundaries are maintained within the project"*.

Next door to the project, in another part of the Friary, there is a crèche which is run by Focus Point, where clients can leave their children when visiting the project. Some bring their children into the project and this is also acceptable.

2.4 Services Offered to Clients

Merchants' Quay Project offers services to clients at each stage in the drug-using cycle including crisis intervention, stabilising programmes, detoxification supports and drug free programmes. The services are offered through two centres: the project's Contact Centre in Merchants' Quay and the project's Respite Centre in a suburb in north County Dublin. The following are the key services offered to clients in the Contact Centre:

- assessing client needs and working out a treatment plan to suit the needs of each
- 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
- helping clients with welfare and housing problems
- helping clients with marital and other relationship problems » supporting persons who are detoxifying
- preparing court reports for clients and appearing in court to speak on their behalf
- visiting clients in hospital, prison or at home
- providing courses in art therapy, drama therapy, acupuncture, personal development, relaxation and literacy
 - providing fitness training in a local gym
 - helping clients to decide on adult education courses and in finding jobs.

The core services of the project are provided in a one-to-one relationship between the client and the Project Worker. However some services, particularly courses, are provided in groups and have led to the formation of an art therapy group, a drama group, a women's group, a relaxation group, etc.

The project's Respite Centre is a four-bedroom semi-detached house in north County Dublin, which accommodates six people, including children. The Centre has two Project Workers on duty 24 hours every day who care for all the client's needs including cooking the meals, providing counselling, going for walks, etc.

The client may also have members of the family staying if that is his/her wish. On average, clients spend about two weeks in the Respite Centre at any one time. Occasionally, larger groups use it for the weekend.

The programme of activities in the Respite Centre is determined by the needs of clients. Three categories of client typically use the Respite Centre. The first category is the client who is stabilising their drug habit by ceasing chaotic use of street drugs and substituting for it a regular daily dose of the heroin substitute, phsyseptone. The programme for this person focuses on the different elements in *the* person's life which also need to be stabilised in addition to their drug habit: relationships, employment, income, housing, etc. The second category is the client who is going through detoxification by phasing out phsyseptone over a period with a view to becoming totally drug-free. The Respite Centre provides support in coping with withdrawal symptoms as well as counselling in relation to drug-free treatment options (eg. Coolmine, Narcotics Anonymous, Merchants' Quay Project, etc.). An important element in the supports for this category of person is helping them to develop a normal daily routine in matters of sleeping, eating, etc. The third category is the client who is drug-free but who is experiencing a life crisis such as the emergence of symptoms associated with AIDS. This type of client is likely to need a lot of support and counselling in learning to live with an illness that is terminal.

Table 2.2 summarises data on the number of persons who have used the Respite Centre in 1990, 1991 and 1992. The table reveals that 91 persons have used the centre in this period, 59 adults and 32 children. The most frequent user of the centre is the client undergoing detoxification (17), followed by clients who are drug-free (15) but experiencing other problems. Twelve clients were in the Respite Centre specifically for AIDS-related illnesses, although other clients may also have had HIV but were not presenting it as their main problem. Thirteen clients were stabilising drug users.

2.5 Recruiting and Training Volunteers

From the beginning, the services of Merchants' Quay Project have been provided mainly by volunteers essentially because no financial resources were available to employ staff. Volunteerism brings a quality of motivation and commitment which many in the project feel would be lost if volunteers were replaced by paid staff. In particular it facilitates the involvement of former drug users which could be jeopardised if the project were run solely by staff given that some of them do not have the formal qualifications that might be required ordinarily in the appointment of staff. Thus notwithstanding the pragmatic reasons for using volunteers to run the project, the concept of volunteerism has become an important cornerstone in the philosophy of the project.

The project has one paid staff. This is the position of Project Co-ordinator which was created in August 1991. In December 1992 the personnel in the project comprised: a Director (unpaid), a Co-ordinator, and 32 volunteers (referred to as Project Workers). Figure 2.1 identifies these positions in the overall organisational structure of the project.

At the beginning of the project, the recruitment and selection of volunteers was carried out by Sean Cassin. Since then a more formal selection process has been established, the elements of which are described in the project's literature to applicants as follows:

1. *Applicants visit the Project and are given information on its principles and operation.*
2. *Each one receives an application form that assesses their background and motivation for wanting to do the course.*
3. *Interviews are conducted by a professional in the field of drug use and AIDS and by a Project Worker.*
4. *On the basis of the interview, applicants are selected for initial training. Selection seeks to choose a mix of those with training in the service delivery field and former drug users and people who are themselves HIV positive.*
5. *On completion of the initial training those volunteers who have demonstrated an ability to achieve the aims of training are accepted for in-service training".*

The training of volunteers is a crucial activity in the project since it determines the quality of service provided to clients. The skills required to make a helpful intervention with a drug user are considerable. Sean Cassin describes a typical example: "*When a person comes to the project for the first time it is necessary to find out, in a respectful way, if they are on drugs, what drugs they are on, what their dosage levels are, etc. From this, a*

Figure 2.1 Organisational Structure of Merchant's Quay Project, 1992

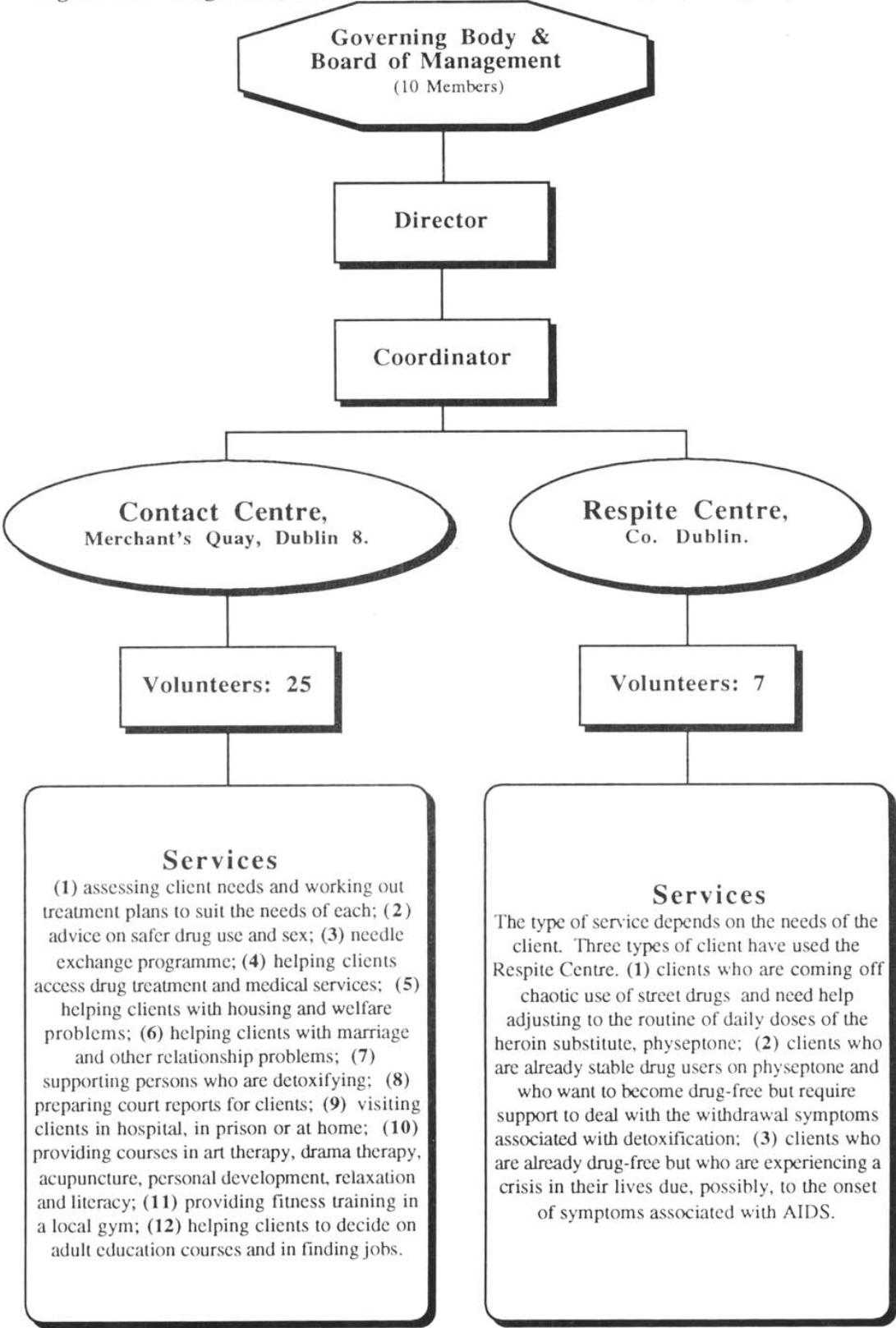


Table 2.2 Number and Category of Clients Using Respite Centre of Merchants’ Quay Project, 1990,1991,1992

Category of Client	Feb-Dec 1990	Jan-Dec 1991	Jan-Dec 1992	Total
Stabilising	10	i	2	13
Detoxification	4	6	7	17
Drug Free	0	12	3	15
HIV/AIDS	5	5	2	12
Other Problems	0	0	2	2
Sub total	19	24	16	59
Children	10	16	6	32
Total	29	40	22	91

Table 2.3 First Training Programme for Volunteers of Merchants’ Quay Project: Drugs/HIV Service, February - March 1990

Date	Theme	Presenter/ Facilitator	Organisation
23-25 Feb 1990	Induction, Information and Team Building	Sean Cassin Fergus O’Kelly Deirdre Foran Anne Marie Jones	Merchants’ Quay Project, Dublin 8. General Practitioner, Dublin 8. AIDS Resource Centre, Dublin 2. Cairde, Dublin 1.
3 March 1990	Harm Reduction	Luke Tiemey	Roma Project, London.
10 March 1990	Listening Skills	Sean Cassin Rosaleen Hogan	Merchants’ Quay Project, Dublin 8. Merchants’ Quay Project, Dublin 8.
17 March 1990	Detached Work	Brian Travers	Soho Project, London.
24 March 1990	Group Work, Reviews, Choices	Sean Cassin	Merchants’ Quay Project, Dublin 8.
31 March 1990	Bereavement and Loss Issues	Anne Marie Jones Sean Cassin Frances Dwyer Ciaran O’Maolaoín	Cairde, Dublin 1. Merchants’ Quay Project, Dublin 8. Cairde, Dublin 1. Cairde, Dublin 1.

Table 2.4 Training Sessions for Volunteers Held by Merchants’ Quay Project, 1990 -1992

Date of Training	Number of Volunteers
Feb/March 1990	15
November 1990	15
May 1991	14
November 1991	15
May 1992	18
October 1992	20
Total	97

Project Worker must be able to infer if there are any particular health problems (eg. abscesses), how much money their habit is costing, etc. The client may not be presenting any specific problem so it may be necessary to ask some further questions about housing, relationships, money, etc. At the end of a 30 minute interview it will be necessary to make some reasonable guesses about the type of drug user involved and prioritise some actions that would help the person “.

In order to provide a basic service to drug users and to persons with HIV a working knowledge of the following areas is necessary:

- types of drugs being used, both street (i.e. illegal) and prescribed
- implications of the dosage and method of using different types of drugs
- main types of drug-related problems
- dealing with relapses and re-negotiating recovery plans with drug users
- services available and how to access them
- some basic counselling skills.

In February 1990 Sean Cassin organised the first initial training programme for 18 volunteers. About half these volunteers were former drug users and some were HIV+. The course consisted of one residential weekend and five consecutive Saturdays, all between February and March 1990. It was held in the Franciscan Friary, Broc House, Donnybrook, Dublin 4.

Details of the course are summarised in Table 2.3. The objective of the course was to develop skills for working with drug users and persons with HIV, with the additional objectives of building a team spirit among the volunteers and assessing their suitability for the project given that the final selection of volunteers was made only at the end of the course. Eighteen volunteers completed the course and were selected for the project.

Training courses for each new group of volunteers - now referred to by the project as Initial Training - are held twice a year. This training lasts 80 hours over a six week period and, until April 1992, was carried out in conjunction with Cairde. In addition, the project also provides In-Service Training for volunteers through their practical experience with clients as well as facilitating them to attend courses and go on special placements. In 1990 and 1991 some volunteers attended a course on Harm Reduction in Liverpool; others attended a Loss and Bereavement course (Kubler Ross) in Benburb, County Tyrone; one volunteer did a two week placement in Brussels while others were sent to London on a training course.

Between 1990 and 1992 a total of six training sessions were held by the project for volunteers. Table 2.4 summarises information on these training sessions and the number of volunteers involved. Up to the end of 1992, the project had trained 97 volunteers.

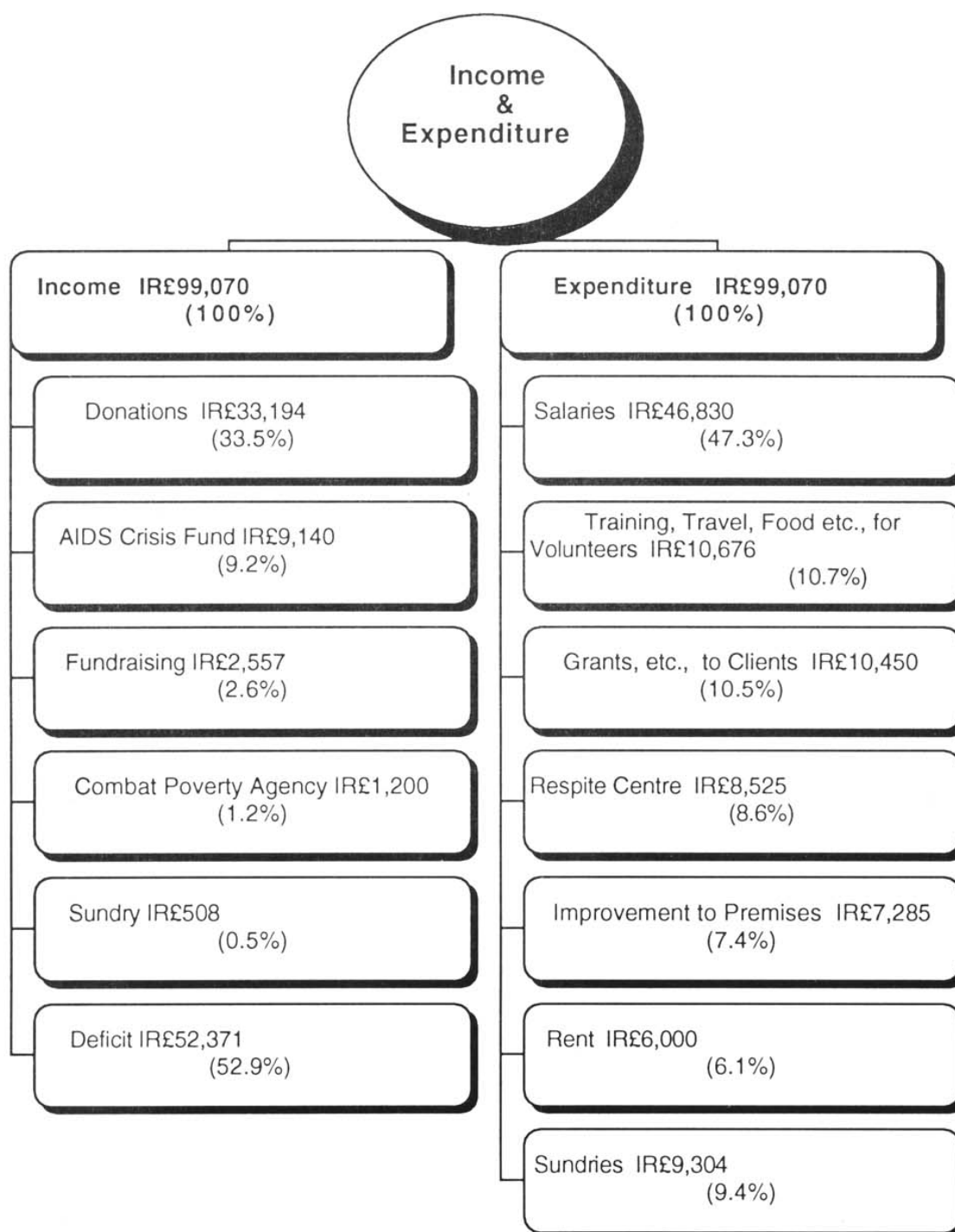
The growing numbers of clients being seen in the project (see Chapter Four below) and the pressing nature of their needs often places considerable stress on volunteers. For this reason, volunteers themselves need support to cope with the demands of the job. The project has a Volunteer Support Group which meets once a fortnight to share experiences of the work. There is also a Volunteer Policy Group which meets once a fortnight to discuss more strategic issues affecting the project (eg. the introduction of a needle exchange programme in June 1992). The Co-ordinator of the project also provides weekly supervision of the work of volunteers and regular support and review days are held. In June 1991 the project was given the use of a house on the outskirts of Monaghan town by the Sisters of Saint Louis and this is typically used to give volunteers a break away.

Given the centrality of volunteers in the provision of services within the project, a detailed survey of current and former volunteers was undertaken, the results of which are analysed in the Chapter Three below.

2.6 Income and Expenditure

Volunteers are the main resource input to the Merchants' Quay Project. However the project also requires a substantial amount of financial resources to maintain its level of services. Figure 2.2 summarises the main elements in the income and expenditure of the project for the year ended 31 May 1992. The figure reveals that the annual expenditure of the project was IR£99,070.

Figure 2.2 Income and Expenditure of Merchants' Quay Project
for Year Ended 31 May 1992



Analysis of the project's income reveals that it had a deficit of IR£52,371 for the year under review, equivalent to 52.9% of total expenditure. The project's deficit is effectively an indirect subvention from the Franciscan community in Merchants' Quay. Apart from this indirect subvention, donations were the main source of funding for the project in 1991/1992 constituting 33.5% (IR£33,194) of total income. The other main source of funding was the AIDS Crisis Fund which gave the project IR£9,140, equivalent to 9.2% of total income. Other income was generated through fund-raising (IR£2,557, 2.6%) and through a grant from the Combat Poverty Agency (IR£1,200, 1.2%).

On the expenditure side, the main item is salaries for the Director and Co-ordinator of the Project which constitute 47.3% (IR£46,830) of total expenditure. In reality the Director, Fr. Scan Cassin, OFM, has not received a salary from the project so that the value of his services in the audited accounts (IR£30,000) was an indirect subvention to the project from the Franciscan Community of which he is a member. In addition, a substantial amount of expenditure (IR£7,285, 7.4%) was incurred in improving and adapting the premises to meet the needs of the project.

Volunteers do not receive payment from the project. However the project spent IR£10,676 (10.7%) on volunteers in the year under review mainly on training, travel and food. A similar amount (10.5%) was paid out to clients who received IR£ 10,450 in grants which had been made available by the AIDS Crisis Fund until this fund was abolished in the autumn of 1992. The cost of running the Respite Centre was IR£8,525. Other items, classified as sundries, amounted to IR£9,304 (9.4%).

It is clear from Figure 2.2 that substantial amounts of financial resources are required to run the project notwithstanding the fact that most of the labour is provided free by volunteers. The figure also reveals that more than half of these financial resources are provided as an indirect subvention by the Franciscan community who are ultimately responsible for the project's accounting deficit. This level of subvention cannot be sustained by the Friary.

2.7 Summary

The Merchants' Quay Project: Drugs/HIV Service originated in the latter half of 1989 when the Franciscan Friars in Merchants' Quay became increasingly aware of the substantial number of persons in the locality who were drug users or HIV+, or both. The project offers services to clients at each stage in the drug-using cycle including crisis intervention, stabilising programmes, detoxification supports and drug free programmes. The services are offered through two centres: the project's Contact Centre in Merchants' Quay and the project's Respite Centre in north County Dublin. From the beginning, the services of the project have been provided mainly by volunteers. In December 1992 the personnel in the project comprised: a Director, a Project Coordinator, and 32 volunteers. The financial resources required to run the project in the year ended 31 May 1992 amounted to IR£99,070, of which half came in the form of an indirect subvention from the Franciscan community. The Franciscan community is not in a position to maintain this level of funding in the future.

Chapter Three

Volunteers

3.1 Introduction

Volunteers are the labour force of Merchants' Quay Project who deliver the service to clients. It follows that their characteristics have a decisive impact on the project and on the type of service provided. Between February 1990 and May 1992, a total of 77 volunteers trained and participated in the project (see Table 2.4 above). Just under half of these (35) completed a detailed questionnaire for this report on the following themes:

- demographic characteristics of volunteers
- family background characteristics of volunteers
- socio-economic characteristics of volunteers
- volunteer commitment to project
- volunteer assessment of training programme
- volunteer satisfaction with project
- volunteers' suggestions for new services.

This chapter analyses the results of these questionnaires. The chapter is divided into nine sections and follows the same thematic structure used in the questionnaires.

3.2 Demographic and Other Characteristics

Figure 3.1 summarises the key demographic characteristics of volunteers. This reveals that slightly more than half the volunteers (20, 57%) are women. Volunteers cover a wide age spectrum from under twenty to over sixty although the main concentration (14, 40%) is in the twenty to twenty nine age group. Slightly more than a quarter (9, 26%) are aged between thirty and thirty nine with a further one fifth (7, 20%) aged between forty and fifty nine.

More than half of all volunteers (19, 55%) were brought up in Dublin and most of the remainder were brought up elsewhere in Ireland (13, 37%). However nearly three quarters (26, 74%) have lived outside Ireland, mainly in England and the United States, for periods averaging 8.6 years.

Figure 3.1 reveals that more than two thirds of volunteers are either single (21, 60%) or separated (3, 9%). However one fifth (7, 20%) are married and just over one tenth (4, 11 %) are members of a religious community (4, 11%). One third of volunteers (12, 33%) have an average of two children each.

Volunteers in Merchants' Quay Project are drawn from those who have no previous experience of drug use as well as former drug users. Figure 3.1 reveals that the majority of volunteers (21, 60%) have never been drug users. However two fifths (14, 40%) are former drug users. Moreover these volunteers have been drug users for relatively long periods, averaging 9.2 years each.

3.3 Family Background Characteristics

Information on the family background characteristics of volunteers is summarised in Figure 3.2. Its purpose is to compare volunteers with the general population in Ireland on selected indicators. The data in Figure 3.2 reveals that more than three quarters (27, 77%) of volunteers were brought up in a house owned by the family. Less than a fifth (6, 17%) rented from the local authority and only one (3%) rented from a private landlord. In Ireland 77% of all homes are owner occupied, 14% are rented from the local authority and 8% are rented from private landlords (Household Budget Survey, 1987, Table 4). Accordingly, volunteers are very similar to the general population in terms of their housing tenure.

The vast majority of volunteers (32, 91%) were brought up by parents who were married to each other. A very small minority (2, 6%) had parents who were separated, although this is still higher than the 2.7% (37,245) of

Figure 3.1 Demographic and Other Characteristics of Volunteers in Merchants' Quay Project, 1990 -1992

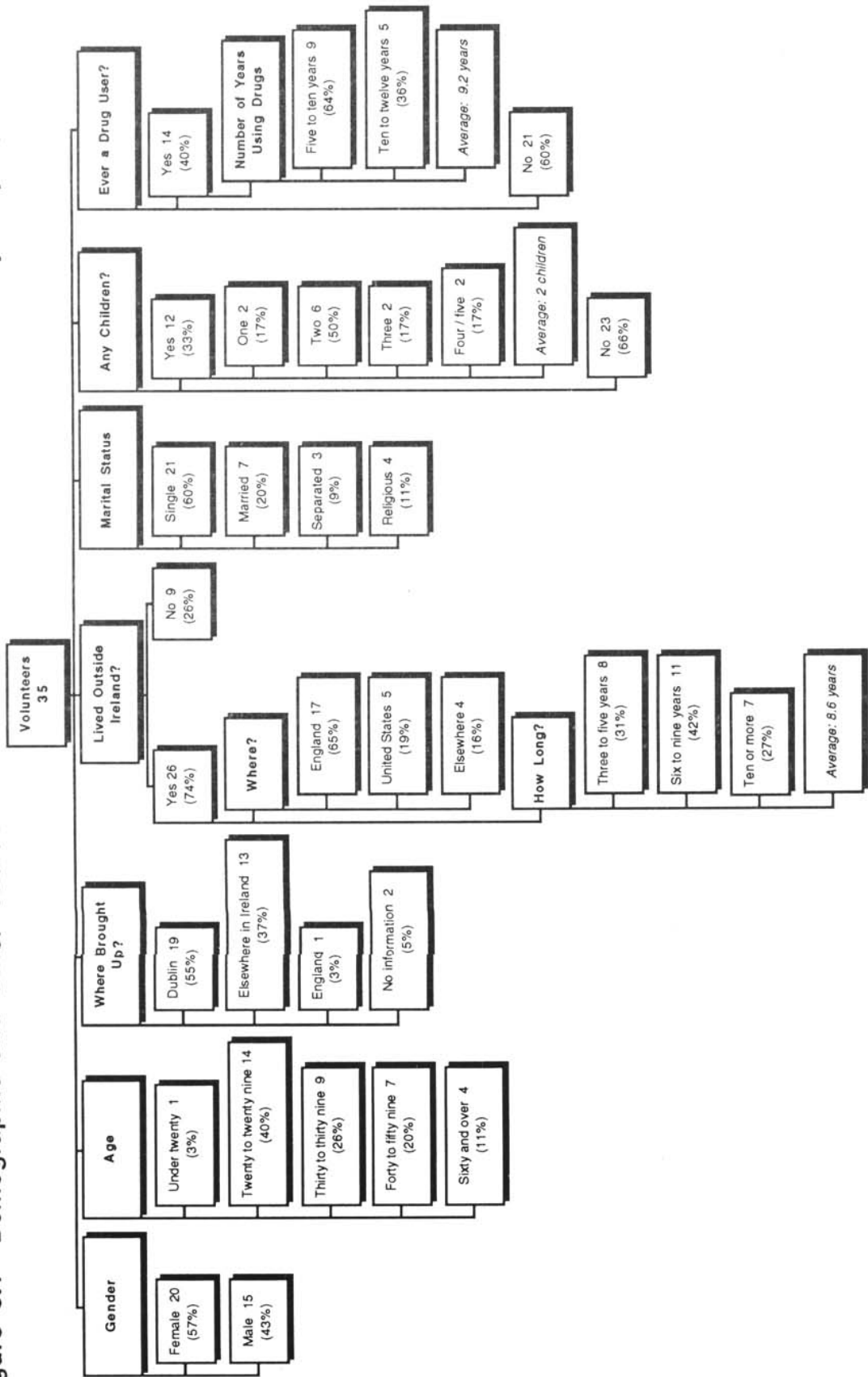
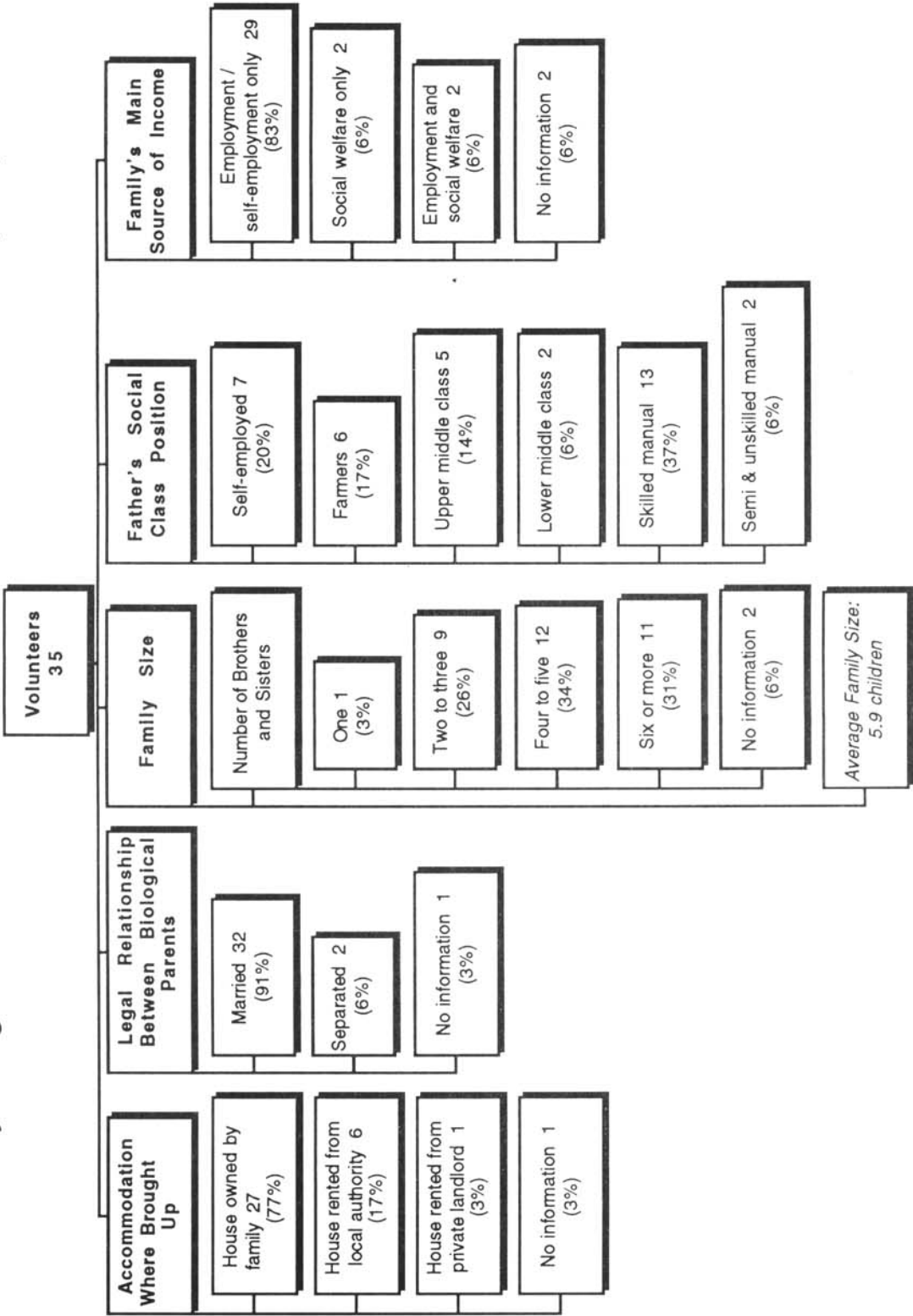


Figure 3.2 Family Background Characteristics of Volunteers in Merchants' Quay Project, 1990 -1992

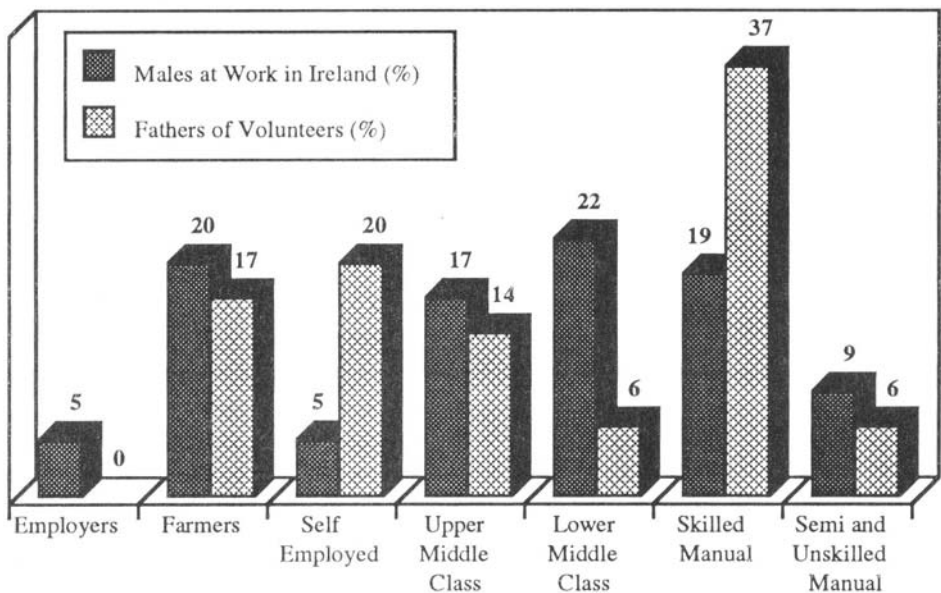


the “ever married” population in Ireland (excluding widows) who declared themselves as “separated” in the 1986 Census of Population (see Census of Population, Table 1A; Government of Ireland, 1992b, Chapter Four).

Volunteers come from families with an average of 5.9 children. This is higher than the average completed family size in Ireland in 1981, the latest year for which data is available, which was 4.16 (Clancy, 1991, p.24).

The usual indicator of a person’s social class background is the father’s occupation. Using this indicator. Figure 3.3 compares the social class background of volunteers with the social class structure of males at work in Ireland in 1985. The results indicate that three quarters of volunteers (26, 74%) come from three main social class categories: skilled manual, self-employed and farmers. By comparison with the male labour force in Ireland, they are over-represented in the self-employed and skilled manual categories and under-represented in the lower middle class and employer categories. Overall the class backgrounds of volunteers suggests that they come from relatively comfortable strata in Irish society and this is further confirmed by the fact that, as indicated in Figure 3.2, the main source of family income for more than four fifths (29, 83%) of volunteers was employment/self-employment.

Figure 3.3 Social Class Characteristics of Volunteers’ Fathers Compared to Males at Work in Ireland in 1985

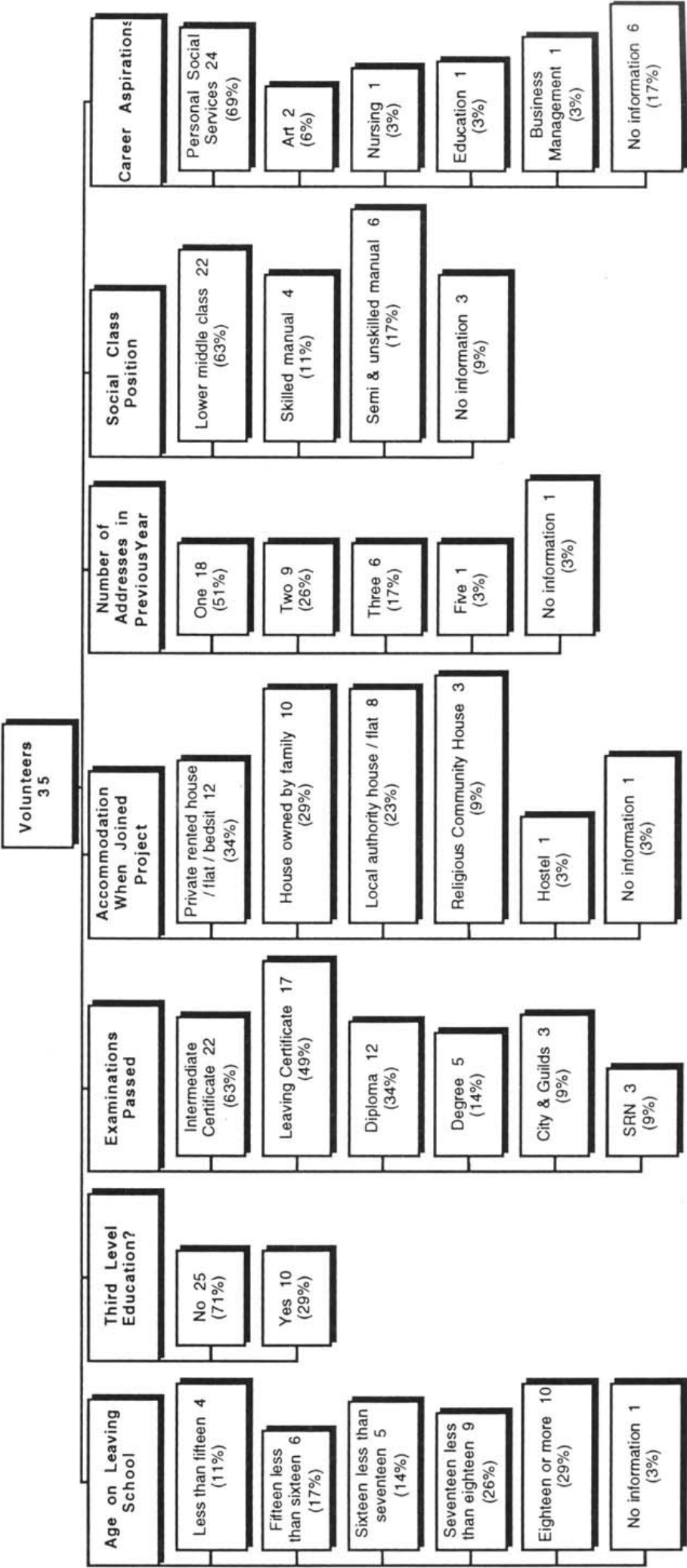


Source: The data on males at work in Ireland in 1985 is taken from Breen, Hannan, Rottman and Whelan, 1990, p.57.

3.4 Socio-Economic Characteristics

Figure 3.4 summarises some selected socio-economic characteristics of volunteers. In relation to education, the data shows that the vast majority of volunteers (31, 89%) attended school up to and beyond the statutory minimum age of fifteen. Just over one tenth (4, 11%) left school before the age of fifteen. This is about half the proportion (28.6%) of the population in Ireland aged fifteen years and over who reported leaving school before the statutory minimum age of fifteen in 1986 (Census of Population, 1986). Equally the proportion of volunteers who proceeded to third level education (10, 29%) is more than three times higher than the proportion (8.1%) of the population in Ireland aged twenty years and over who, according to the 1981 Census of Population, attended third level education (Census of Population, 1981, Volume 10, Tables 3A and 3B). In recent years however up to 40% of those leaving second level education proceeded to third level (Government of Ireland, 1992a, p.183). Another indicator of educational attainment is the proportion passing the Leaving Certificate Examination. About half the volunteers (17, 49%) passed the Leaving Certificate. This is substantially higher than the proportion in the Irish labour force (28%) who reported that the Leaving Certificate

Figure 3.4 Socio-economic Characteristics of Volunteers in Merchants' Quay Project, 1990 -1992



was their highest educational qualification in 1989 (Corcoran, Sexton, O'Donoghue, 1992, Table 2.4). However it is lower than the proportion of school leavers (77.5%) who passed the Leaving Certificate in 1990 (Department of Labour, 1991, Table 2). Overall therefore it would appear that the level of education among volunteers is above that of the Irish population in general but may be somewhat below those currently completing their education.

Figure 3.4 also summarises information on the housing tenure of volunteers at the time of joining the project. More than a third of volunteers (12, 34%) live in the private rented sector while just under a quarter (8, 23%) rent from the local authority. The proportion (10, 29%) who live in a house owned by the family is low by comparison with the pattern of housing tenure in Ireland but this is largely explicable in terms of the age of volunteers, two fifths of whom (14, 40%) are in their twenties (see Figure 3.1). In general persons living in private rented accommodation tend to be younger than persons living in any other type of accommodation (Household Budget Survey, 1987) and this is the pattern found among volunteers. Younger persons also tend to change address more frequently and this is reflected in Figure 3.4 which reveals that nearly half (16, 46%) of all volunteers changed address in the year prior to joining the project.

Volunteers occupy a very different set of class positions to their family of origin. Figure 3.4 reveals that the predominant class position of volunteers, as measured by their present or last job, is lower middle class. Nearly two thirds (24, 63%) are in this class category. Moreover their career aspirations, which are towards personal and social services, art, nursing and education, suggests that they are likely to remain within this broad class category.

3.5 Volunteer Experience and Commitment

Figure 3.5 reveals that nearly two thirds of volunteers (22, 63%) have worked previously in a voluntary capacity. In the main they have worked for organisations providing personal and social services (Simon Community, Samaritans, Focus Point, Coolmine, etc.) although some have also worked for environmental (Earth Watch) and human rights (Amnesty International) organisations.

Their reasons for becoming involved in (lie Merchants' Quay Project fall into three broad categories. The most popular reason, according to just under half the volunteers (16, 46%), is that they were "*interested in persons with addictions/HIV & AIDS*". More than a third (12, 34%) joined the project for reasons to do with their own personal and professional development while one fifth (7, 20%) were prompted by a "*desire to help others*". On average, each volunteer works 2.8 days per week on the project.

The 35 volunteers who completed this survey fall into two categories: those who are still on the project (21, 60%) and those who have left (14, 40%). Half of those who left (7, 50%) did so because "*it was time to move/could not give enough time to the project*". Four of those who left were unhappy with the management of the project or with oilier volunteers and two left for other reasons. On average current volunteers have been on the project for 18.5 months (up to December 1992) compared to ex-volunteers who spent an average of 12.5 months on the project.

3.6 Volunteers' Assessment of Training Programme

All volunteers on the project go through a training programme as described in Chapter Two. Figure 3.6 reveals that nearly three quarters of volunteers (26, 74%) found this training programme useful from the point of view of obtaining information, confidence and skills although some of these found that it was not enough. However a much smaller proportion (13, 37%) found the training programme adequate. More than half (18, 51%) did not find it adequate essentially because they needed more skills, more preparation, more personal development and more practical information. Some volunteers found the work very stressful as a result.

Volunteers made three main suggestions for improving the training programme in the project. The first would involve changes to the content of the programme to cover such topics as role play with clients, the needs of volunteers as well as information on other agencies. The second would involve changes to the organisation of the course to make it longer, have smaller groups, and the use of more professionals rattier than former drug

Figure 3.5 Characteristics of Volunteer Commitment to Merchants' Quay Project, 1990 -1992

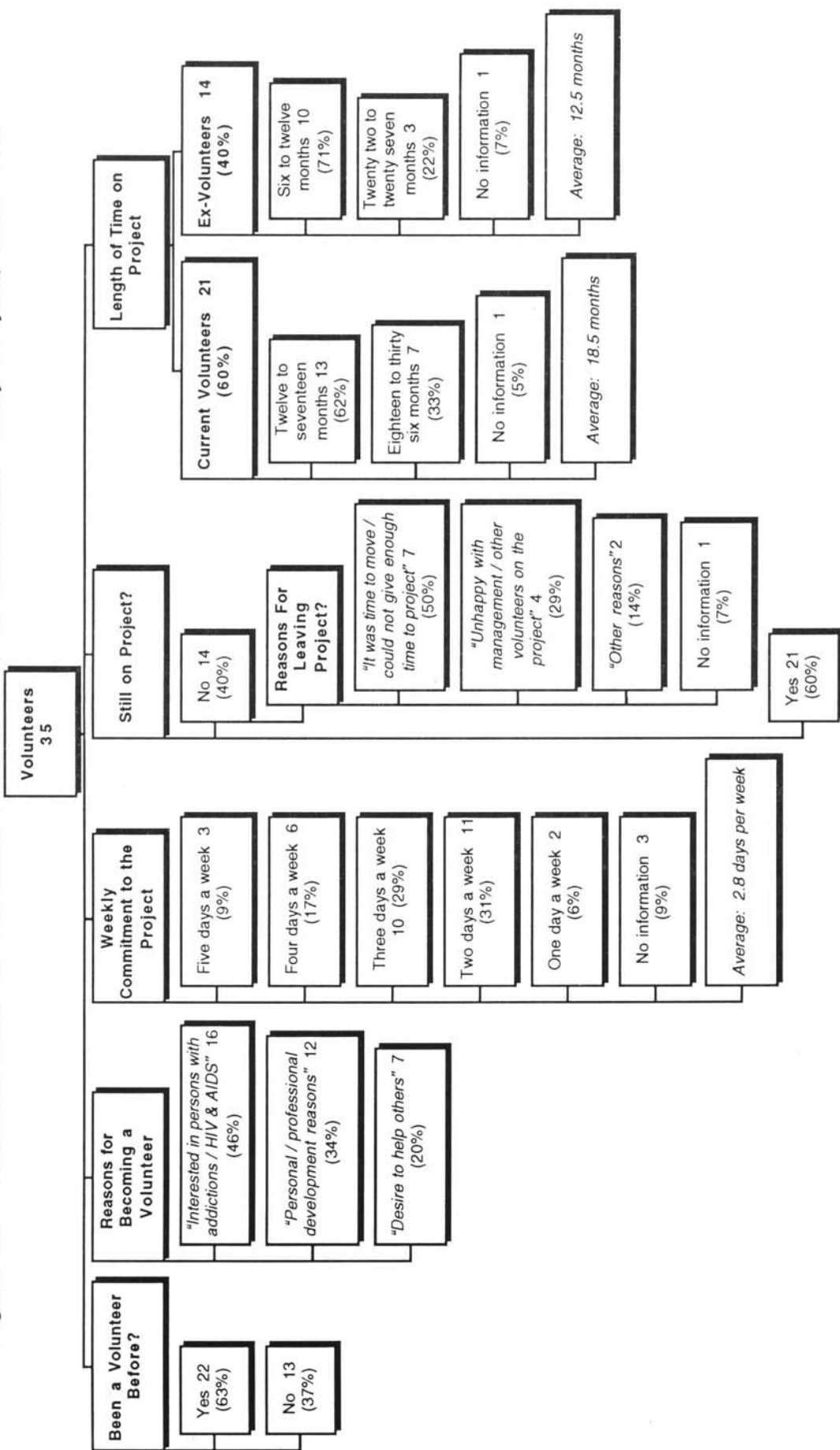
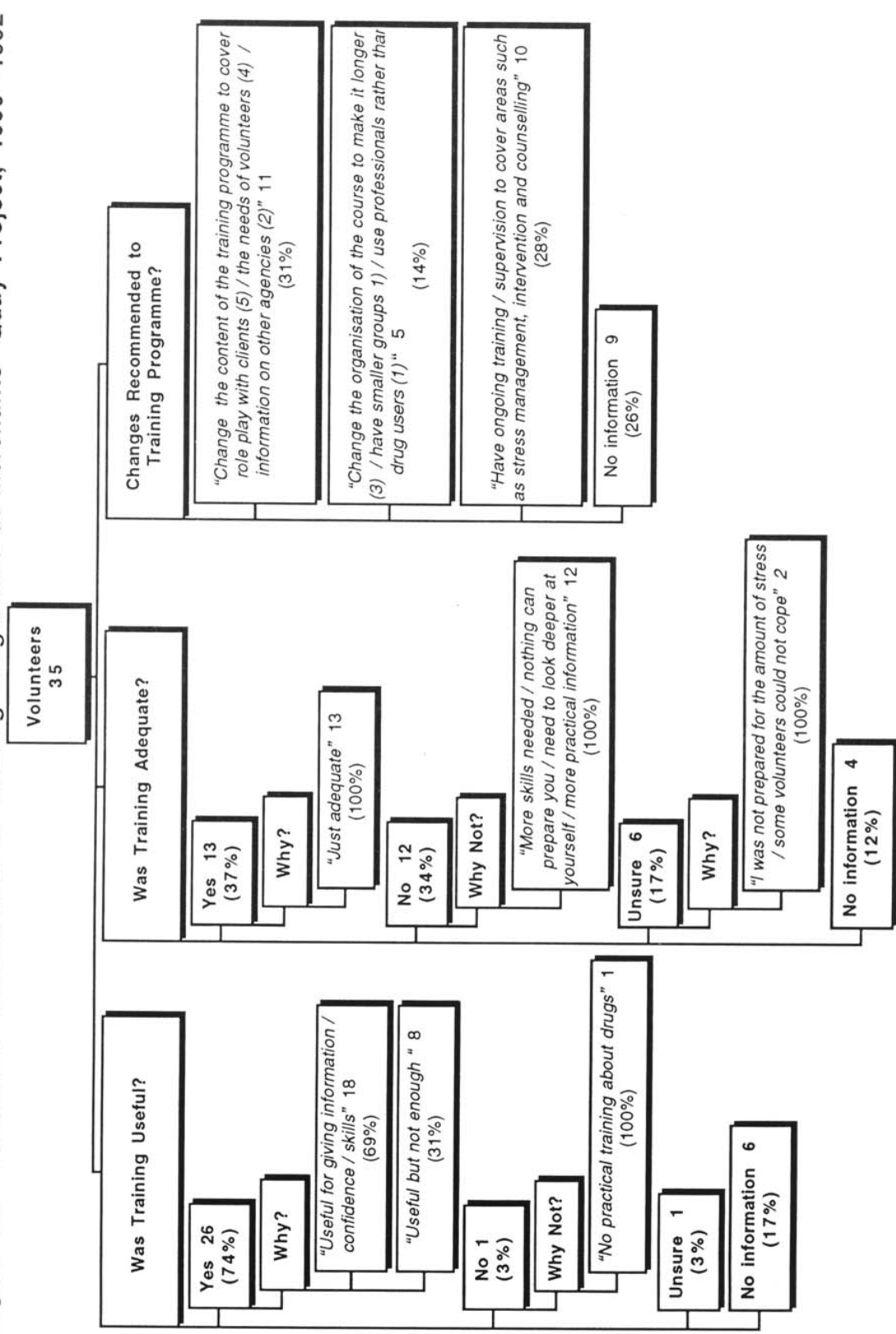


Figure 3.6 Volunteers' Assessment of Training Programme at Merchants' Quay Project, 1990 -1992



users. The third change would involve ongoing training and more supervision in areas such as stress management, intervention and counselling.

3.7 Volunteer Satisfaction With Project

The quality of service delivered to clients is largely dependent on the quality of volunteers and this, in turn, is likely to be affected by the team spirit among volunteers. Figure 3.7 reveals that the team spirit among volunteers is good or very good, in the opinion of just under three quarters (25, 71%) of volunteers. These volunteers regard the team spirit as good or very good because there is support, trust, honesty and good communications between them. However nearly a quarter feel that the team spirit is poor or very poor essentially because there is no cohesion between the volunteers. This is attributable, at least in part, to perceived divisions between former drug users and other volunteers and to divisions between old and new volunteers. However it is noteworthy that the five of the eight volunteers who believe the team spirit is poor or very poor are now ex-volunteers. This implies that the team spirit among current volunteers is widely regarded as good or very good.

The involvement of volunteers in running the project is an important issue given their central role in the delivery of services. Figure 3.7 summarises information on volunteer satisfaction with the running of the project. This reveals that just under half the volunteers (16, 46%) are unequivocally satisfied with the way the project is run. The other half (18, 51%) expressed some degree of dissatisfaction and more than a quarter of these (10, 28%) pointed to poor communication and their lack of involvement and/or influence at the level of management. In this context it is noteworthy that those expressing some degree of dissatisfaction with the running of the project were evenly divided between ex-volunteers (8) and current volunteers (8). This suggests that issues pertaining to communication and participation may need to be addressed within the project.

By definition, volunteers are not paid for their work. However working as a volunteer is not without its benefits. Figure 3.7 reveals that all but three volunteers (32, 91%) benefited from participation in the project, in their opinion. For approximately half of these (15, 47%) the main benefit came in the form of learning about themselves and their needs, fears and problems. For over a third (11, 34%) the benefit involved gaining skills, friends and information about drugs/HIV & AIDS. Finally a smaller group (4, 13%) described the benefit of the project in terms of the enjoyment obtained from working with clients, doing something positive and seeing someone become drug-free.

3.8 New Services for the Project

In the survey, volunteers were asked the following question: *“What services would you like to see developed in Merchants’ Quay Project to make it more effective/or clients?”* Figure 3.8 reveals that one third of the volunteers made no suggestions while the remainder made suggestions which fall into two categories: new services for clients (19, 54%) and new services for volunteers (5, 14%)

The most frequently mentioned new service for clients was a needle exchange programme. This was suggested by eleven volunteers, nine of whom are current volunteers. This is noteworthy in view of the fact that a needle exchange programme was introduced into the project in July 1992. At the time of the survey in March 1992 the possible introduction of a needle exchange programme was the subject of intense discussion within the project. Other services suggested for clients included more space (5), a doctor (4), treatment and therapy (4), work projects (3) and more contact with other agencies (1).

New services for volunteers were also suggested including paid staff to stabilise the project (2), more supervision (1), more counselling skills (1) and the recruitment of more ex-drug users as volunteers (1). Some of these suggestions are a further reflection of the need expressed by some volunteers in section 3.7 for more ongoing training and support within the project. This is an issue which needs to be addressed, possibly on an individual basis with each volunteer as required.

Figure 3.7 Indicators of Volunteer Satisfaction with Merchants' Quay Project, 1990 -1992

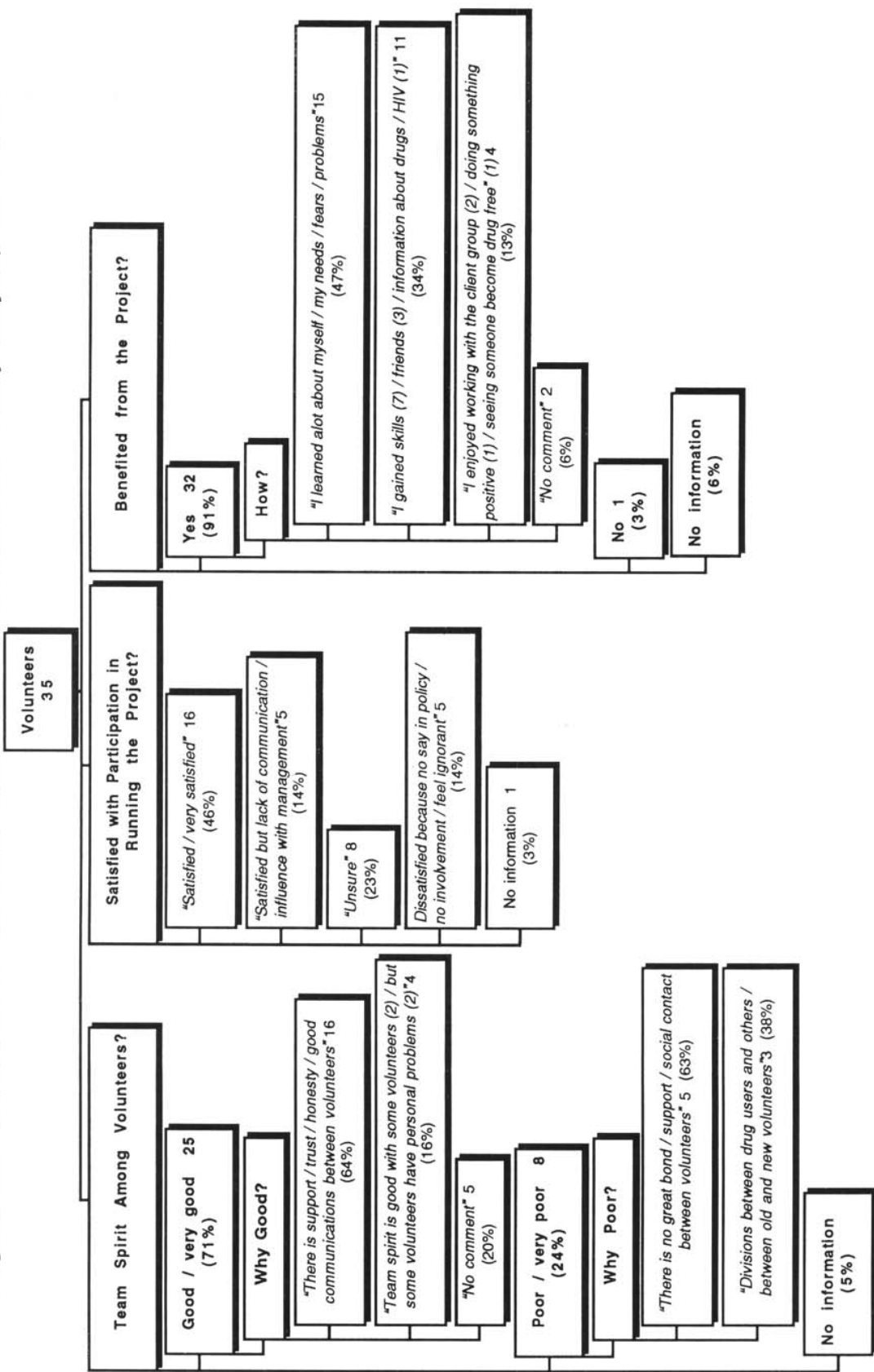
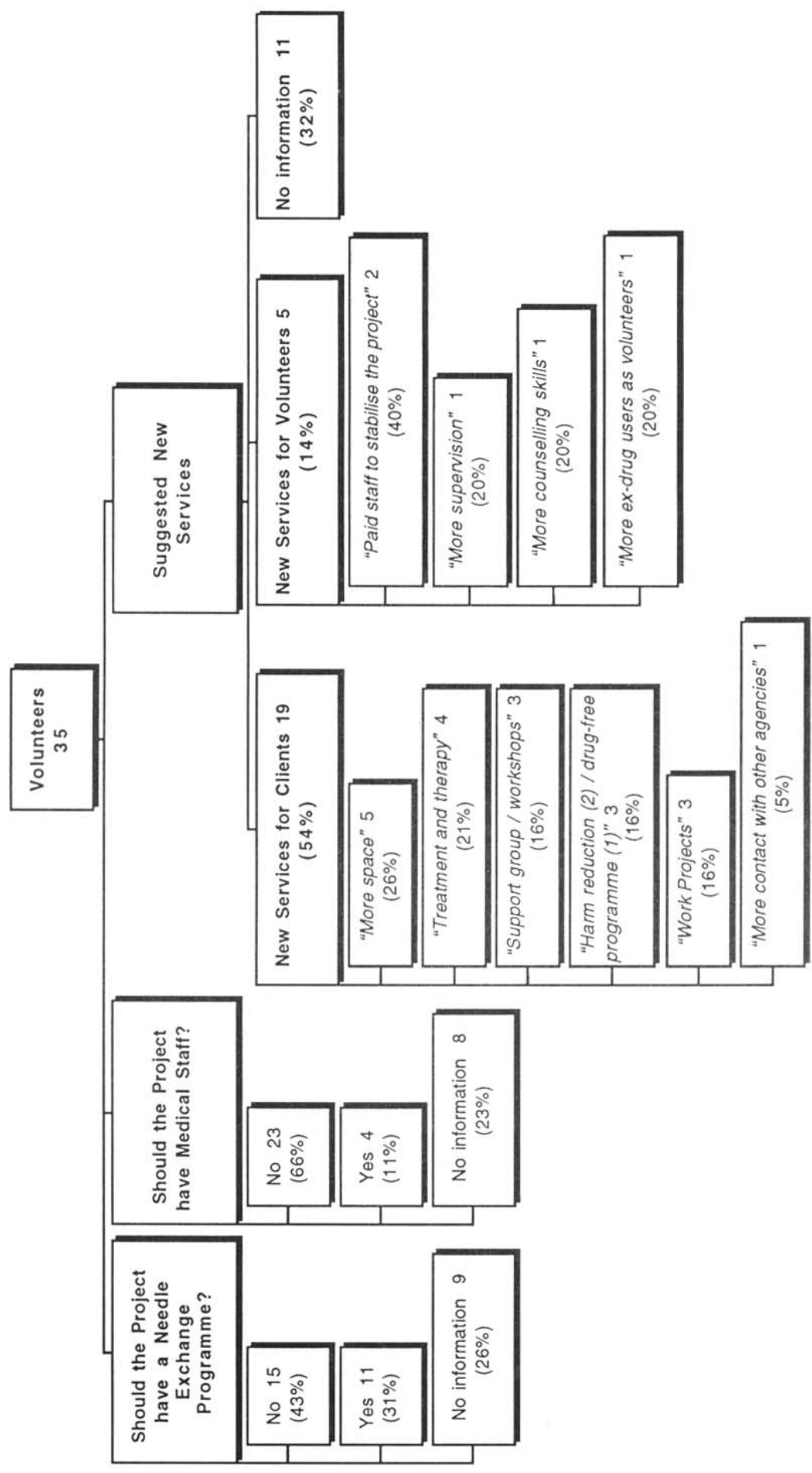


Figure 3.8 Volunteers' Attitude to Possible New Services at Merchants' Quay Project, 1990-1992



3.9 Summary

This chapter has highlighted some of the salient characteristics of volunteers. As a group, volunteers are mainly in their twenties and thirties, single, have lived abroad and are relatively evenly divided between women and men and between former drug users and non-drug users. They come from families where the father's occupation (mainly skilled manual, self-employed and farmers) suggests that they had a relatively comfortable upbringing. Volunteers have a level of education that is above that of the Irish population in general but may be somewhat below those currently completing their education. Two thirds have worked previously in a voluntary capacity and their career aspirations are mainly towards personal and social services, art, nursing and education.

All volunteers on the project go through an initial training programme which most found useful but inadequate. They suggested three things for improving the project's training programme: (1) change the content of the course to cover such topics as role play with clients, the needs of volunteers as well as information on other agencies; (2) change the organisation of the course to make it longer, have smaller groups, and use more professionals rather than former drug users; (3) provide ongoing training and more supervision in areas such as stress management, intervention and counselling. Elsewhere in the survey, volunteers mentioned the need for more supervision of their work as a way of improving their skills and learning from their mistakes.

Team spirit is good or very good among volunteers and all but one claimed to have benefited from working in the project, both personally and professionally. However about half are not satisfied with the way the project is run because of their lack of involvement and influence at the level of management. Analysis of the comments of volunteers suggests that there are some problems in the project in the areas of communication and participation which need to be addressed.

A needle exchange programme was introduced into the project in July 1992 and there appears to be widespread support for this development among volunteers. Some volunteers would also like to see more services for clients including a doctor, more treatment and therapy as well as work projects. This would require additional space, as some volunteers pointed out; it would also require additional financial resources.

Chapter Four

Socio-Economic Characteristics of Clients

4.1 Introduction

This chapter analyses some of the main socio-economic characteristics of clients using the Merchants' Quay Project: Drugs/HIV Service. In 1991, 247 clients visited the project. Of these 120 were contactable and were interviewed for the study. Given the difficulty of contacting clients it is almost impossible to draw a random sample of this group. Nevertheless, the number of clients interviewed for this survey constitute more than a fifth of all clients who ever visited the project (22% of 549) and more than two fifths of those who visited the project in 1991 (44% of 274). For this reason it is highly likely that the results of the survey are a reasonably reliable indicator of general trends within the client population.

The interviews with clients collected information on three main areas: socio-economic characteristics, drug use and related behaviours, usage and impact of services. A detailed analysis of the socio-economic characteristics of clients is presented in this chapter. The drug use and related behaviours of clients are analysed in Chapter Five while Chapter Six presents the results on usage and impact of services.

This chapter is divided into nine sections. Section 4.2 describes the throughput of clients to the project between February 1990 and June 1992. The analysis of the socio-economic characteristics of 120 clients begins in section 4.3 with a description of their demographic characteristics. This is followed in section 4.4 by a description of the family and living arrangements of clients. The employment and income characteristics of clients is the theme of section 4.5, while sections 4.6 and 4.7 respectively describe the family and social class background of clients. Clients' educational attainments are analysed in section 4.8. Finally, a summary of the key findings in the chapter is presented in section 4.9.

4.2 Throughput of Clients

Table 4.1 summarises data on the number of clients and the number of client visits made to the project in 1990, 1991 and in the first six months of 1992. The table reveals that, up to June 1992, the project was visited by 549 separate clients. Of these, two thirds were men (370, 67%) and one third were women (179, 33%). The proportion of women attending the project is higher than the proportion attending drug treatment services generally in the Greater Dublin Area. In 1990, nearly three quarters of the estimated drug treated population in the Greater Dublin Area were men (1,296, 74%) and just over one quarter (456, 26%) were women (O'Hare and O'Brien, 1992, p.18).

The data in Table 4.1 indicates a pattern of sustained growth in the number of clients and in the number of client visits between 1990 and 1992. In 1990 there was an average of 8.6 visits per day to the project, rising to 11.2 visits per day in 1991, rising again to 30.8 visits per day in 1992. This is a useful measure of workload within the project which increased by 258% between February 1990 and December 1992.

On average, each client made about four visits per month to the project, equivalent to approximately one visit per week. The number of monthly visits per client was highest in 1990 at 4.8 per client, falling to 3.4 per client in 1991 and rising again to 3.8 in 1992.

An important aspect of client visits is the distribution between "*new clients*" and "*old clients*" from one year to the next. In this context, a "new client" is someone who has not visited the project in a previous year;

conversely an "old client" has visited the project in the previous year. Table 4.2 summarises data on the number of new and old clients coming to the project in each year. Two trends are particularly noteworthy. The first is that the rapid growth in the number of clients between February 1990 and June 1992 means that the majority of clients in each year are new clients. In 1990 all clients were, by definition, new clients; in 1991 nearly three quarters of all clients (71.2%) were new clients while, in the first half of 1992, nearly three fifths of all clients (59.4%) were new clients.

Table 4.1 Number of Clients and Visits at Merchants’ Quay Project, February 1990 to December 1992

Month	Client Visits in 1990						Client Visits in 1991						Client Visits in 1992					
	No. of Visits		No. of Clients		Average Number of Visits per Client		No. of Visits		No. of Clients		Average Number of Visits per Client		No. of Visits		No. of Clients		Average Number of Visits per Client	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
January	NA*	NA*	NA*	NA*	NA*		204	7.6	41	5.1	5.0		379	5.1	101	5.0		3.8
February	74	3.9	15	3.8	4.9		198	7.4	55	6.9	3.6		597	8.1	145	7.2		4.1
March	100	5.3	25	6.3	4.0		187	7.0	54	6.8	3.5		652	8.8	154	7.6		4.2
April	90	4.8	31	7.8	2.9		149	5.5	58	7.3	2.6		556	7.5	152	7.5		3.7
May	199	10.5	41	10.3	4.9		210	7.8	67	8.4	3.1		569	7.7	138			4.1
June	212	11.2	43	10.8	4.9		221	8.2	63	7.9	3.5		642	8.7	139	6.8		4.6
July	247	13.1	48	12.1	5.1		184	6.8	60	7.5	3.1		744	10.1	162	6.9		4.6
August	168	8.9	41	10.3	4.1		206	7.7	79	9.9	2.6		657	8.9	190	8.0		3.5
September	235	12.4	46	11.6	5.1		264	9.8	76	9.5	3.5		621	8.4	178	9.4		3.5
October	226	12.0	44	11.1	5.1		259	9.6	76	9.5	3.4		636	8.6	201	8.8		3.2
November	178	9.4	35	8.8	5.1		354	13.2	87	10.9	4.1		636	8.6	232	10.0		2.7
December	162	8.6	28	7.1	5.8		252	9.4	81	10.2	3.1		703	9.5	227	11.5		3.1
Total	1,891	100	397	100	NA*		2,688	100	797	100			7,392	100	2,019	11.2		
Average per Month	172		36		4.8		224		66		3.4		616		168	100		3.8
Average per Day**	86		1.8				11.2		3.3				30.8		8.4			

The total number of clients who visited the project between February 1990 and June 1992 was 549, of whom 370 (67%) were women, and 179 (33%) were men.

Sixteen of the clients who visited the project in this period have since died.

*NA = No applicable because the project started in February 1990. **Based on the assumption of 20 days per month.

The total number of clients who visited the project between February 1990 and June 1992 was 549, of whom 370 (67%) were women, and 179 (33%) were women. Sixteen of the clients who visited the project in this period have since died.
 *NA = No applicable because the project started in February 1990. **Based on the assumption of 20 days per month.

Table 4.2 Distribution of Clients in Each Year by year of First Visit to Merchants' Quay Project, February 1990 – June 1992						
Year of first visit	Number of Clients seen in 1990		Number of Clients see in 1991		Number of Clients seen in 1992	
	N	%	N	%	N	%
1990	147	100.0	79	28.8	55	15.5
1991	NA*	NA*	195	71.2	89	25.1
1992	NA*	NA*	NA*	NA*	211	59.4
Total	147	100	274	100	355	100

NA* = not applicable

Visits by Clients to Merchants' Quay Project, February 1990 to June 92						
Number of Visits	Clients in 1990		Clients in 1991		Clients Jan-June 1992	
	No. of Clients	% of Annual Total	No. of Clients	% of Annual Total	No. of Clients	% of 6 mth Total
One	40	27.2	69	25.2	127	35.8
Two to ten	65	44.2	130	47.4	136	38.3
Eleven or more	42	28.6	75	27.4	92	25.9
Total	147	100	274	100	355	100

The second pattern is that about half of all clients continue to attend the project after one year and about a third after two years. In the case of clients who first visited the project in 1990, for example, more than half (79, 54%) attended the project in 1991 and more than a third (55, 37%) attended in the first half of 1992. Similarly in the case of clients who first visited the project in 1991, just under a half (89,46%) attended in the first half of 1992. If this pattern continues, along with the growth rate in the number of new clients, the overall throughput in the number of clients will continue to rise rapidly. If the average number of client visits per month remains constant, then the overall workload for the project will continue to rise substantially.

Notwithstanding the relatively high proportions of clients who continue to attend the project after one and two years, the question still arises as to why “old clients” cease coming and what happens to them subsequently. The project has no systematic information on this issue which moreover would be extremely difficult to collect.

Further information on the pattern of visits is outlined in Table 4.3. This reveals that more than a quarter (29.4%) visited the project only once. Nearly a third (30.9%) visited between two and five times while two fifths (39.6%) made more than ten visits. From this it emerges that three main types of client can be distinguished. The first type is the “*once-off client*” who comes to the project once and never returns. This type constitutes about 30% of the total. The second type is the “*occasional client*” who makes between two and ten visits to the project. This type also constitutes about 30% of the total. The third type is the “*regular client*” who visits the project more than ten times. This is the largest category of client constituting 40% of the total.

Table 4.3 reveals some relatively minor variations between 1990,1991 and the first half of 1992 in terms of the relative size of these three client types. The first variation is that the proportion of “regular clients” was significantly higher in 1990 than in either of the subsequent years. The second variation is that the proportion of “once-off clients” is much higher in the first half of 1992 than in either of the previous two years. This however may even out by the end of 1992.

4.3 Demographic Characteristics

Figure 4.1 reveals that nearly two thirds (78, 65%) of clients are men. Most clients are in their twenties or thirties with an average age of 30.3 years. Some of the clients who visit the project are known to be under 20 years but none of these appeared in the survey because they were not contactable. It is noteworthy that the average age of women is slightly lower (29 years) than men (31 years) in view of the fact that women tend to present for drug treatment at a later age than men (O’Hare and O’Brien, 1992, p.59; Woods, 1991, p.11).

The vast majority of clients (113,94%) were brought up in Dublin with more than two thirds of them (80, 67%) coming from the inner city. The high concentration of clients from the inner city of Dublin may reflect the location of the project in that area although it is also consistent with the known concentration of drug users in that area (see Chapter One above).

As a group, drug users appear to be relatively settled in terms of their residential accommodation. Nearly half (57,48%) did not change address in the previous year notwithstanding the relatively high residential mobility of this age group. On average, clients stayed at 2.1 different addresses in the previous year.

Approximately two thirds (78, 65%) of clients live in a local authority house or flat. In Ireland only 14% of households live in this type of accommodation (Household Budget Survey, 1987, Table 4). By contrast, the percentage living in a private rented house/flat/bedsit (11, 9%) is close to the national norm of 8% (Ibid). However the proportion who reported themselves as homeless (7, 6%) would appear to be exceptionally high given that the estimated number of homeless persons in Ireland is 5,000, equivalent to 0.1% of the total population (National Campaign for the Homeless, 1991; Nexus, 1992).

4.4 Family and Living Arrangements

Figure 4.2 reveals that the marital status of clients can be classified into two broad categories: those (70, 58%) who are not in a relationship (single, separated, deserted or widowed) and those (49, 41%) who are in a relationship (married or cohabiting).

Figure 4.1 Demographic and Other Characteristics of Clients at Merchants' Quay Project, 1992

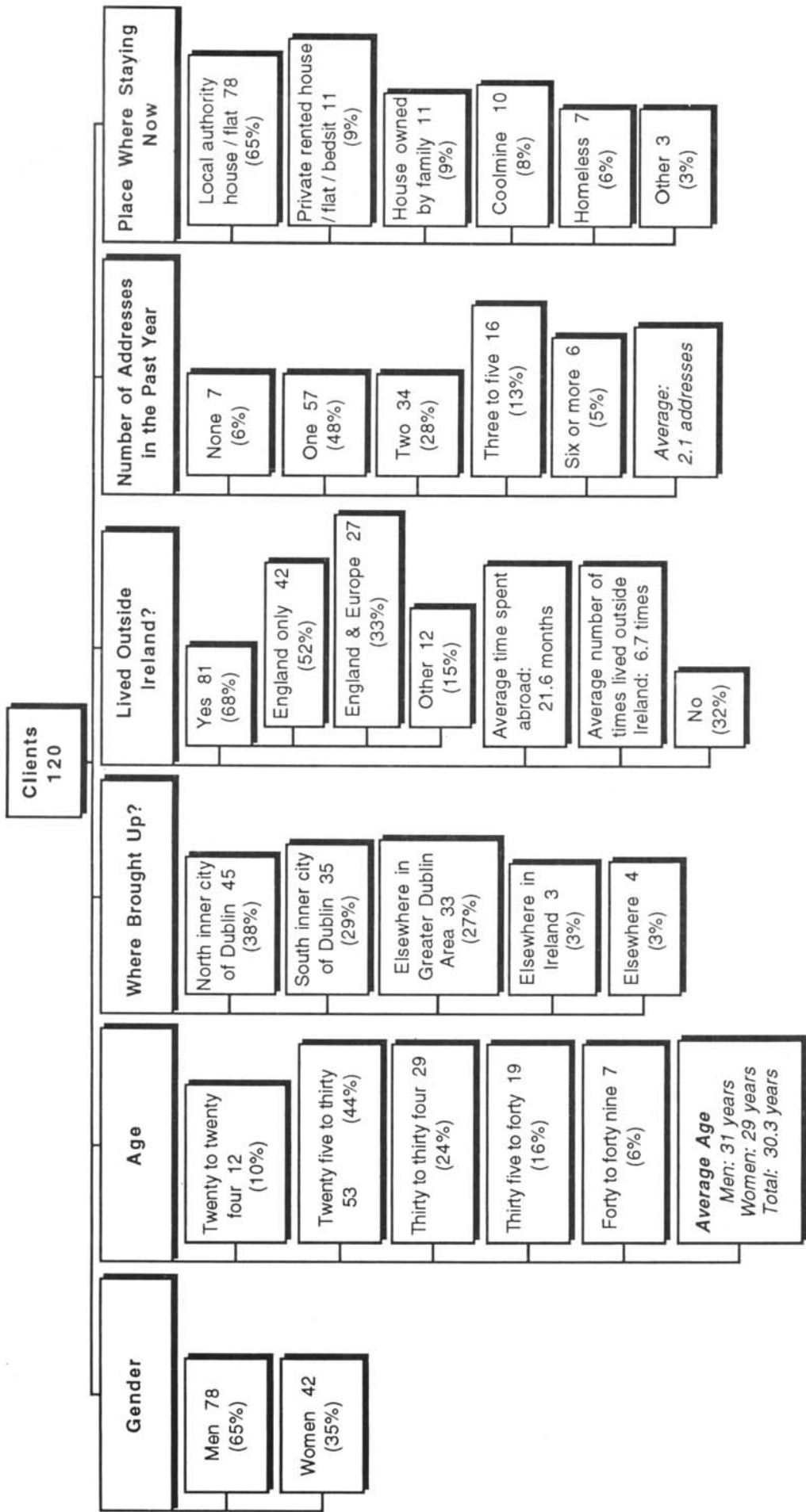
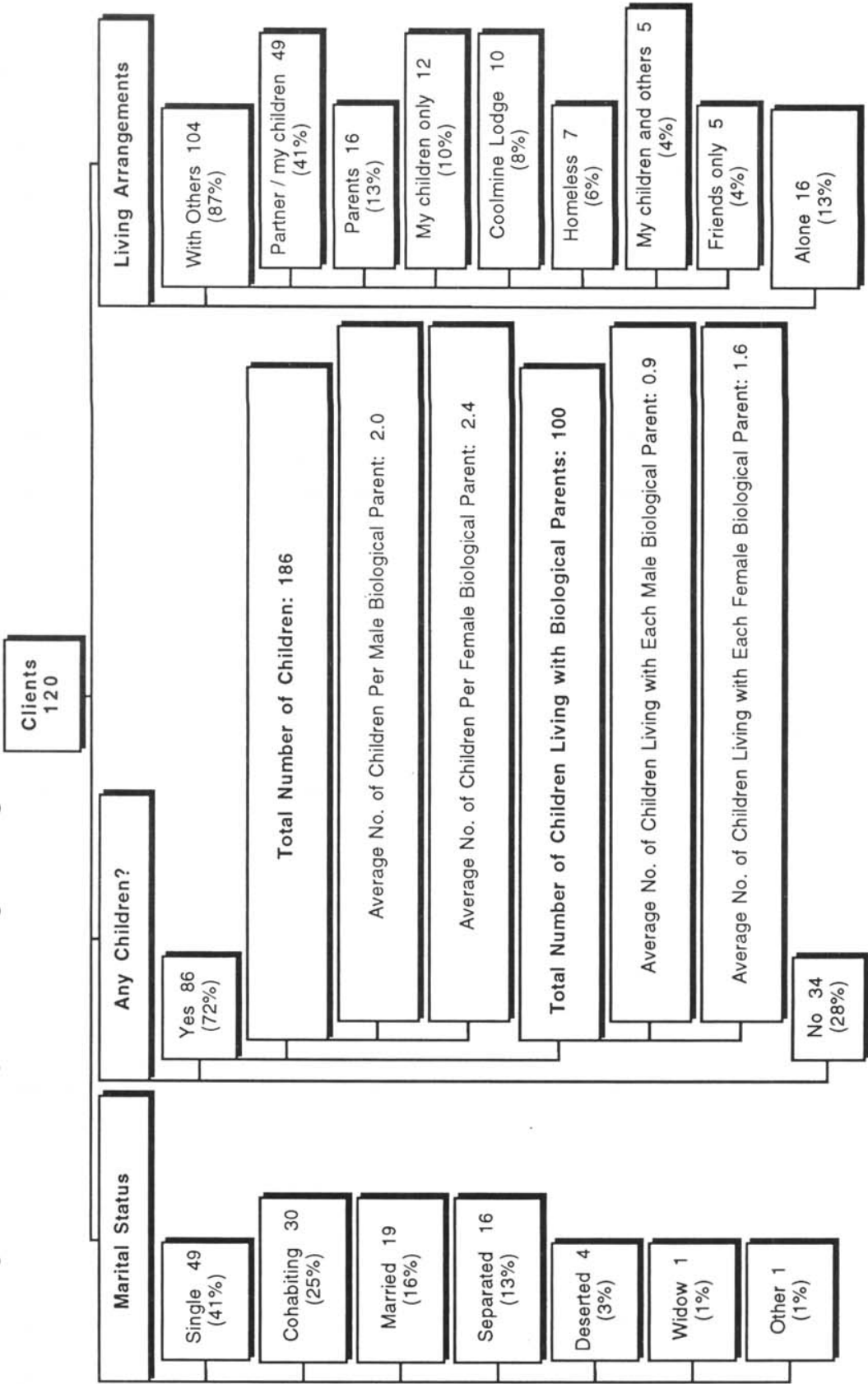


Figure 4.2 Family and Living Arrangements of Clients at Merchants' Quay Project, 1992



Nearly three quarters (86, 72%) of all clients have children. Collectively, these clients are biological parents to 186 children. Female clients have a slightly higher number of children (2.4) than male clients (2.0). A noteworthy feature of Figure 4.2 is the finding that only 100 of these children are living with their biological parents, a slightly higher proportion living with female parents compared to male parents. In other words, 86 children born of clients are no longer living with them. This means that 46% of the children of clients are being cared for by persons other than their biological parents. For comparative purposes it is worth noting that in Ireland in 1988 there were 2,756 children in health board care representing a rate of 2.12 per 1,000 children under 18 years, equivalent to 0.2% of this age group (Department of Health, 1990, Table D4, p.44; Census of Population, 1986; see also Gilligan, 1991, Chapter 9). In other words the number of children born of clients who are not living with their biological parents is extraordinarily high.

Figure 4.2 reveals that the vast majority of clients (104, 87%) live with others. All of those who are married or cohabiting (49, 41%) live with their partner and children. Others (12, 10%) live with their children only or with their children and others (5, 4%). Other living arrangements include those (12, 10%) who live with their parents, those who live in Coolmine Lodge, a therapeutic community for drug users (10, 8%), those who live with friends (5, 4%), and those who are homeless (7, 6%).

4.5 Employment and Income Characteristics

Figure 4.3 reveals that four fifths (97, 81%) of clients were unemployed at the time of interview, in June 1992. At that time, the seasonally adjusted unemployment rate in Ireland was 17% of the labour force (Live Register Statement, 1992, Table 8, p.7). Accordingly, clients have a much higher rate of unemployment rate than the labour force generally. Nevertheless it is significant that nine clients were employed. Further analysis of these clients reveals that four of them were drug free at the time of interview while a further two defined themselves as reducing/rehabilitating drug users. A small proportion of clients (7, 6%) classified themselves as housewives while a smaller proportion (6, 5%) are on long-term disability.

All of those who are unemployed have been in that position for over a year. Figure 4.3 reveals that more than four fifths (99, 83%) have been unemployed for the past year and can therefore be regarded as long-term unemployed. However a significant minority (21, 17%) had at least one job in the past year.

The present or previous work experience of clients is mainly in manual occupations. More than two fifths (51, 42%) are in semi- and unskilled manual occupations and more than a quarter (33, 28%) could be classified from their job description as skilled manual. It is noteworthy however that over one fifth of clients (25, 21%) have never worked.

It follows from the employment status of clients that the vast majority (108, 90%) are dependent on social welfare for their income. Only seven (6%) clients derive an income from employment. One client is in prison while another derives his income from male prostitution.

4.6 Family Background Characteristics

Figure 4.4 reveals that the vast majority of clients (116, 97%) were brought up in a family home. However the data also reveals that more than a quarter (33, 28%) spent some time in residential care when they were growing up. One fifth (23, 20%) were partly brought up by relatives/friends while a small proportion (4, 3%) spent some time during their upbringing in foster care.

The proportion of clients (36, 30%) who spent some time in residential care or in foster care (one client spent time in both) is extraordinarily high by Irish standards where, as indicated above, only 0.2% of children under the age of 18 were in any form of Health Board care in 1989. In view of the high proportion of clients' own children (86, 46%) who are not living with them, it would appear that the pattern of children not being reared wholly by their biological parents is a feature of both generations. This suggests that families, for whatever reason, are unable to deal with the demands of childrearing.

Some of the reasons which may have contributed to the high proportion of clients spending time in care are indicated in Figure 4.4 which lists some of the main problems experienced by them during their upbringing.

Figure 4.3 Employment and Income Characteristics of Clients at Merchants' Quay Project, 1992

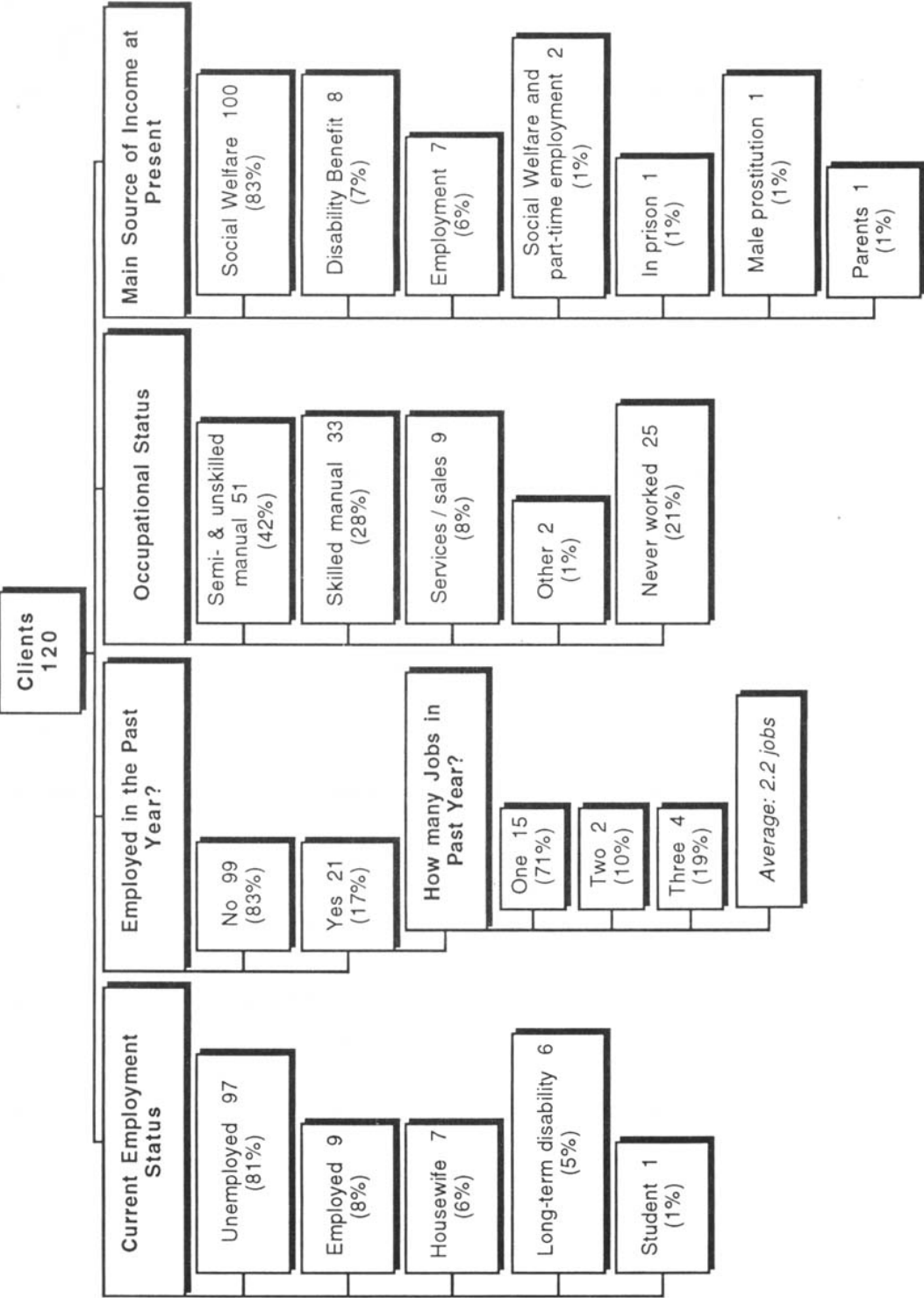
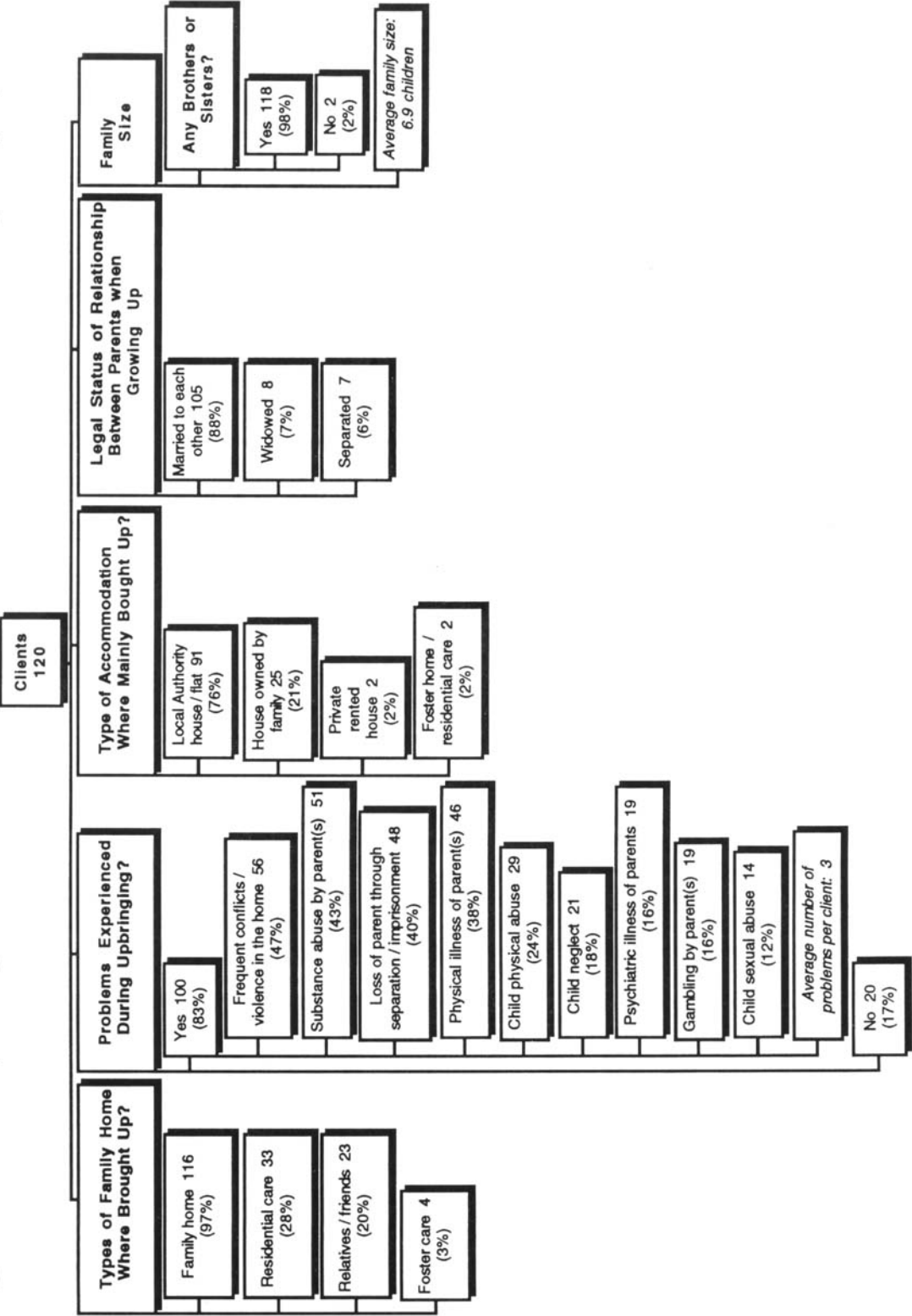


Figure 4.4 Family Background Characteristics of Clients at Merchants' Quay Project, 1992



Nearly half of all clients (56, 47%) reported that they experienced frequent conflicts/violence in the home. More than two fifths (51, 43%) experienced substance abuse by parents while two fifths (48, 40%) experienced the loss of parent(s) through separation or imprisonment. For under two fifths of clients (46, 38%) the physical illness of parents was a problem experienced during their upbringing. Nearly a quarter of all clients (29, 24%) experienced child physical abuse while they were growing up and just under a fifth (21, 18%) experienced child neglect. Smaller but significant proportions reported other problems during their upbringing including psychiatric illness of parents (19, 16%), gambling by parents (18, 15%) and child sexual abuse (14, 12%).

Only a small proportion of clients (20, 17%) experienced none of these problems. The vast majority (100, 83%) experienced an average of three problems each. No information is available on the prevalence of these problems in Irish families generally so that it is not possible to place these experiences of clients in a truly comparative perspective. Nevertheless the high proportion of clients who spent some time in care (37, 31%) suggests, other things being equal, that their upbringing was far from that typically experienced by the majority of Irish children. Other data, particularly in the area of education (see section 4.8 below), strongly supports this view.

Figure 4.4 reveals that more than three quarters of clients (91, 76%) were brought up in a local authority house/flat. One fifth (25, 21%) were brought up in a house owned by the family. This differs from the pattern of housing tenure in Ireland where 77% of all homes are owner occupied, 14% are rented from the local authority and 8% are rented from private landlords (Household Budget Survey, 1987, Table 4).

Figure 4.4 also summarises data on the legal status of the relationship between the biological parents of clients. It reveals that the biological parents were married to each other in the vast majority of cases (105, 88%). The remainder were either widowed (8, 7%) or separated (7, 6%). The proportion in the separated category is relatively low, although still higher than the proportion of the “ever married” population in Ireland (excluding widows) who described themselves as “separated” in the 1986 Census of Population (37,245, 2.7%).

Clients come from relatively large families, the average being 6.9 children. This is substantially higher than the average completed family size in Ireland in 1981, the latest year for which data is available, which was 4.16 children (Clancy, 1991, p.24).

4.7 Social Class Background

Figure 4.5a reveals that nearly three quarters of all clients (87, 72%) come from a background where the father was involved in some type of manual occupation. This is very different to the class profile of males at work in Ireland in 1985 where, as Figure 4.5b reveals, only 28% were involved in these types of occupations. However the proportion of clients’ fathers who were self-employed (10, 8%) is considerably higher than the 5% of males at work in Ireland who were in this category in 1985. Clients’ fathers are seriously underrepresented in middle class occupations (10, 9%) compared to males at work in Ireland generally (39%).

The majority of clients (90, 76%) reported that their fathers were employed full-time or were self-employed while they were growing up. The level of unemployment among clients’ fathers (8, 7%) appears rather low by comparison with the current employment experience of clients (see section 4.5 above). However the proportion of fathers who were employed part-time or occasionally (11, 9%) suggests that, in addition to those who experienced long-term unemployment, an even larger proportion may have experienced intermittent unemployment.

Figure 4.5a reveals that the predominant employment status of mothers (63, 53%) while the clients were growing up was housewife. This is identical to the national picture where, according to the 1989 Labour Force Survey, 53% of all women aged 15 years and over were described as being on “home duties” (Labour Force Survey, 1989). Less than a fifth of mothers (21, 18%) were employed or self-employed compared to over a quarter (27.5%) in the 1986 Census of Population. It is noteworthy however that over a quarter of the mothers (31, 26%) worked part-time or occasionally, twice the proportion of clients’ fathers. This is in line with most research on part-time work which identifies it as “female dominated” and involving low skill and low pay (Daly, 1984; Barry, 1991; Corcoran, Sexton, O’Donoghue, 1992).

Figure 4.5a Socio-economic Background Characteristics of Clients at Merchants' Quay Project, 1992

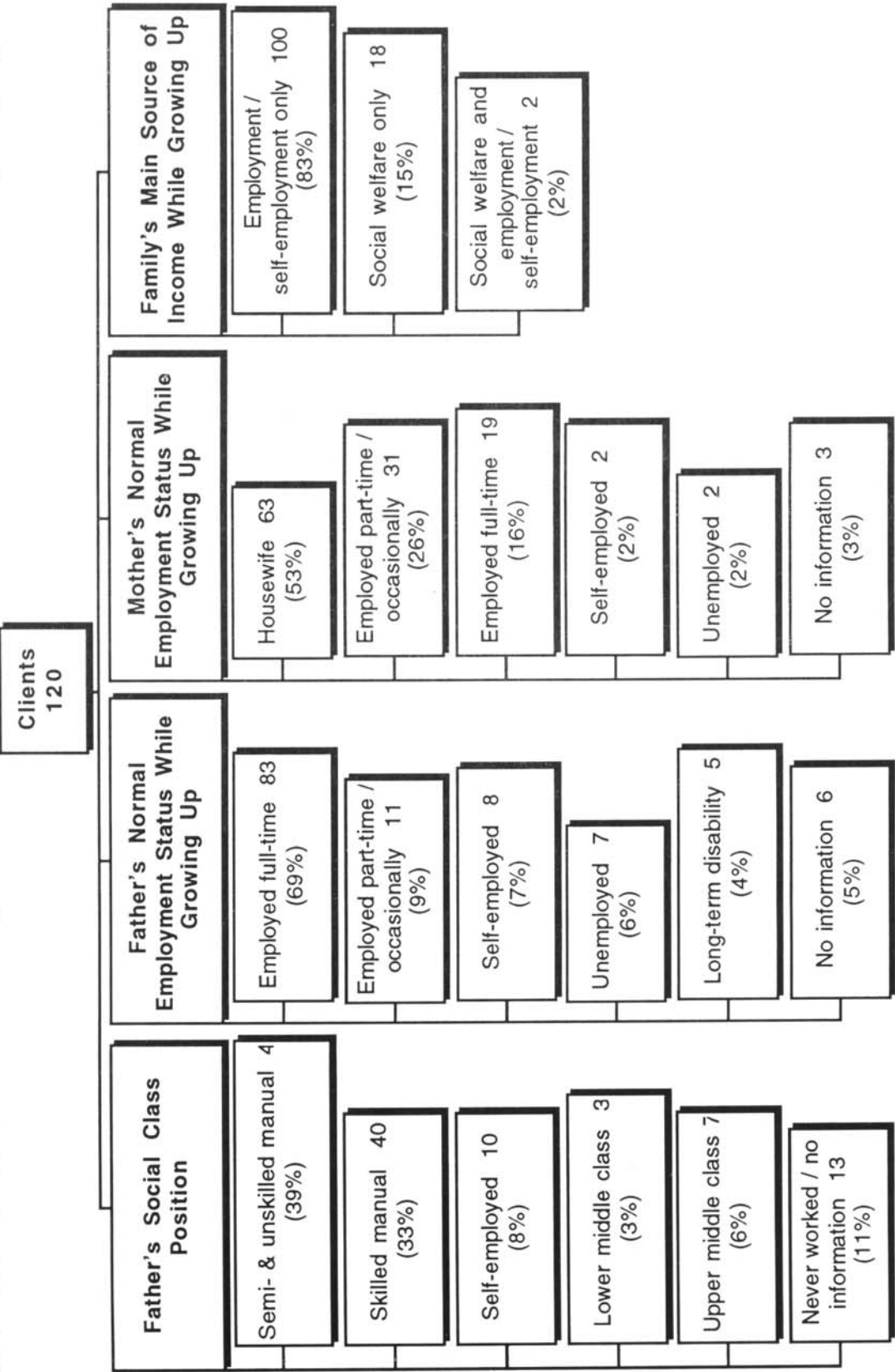
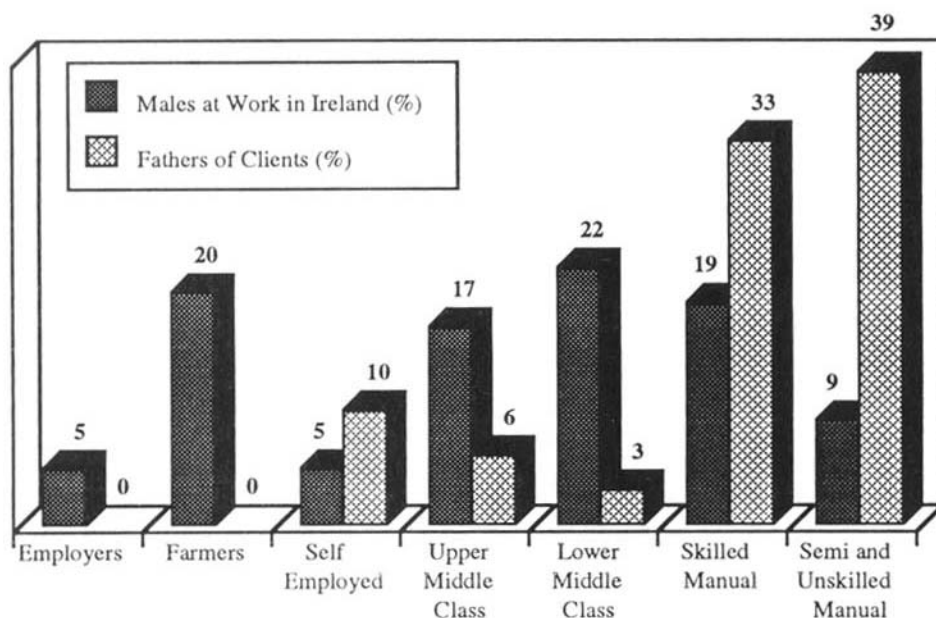


Figure 4.5b Social Class Characteristics of Clients' Fathers Compared to Males at Work in Ireland in 1985



Source: The data on males at work in Ireland in 1985 is taken from Breen, Hannan, Rottman and Whelan, 1990, p.57.

In line with the employment status of clients' fathers and mothers, the main source of family income in over four fifths of cases (100, 83%) was employment/self-employment. A substantial minority (18, 15%) were long-term dependants on social welfare. It is difficult to draw any definitive conclusions from this about the incidence of poverty in the families of clients while they were growing up. Nevertheless the relatively high proportion of fathers who were employed in semi- and unskilled manual occupations suggests that the wages coming into these families were probably quite low. This suggests, when added to the proportion who were long-term dependants on social welfare, that at least half of all the families of clients may have living close to the poverty line.

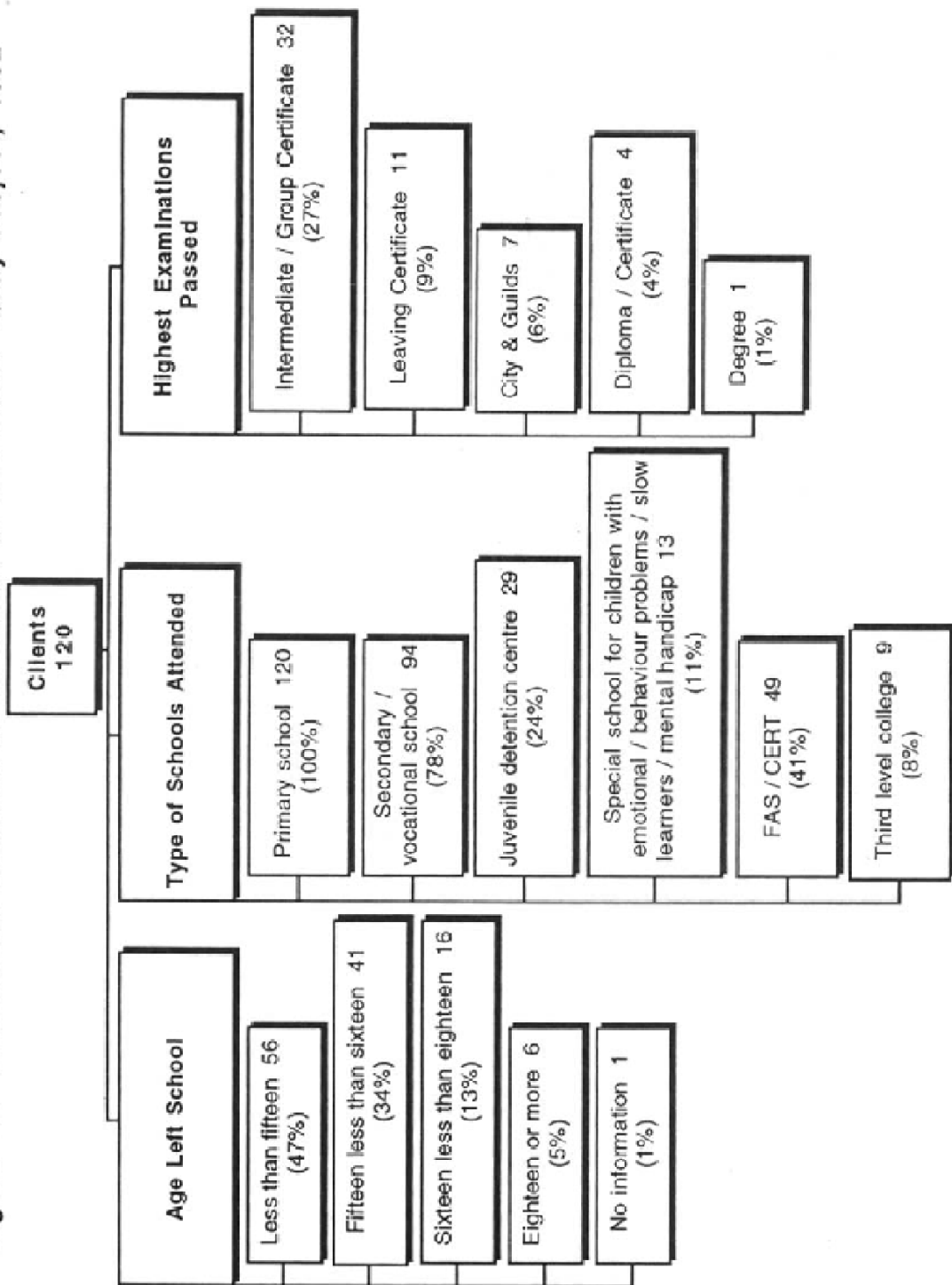
4.8 Educational Attainments

Figure 4.6 indicates that nearly half (56, 47%) of all clients dropped out of school before the age of 15 years, the statutory minimum age for leaving school in Ireland since 1972. Another third of all clients (41, 34%) left school between the ages of 15 and 16 years. Less than one fifth of clients (22, 18%) stayed on at school after the age of 16.

The drop-out rate from school among clients is 1.6 times higher than among the population in Ireland generally. In the 1986 Census of Population, 28.6% of the population aged 15 years and over reported leaving school before the age of 15 (Census of Population, 1986). For younger age groups the drop-out rate is likely to be lower still thereby exacerbating the contrast between clients and their contemporaries.

Every client (120, 100%) attended primary school and more than three quarters (94, 78%) attended secondary school. It is remarkable however that nearly a quarter (29, 24%) attended a juvenile detention centre. These were formerly known as reformatories and industrial schools but are now referred to as special schools. Only five of such schools for young offenders exist in the country with a capacity of around 170 places. Children attending such schools typically have serious personal and family problems and the background experiences of some clients described in section 4.6 would be consistent with this. Indicators of childhood trauma would also seem to be suggested by the fact that more than a tenth of clients (13, 11%) attended a special school for children with emotional problems/behaviour problems/slow learners/mental handicap.

Figure 4.6 Educational Attainments of Clients at Merchants' Quay Project, 1992



A relatively high proportion of clients attended a FAS/CERT course, probably due to the high levels of unemployment experienced since they left school (see section 4.5 above). By contrast the proportion who attended a third level college (9, 8%) is about five times lower than the norm among the school leaving population in Ireland in 1991/1992, 40% of whom attended a third level college (Government of Ireland, 1992a,p.183).

The educational attainments of clients is also well below the norm when measured by the highest examination passed. Figure 4.6 reveals that the highest educational qualification of just over a quarter (32, 27%) of clients is the Intermediate Certificate/Group Certificate. This however is only half the proportion in the Irish labour force (28%) who reported that this was their highest educational attainment in 1989 (Corcoran, Sexton, O'Donoghue, 1992, Table 2.4, p.18). The highest educational qualification of less than one tenth of clients (11, 9%) is the Leaving Certificate. The comparable figure for the Irish labour force in 1989 was 28%, nearly three times higher (Ibid). However it is worth noting that in 1990 more than three quarters (77.5%) of all school leavers passed the Leaving Certificate thus placing the educational achievements of clients in an even more invidious light (Department of Labour, 1991, Table 2). *The* proportion of clients with a third-level qualification (5, 4%) is small compared to the 1989 labour force where 17% have a third level qualification (Corcoran, Sexton, O'Donoghue, 1992, Table 2.4, p.18). Again the proportion attending third level education in Ireland in the 1990s and graduating with a qualification is much higher than in the population/labour force generally.

Overall the level of educational attainment of clients as measured by age on leaving school and by highest examination passed is quite low. Moreover the substantial proportion of clients who attended special schools suggests that, for this substantial minority at least, their lack of educational achievement was only one of their problems.

4.9 Summary

The overall picture emerging from this analysis suggests that clients of Merchants' Quay Project are predominantly men in their twenties and thirties from the inner city of Dublin. Most are parents of children but nearly half of the children born of clients are not living with them. The phenomenon of children not being reared by their biological parents, while exceptional in Irish society, is not entirely new to clients since more than a quarter of them spent time in residential care during their upbringing. The vast majority of clients appear to have experienced major family traumas in their upbringing and this may help to explain not only the high proportion who spent some time in residential care but why a similar proportion spent some time in a juvenile detention centre. In terms of education and employment, clients are a seriously disadvantaged group and this is further compounded by their family background experiences and their current drug use and HIV status. The converse of this profile is that (lie needs of clients are complex and multifaceted. In addition to providing support, counselling and treatment for the problems associated with drug use and HIV, clients would also appear to have acute needs in the areas of education, training and personal development. The particular characteristics and needs of drug users in terms of their drug use and related behaviours will now be analysed in Chapter Five.

Chapter Five

Drug Use and Related Behaviours of Clients

5.1 Introduction

This chapter analyses the drug use and related behaviour of clients using the Merchants' Quay Project: Drugs/HIV Service. As in the previous chapter, the data is based on a survey of 120 clients who visited the project in 1991. The analysis begins in section 5.2 with a profile of the type of drugs used by clients followed, in section 5.3, by a description of their injecting practices. In section 5.4 the danger of hospitalisation and overdosing from drugs is examined. The prevalence of drug use within clients' social network is the theme of section 5.5. Drug use can be an expensive habit as the analysis in section 5.6 reveals and frequently leads clients into conflict with the law, as section 5.7 confirms. The prevalence of HIV among drug users is known to be high (see Chapter One) and its perceived prevalence in the social networks of clients is examined in section 5.8. Sexual activity is one of the modes of transmission of HIV and some basic features of this behaviour among clients are analysed in section 5.9. Finally, in section 5.10, there is a brief summary of the key findings of the chapter.

5.2 Type of Drugs Used by Clients

Figures 5. 1a and 5.1b summarise data on the primary and secondary drugs used by clients. In this context, the term "primary drug" is used to refer to the drug which is taken most frequently; the "secondary drug" is used less frequently either as a substitute or a supplement to the primary drug.

The data in Figure 5.1a reveals that more than three quarters of all clients (95, 79%) currently use drugs. Conversely more than one fifth (25, 21%) do not use drugs and would classify themselves as either recovered or rehabilitating drug users.

Among current drug users, the primary drug used by the vast majority (85, 89%) is an opiate. This consists mainly of physeptone (55, 58%), a synthetically produced heroin substitute whose generic name is methadone. Heroin itself is used by a fifth (19, 20%) of drug-using clients. The other opiate used is MST (Morphine Sulphate Tablet), a morphine-based pain-killing tablet produced by Napps and used by just over one tenth (11, 11%) of drug-using clients. The remainder of drug-using clients (10, 11%) use other drugs, mainly cannabis. The reported use of cannabis is low in view of the recent claim that "*cannabis is probably the most widely misused drug in Ireland*" (O'Hare and O'Brien, 1992, p.63) although this may be due to the fact that few of these users present for treatment.

Figure 5. 1a also reveals that more than four fifths (78, 82%) of drug-using clients take their primary drug at least once a day. The remainder (17, 17%) is relatively evenly divided between those (8, 8%) who take drugs twice or more weekly and those (9, 9%) who take them once weekly or less. The reduced frequency of drug use in this group is due mainly to the availability of drugs since many of these clients would still describe themselves as problematic drug users and some of them were in prison at the time of interview. Moreover the usual method of reducing drug use, at least in the short term, involves decreasing the amount rather than the frequency of drug taking so that less than daily usage is usually determined more by the availability of drugs than by the desire to take them less frequently.

The main method of using primary drugs, according to Figure 5.1a, is eating/drinking. More than half (55, 58%) of all drug-using clients use this method and is clearly related to the fact that a similar proportion use physeptone which is an oral solution. More than a quarter (27, 28%) inject, similar to the proportion who use heroin and Napps/MST. Smoking is the method used by more than one-in-seven drug-using clients (13, 14%) while only one person reported sniffing drugs. The proportion of clients who inject is nearly two and a half times less than that found among the drug-treated population in the Greater Dublin Area in 1990, two thirds of whom (1,191, 68%) indicated that they inject their primary drug (O'Hare and O'Brien, 1992, p.24).

Figure 5.1a Primary Drug Used By Clients of Merchants' Quay Project, 1992

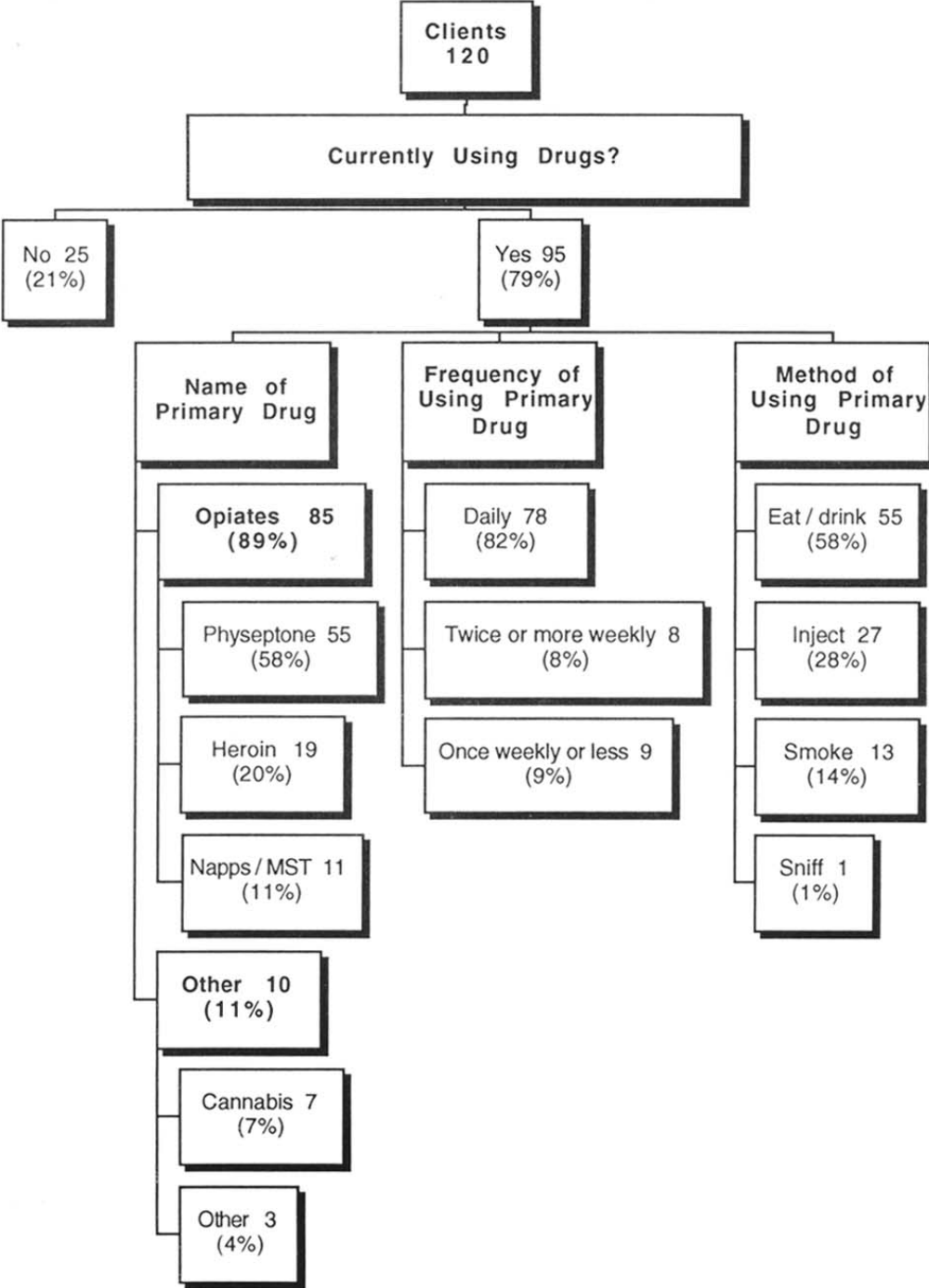


Figure 5.1b Secondary Drug Used By Clients of Merchants' Quay Project, 1992

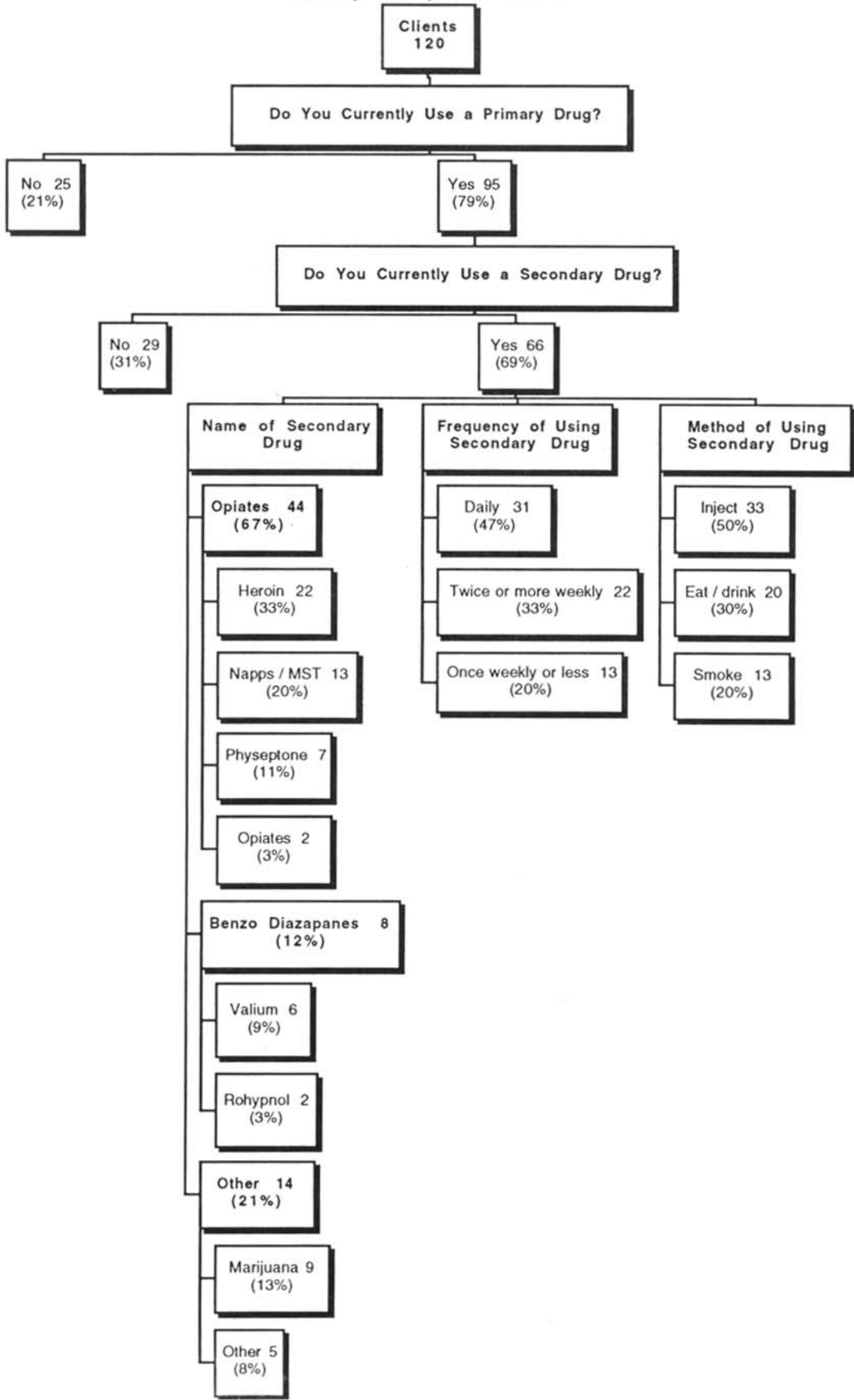


Figure 5.1b reveals that more than two thirds (66, 69%) of drug-using clients also use a secondary drug. More than two thirds of these (44, 67%), in turn, use an opiate, either heroin (24, 36%) or its substitute, physeptone (7, 11%) or MST (13, 20%). Just over a tenth (8, 12%) use some form of benzodiazapane, either valium (6, 9%) or rohypnol (2, 3%). About one fifth (14, 21%) use other drugs, including marijuana, as their secondary drug.

Just under half of drug-using clients (31, 47%) take a secondary drug every day. As with the primary drug, the frequency of taking a secondary drug seems to be determined mainly by its availability.

Figure 5.1b reveals that half (33, 50%) of all secondary drugs are injected since this is probably the preferred way of taking heroin and MST. The other methods of taking secondary drugs are eating/drinking (20, 30%) and smoking (13, 20%).

Overall these findings are rather similar to previous surveys of drug use in Dublin, particularly with respect to the preferred drug, opiate and the use of more than one drug. An important difference from previous studies however is the fact that clients in the project take drugs mainly through eating/drinking rather than, as reported in all previous studies in Dublin, intravenously. The reason for this seems to lie in the fact that physeptone, a heroin substitute in oral form, is the most widely used primary drug. This is a significant finding in view of the fact that drugs taken orally rather than intravenously reduce the risk of HIV transmission and are generally safer from a health point of view. It is worth noting however that in Dublin medically-prescribed, and therefore legally available, physeptone for drug users is extremely limited. The consequences of this for drug users in terms of the cost of street drugs and their involvement in crime are explored more fully below in sections 5.6 and 5.7.

5.3 Injecting Practices of Clients

The method of injecting drugs and the cleanliness of the injecting equipment have important implications for the health of users. Problems with abscesses, collapsed veins and particularly the spread of HIV can all be caused by unsafe injecting practices.

Figure 5.2 reveals that less than half (51, 43%) of all clients inject drugs, although this amounts to slightly more than half (51, 54%) of all drug-using clients. On average, clients who are currently injecting started to inject when they were 17.6 years. However women started to inject at a later age (19.4 years) than men (18.0 years), a finding consistent with previous research which indicates that women start taking drugs later than men (O'Hare and O'Brien, 1992, p.59). Given that the average age of clients is 30.3 years, this suggests, other things being equal, that drug-using clients have been injecting for an average of 12.7 years.

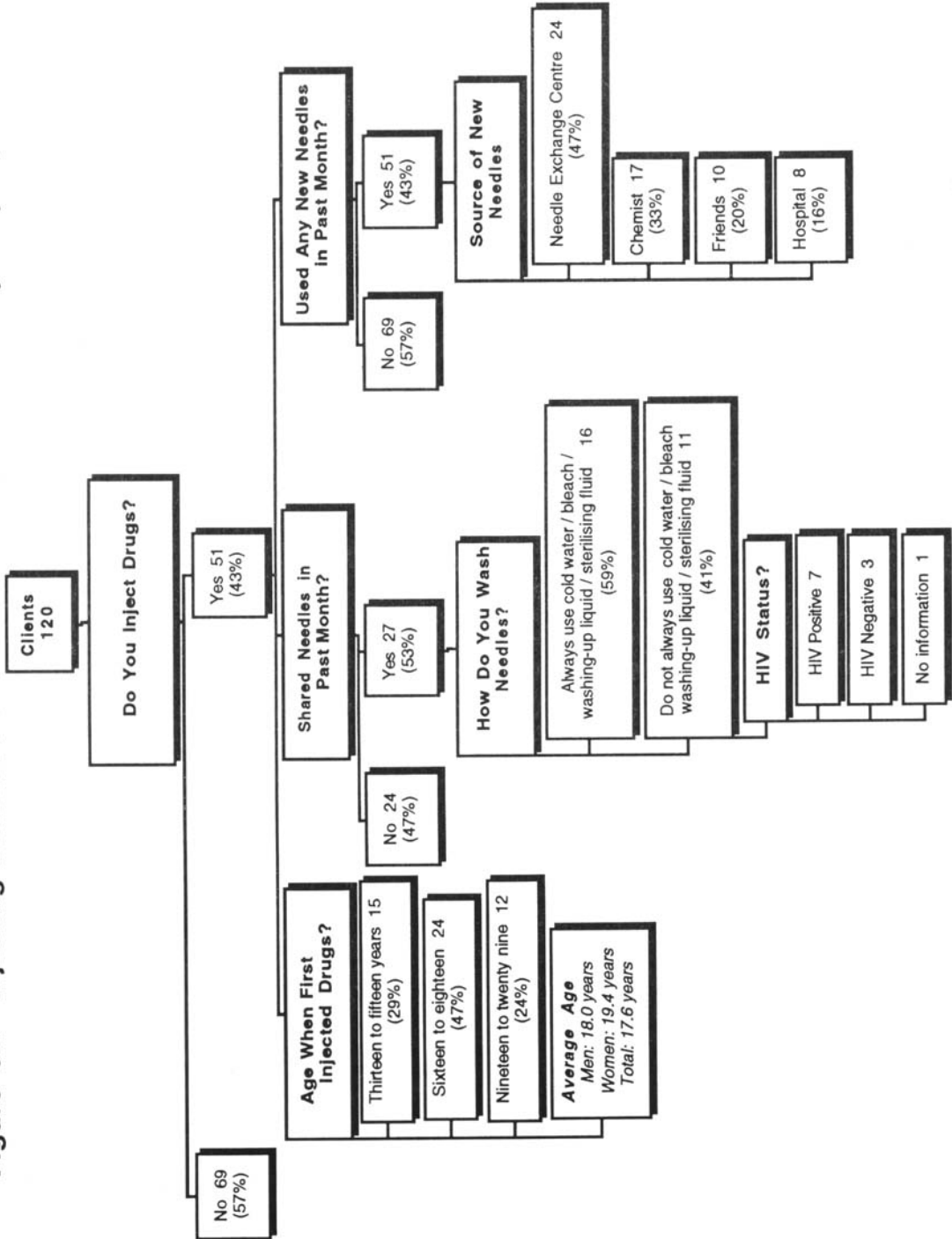
Drug use is a social activity and sometimes involves the exchange of needles between users. This is confirmed in Figure 5.2 by the fact that more than half (27, 53%) of those who inject also share needles. There was no difference between men and women in terms of the proportion sharing needles. Sharing needles can however be a risky behaviour if the needles are not sterile because it can lead to the spread of HIV.

In general, all forms of needle sharing have some risk attached to them. However the risk can be minimised if needles are washed in cold water, bleach, washing up liquid or sterilising fluid. Using this standard, Figure 5.2 indicates that nearly two thirds of those involved in needle sharing do so in a manner which minimises the risk of spreading HIV. The remainder (10, 41%) however indicated that they did not always wash their needles in cold water, bleach, washing-up liquid, or sterilising liquid. Consequently they could be spreading HIV through needle sharing.

Further analysis of this group reveals that two thirds of them (7, 64%) are HIV+ and one has not been tested. In other words, seven clients are engaged in definitely risky needle sharing practices and one is involved in potentially risky needle sharing practices from the point of view of HIV transmission. Overall therefore, approximately 7% of all clients - but 16% of all injecting drug users - are involved in needle sharing practices which are risky from the point of view of HIV transmission.

The number of clients who share contaminated needles is relatively small as a proportion of total population surveyed (10, 8%). This may be due to the fact that within the project, considerable emphasis is placed on

Figure 5.2 Injecting Practices of Clients at Merchants' Quay Project, 1992



providing clients with information on safer methods of drug use including information on how to clean needles. Since July 1992, the project also supplies clients with new needles and syringes. The evidence in Figure 5.2 suggests that drug users may be adopting increasingly safe practices in respect of needle sharing, although this may not be true of the drug-using population in general. In particular it may not be true of the drug-using population who are not in contact with any services and may not be aware of the dangers of sharing contaminated needles, or are unable to procure sterile equipment.

The safest method of injecting drugs is to use a sterile needle and a sterile syringe for each injection. Syringes that have already been used may become contaminated if the user draws blood into the barrel in order to ensure that the needle is in the vein. It is for this reason that in 1992 the Eastern Health Board, in its six needle exchange centres throughout Dublin, provide drug users with a sufficient supply of both sterile syringes and sterile needles to meet their injecting requirements. As indicated above however, medically prescribed and legally controlled access to drugs is much more limited and could be interpreted as giving contradictory messages to drug users.

Figure 5.2 reveals that all of those who currently inject (51) have used new needles in the past month, nearly half of them (24, 47%) from needle exchange centres. One third (17, 33%) of the new needles came from chemists and the remainder (10, 20%) came from friends. It is noteworthy that only half of all needles were obtained from needle exchange centres where they are distributed free of charge and in sufficient quantity to meet the demands of users. This suggests that the remaining half of injecting drug users may not be using completely sterile equipment each time they inject. The limited use of needle exchange centres is probably due to the fact that most of the needle exchange centres in the Eastern Health Board area (with the exception of the AIDS Resource Centre) have only been set up in the latter half of 1992, after the interviews were completed.

5.4 Impact of Drug Use on Health of Clients

Drug use can damage health depending on the type and amount of drugs taken, the method of taking, and on whether they are taken singly or in conjunction with other drugs. They can also affect health through the lifestyle of drug users particularly in areas such as diet, exercise, stress, etc.

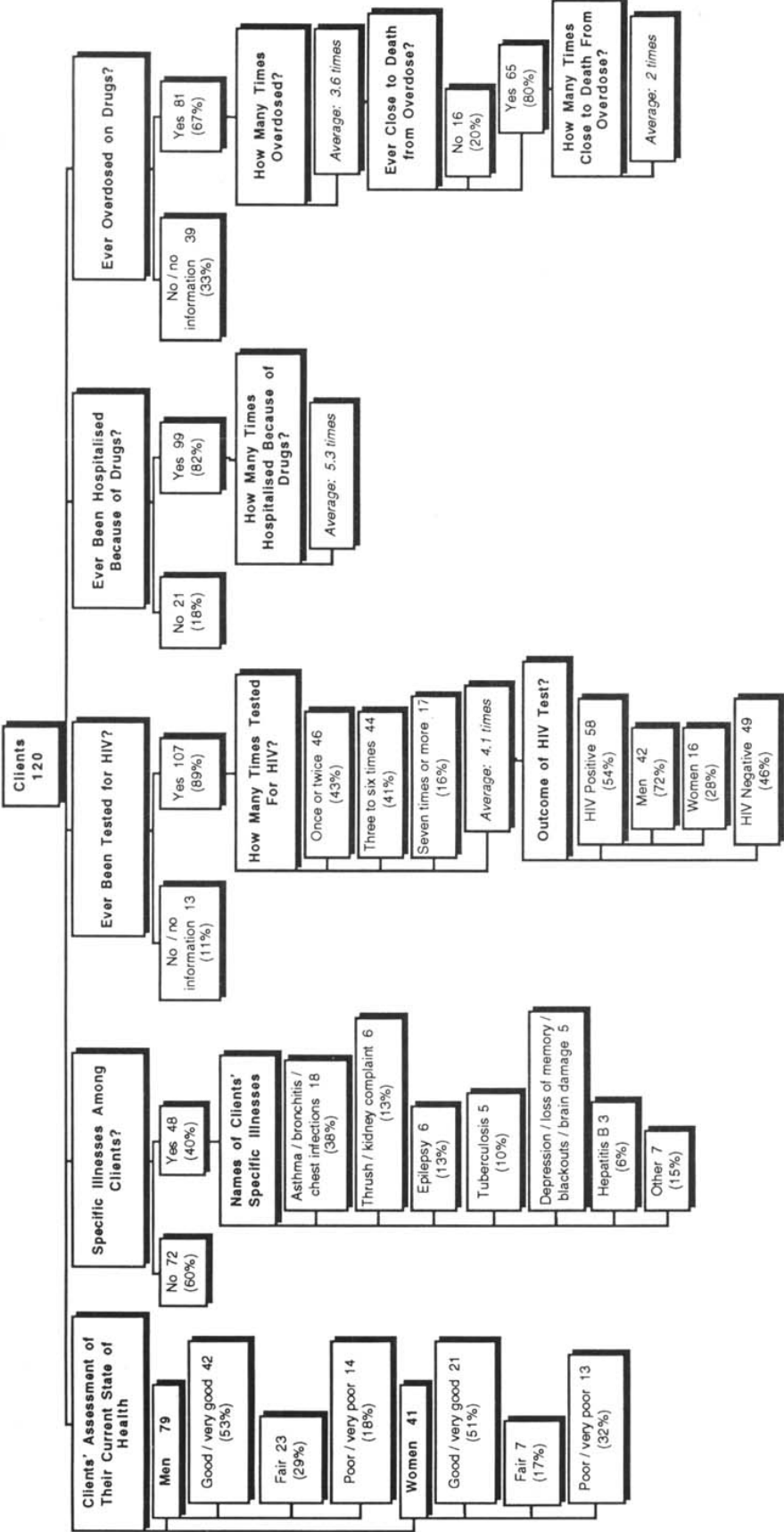
Figure 5.3 provides some general indicators on the health of clients. The data reveals that the majority of clients, both men and women, are in good or very good health, in their own estimation. However nearly a third of women clients (13, 32%) perceive themselves to be in bad or very bad health compared to just under a fifth of men (14, 18%). This difference in perceived health between men and women is not entirely surprising and is consistent with the results of other epidemiological studies which show that, compared to men, women drug users have higher levels of personal distress such as depression and anxiety and lower levels of self-esteem (see United Nations, 1987).

A substantial proportion of clients (48, 40%) reported having specific illnesses. More than a third of these (18, 38%) have respiratory complaints including asthma, bronchitis or chest infections. This is not an uncommon complaint among drug users, particularly those using heroin. Six clients have thrush or a kidney complaint and a similar number have epilepsy. Five clients reported having tuberculosis which could signal the re-emergence of a disease which was eradicated in Ireland in the 1950s. A similar number of clients suffer from either depression, loss of memory, blackouts or brain damage. Three clients reported having Hepatitis B, a complaint usually associated with intravenous drug use.

It is clear from this that a substantial proportion of clients have serious health problems. Moreover these problems should be seen in the context that more than half of all clients (58, 54%) are HIV positive. This is the general prevalence rate of HIV within the client group given that, as Figure 5.3 reveals, nearly nine tenths (107, 89%) have been tested for HIV. This is much higher than the national prevalence among drug users suggested by Department of Health statistics which indicates that 11.8% of drug users who have been tested are HIV+ (Table 1.1).

There is a significant gender difference in the distribution of HIV+ among drug users. Figure 5.3 reveals that nearly three quarters (42, 72%) of those who are HIV+ are men, similar to the proportion in the national population of drug users who have tested positive (see Table 1.1 above).

Figure 5.3 Impact of Drug Use on Health of Clients at Merchants' Quay Project, 1992



The previous medical history of clients also provides an insight into the toll which drug use may have had on their health. The data in Figure 5.3 indicates that more than four fifths (99, 82%) of all clients have been hospitalised as a result of drug use. On average these clients have been hospitalised about five times. The specific drug-related reasons for hospitalisation were not ascertained although they are likely to include detoxification, abscesses, blood clots, septicaemia, and overdoses.

Information on overdosing was collected from clients and reveals that more than two thirds (81, 67%) have overdosed on drugs. On average this occurred 3.6 times.

In the main, overdosing seems to be due to lack of knowledge about the effect of varying the amount of a drug used or about the effect of mixing it with other drugs. Typically this occurs among younger drug users and is usually without any suicidal intent. Nevertheless overdosing can be fatal and four fifths (65, 80%) of those who have overdosed indicated that they have been close to death as a result. On average this group has been close to death twice as a result of overdosing.

Overall the evidence suggests that drug use has had a negative effect on the health of many clients, notwithstanding the fact that more than half describe their current state of health as being good or very good. In addition to their current health problems, the fact that more than half are HIV positive suggests, other things being equal, that the range of health problems and their associated needs are likely to grow in the future.

5.5 Drug Use Within Clients' Social Network

Figure 5.4 provides some indicators of the extent of drug taking within clients' social networks. These networks include the clients' brothers and sisters, the persons living with clients and the persons living in their neighbourhood.

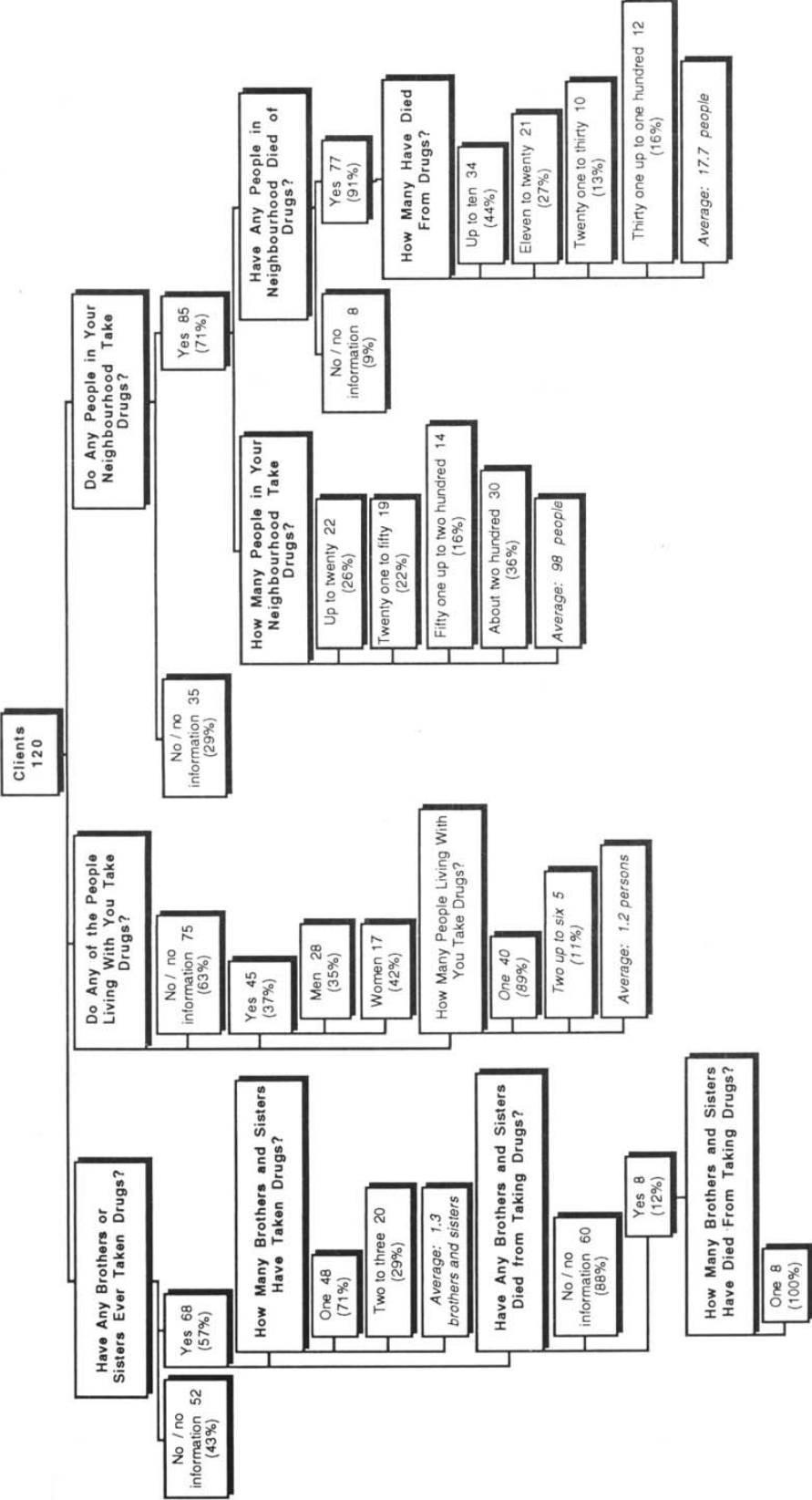
In terms of brothers and sisters, more than half (68, 57%) of all clients have a brother or sister who has taken drugs. The majority of these (48, 71%) have only one brother or sister who has taken drugs although more than a quarter (20, 29%) have between two and three. This suggests that, on average, two persons per family are drug users. This is about one third of the children in each family, given that the average family size of clients is 6.9 children (see Chapter Four). Eight clients have brothers or sisters who have died of drugs.

In terms of the persons living with them. Figure 5.4 reveals that the majority of drug users (75, 63%) are not living with other drug users. Conversely, just over a third (45, 37%) are living with a drug user, typically one other person. A slightly higher proportion of women clients (17, 42%) are living with a drug user compared to men (28, 35%). Among the drug-treated population in the Greater Dublin Area in 1990, the proportion living with a drug user was much lower (13%) and the gender differences much greater with a quarter (25%) of women living with a drug using partner compared to under a tenth (8%) of men (O'Hare and O'Brien, 1992, p.20).

In terms of their neighbourhood, the perception among the majority of clients (85, 71%) is that an average of 98 people are taking drugs in their area. The actual estimate of the number of neighbours who are taking drugs is not necessarily exact. However the high number of neighbours who are estimated to be taking drugs is an indicator that drug use is perceived to be widespread in the clients' immediate environment. By the same reasoning, it is noteworthy that nearly all (77, 99%) of those who know of drug users in their neighbourhood also know neighbours who have died of drugs. On average these clients claim to know of nearly 18 persons each who have died from drugs in their neighbourhood. Deaths on this scale from any other cause and in any other type of community could well be regarded as an epidemic and a major public health hazard.

Overall clients live in an environment where they perceive relatively high levels of drug use, both among their brothers and sisters but especially among their neighbours. This is counteracted somewhat by the fact that the majority do not live with other drug users. However the perception of relatively widespread drug use, including fatalities from drug use, among clients' social networks is not surprising given the known geographical concentration of drug users in selected areas within Dublin's inner city (see Chapter One). The precise way in which these social networks operate has not been researched but are important for understanding some of the

Figure 5.4 Drug Use Within the Social Network of Clients at Merchants' Quay Project, 1992



factors affecting the lifestyle and life cycle of drug use, its mode of transmission as well as the methods used to cope with its vicissitudes.

5.6 Financial Cost of Drug Use

Figure 5.5 summarises information on the financial cost of drug use among clients of the project. The data is based on estimates provided by each client of the amount spent during a typical week within the past month (June 1992) on street drugs, prescribed drugs and doctors' prescriptions. In this context "street drugs" refer to illegal drugs which are purchased "on the street" from drug dealers.

The results reveal that the average total weekly amount spent by all clients on all drugs amounted to IR£14,643. Over a twelve month period, this implies that the cost of procuring drugs for clients exceeds three quarters of a million pounds (IR£761,436).

The breakdown of the weekly amount spent on drugs indicates that more than four fifths (IR£12,511, 85%) was spent on street drugs, one tenth (IR£1,393, 10%) was spent on prescribed drugs and the remainder (IR£719, 5%) was spent on doctors' prescriptions. The amount of money spent by clients on street drugs comes entirely from their "own" resources unlike the amounts spent on doctors' prescriptions and prescribed drugs which, for medical card holders, are reclaimable from the Eastern Health Board under the Drugs Refund Scheme upon submission of appropriate receipts at the end of each month. Of the 38 clients who spent money on doctors' prescriptions and prescribed drugs, 34 had a medical card although it is not known if all of them made a claim under the Drugs Refund Scheme.

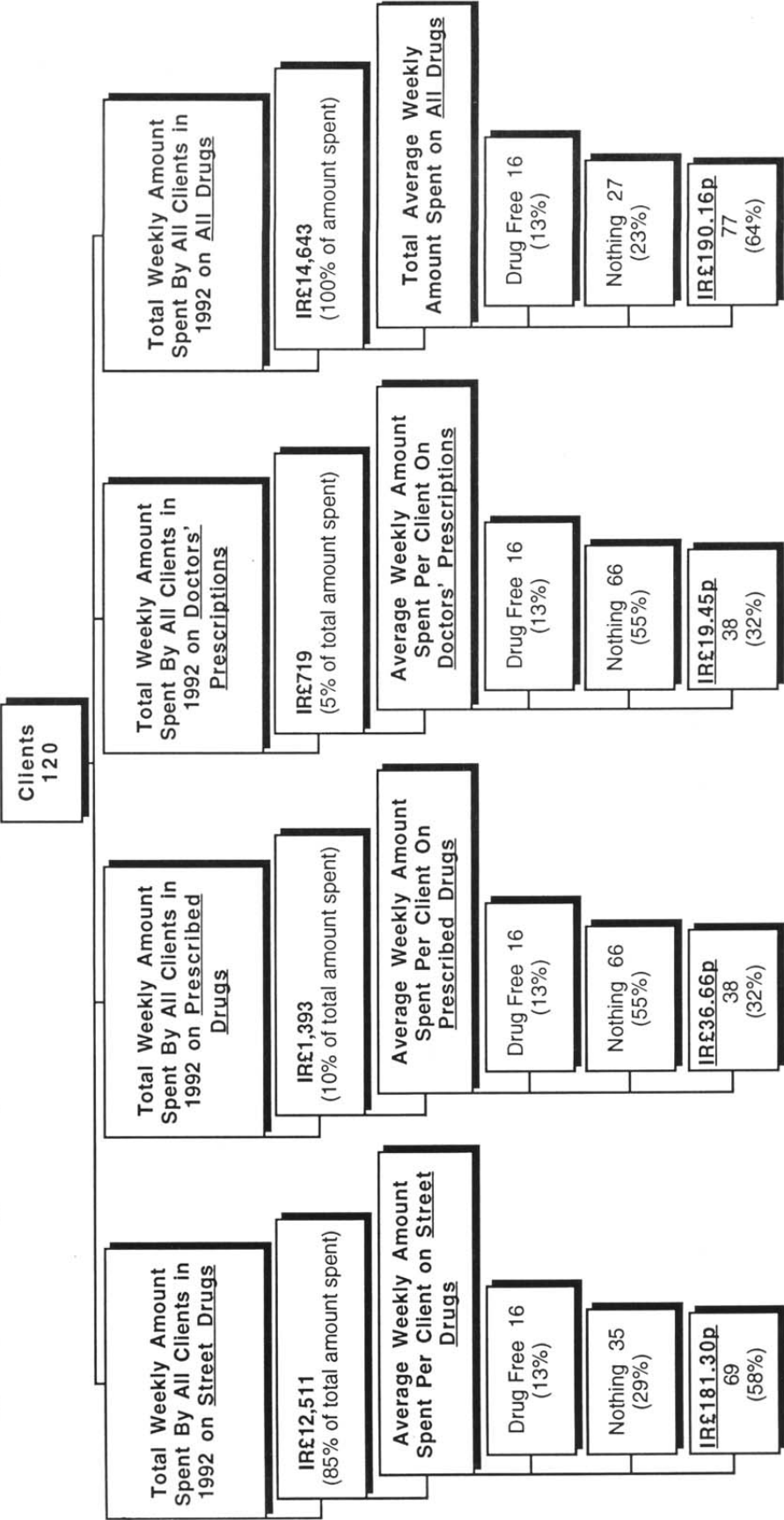
It is possible, on the basis of Figure 5.5, to distinguish three different groups of clients from the point of view of the amount of money needed to support a drug habit. The distinction between each group is based on the amount which each spends on street drugs since the amounts spent on doctors' prescriptions and prescribed drugs are, as indicated, refundable from the Eastern Health Board for medical card holders.

The first and smallest group (16, 13%) are drug-free clients who, by definition, do not spend any money on drugs. The second group, constituting more than a quarter of the total (35, 29%), are active drug users who spend nothing on drugs either. The reason for this is that they obtain their drugs from the Drug Treatment Centre in Pearse Street, Dublin 1 or the AIDS Resource Centre in Baggot Street, Dublin 2, the only two centres at the time of the interview (June 1992) where drug users could obtain free drugs; alternatively they may receive doctors' prescriptions and prescribed drugs on their medical card. The third and largest category (77, 64%) are drug users who pay for their drugs. This category spend a weekly average of IR£181.30 on street drugs, equivalent to IR£9,428 over an entire year. This is a very substantial amount of money for clients whose main official source of income is social welfare. The average weekly income from social welfare in 1992 (using the Supplementary Welfare Allowance rate) was IR£53.00, which is only about a quarter (29%) of the average weekly amount spent on drugs by these clients.

The fact that street drugs absorb the largest proportion of total resources spent on drugs is not surprising given the peculiarities of the drug market arising from its illegality and the limited access of clients to medically prescribed and legally controlled drugs such as physeptone. Legal access to physeptone is controlled by three agencies, namely General Practitioners (GPs), (lie Drug Treatment Centre and the AIDS Resource Centre. In general, GPs are unwilling to prescribe physeptone to drug users (O'Kelly, Bury, Carey, 1990, p.3); however this may change in 1993 following the opening of "Satellite Clinics" in different parts of Dublin city (notably Baggot Street, Dublin 2 and Ballyfennot, Dublin 8) where GPs can work as part of a "Community Drugs Team" and prescribe physeptone. The Drug Treatment Centre only dispenses physeptone under very strict assessment and control procedures while the AIDS Resource Centre in Baggot Street distributes physeptone to all drug users who participate on its needle exchange programme but has resources to deal with only 60 clients.

The net effect of this limited access to physeptone is that drug users have no other option, other things being equal, than to purchase street drugs. This requires substantially more resources than most clients have available and, other things being equal, requires (them to resort to crime in order to get money. In other words, the lack of medically prescribed and legally controlled access to physeptone (and other substitutes to street drugs) contributes directly to the high cost of street drugs and to the high level of crime associated with them.

Figure 5.5 Average Weekly Amounts of Money Spent on Drugs by Clients of Merchants' Quay Project, 1992



5.7 Drug Users and the Law

The connection between drug use and crime suggested in the previous section is clearly underlined in Figure 5.6. Information on clients' contacts with the law was measured in terms of the number of arrests, number of court appearances, number of remands and number of prison sentences experienced by clients.

The data in Figure 5.6 reveals that more than four fifths (102, 85%) of clients have been arrested for drug-related activities. More than half of these (57, 56%) were arrested up to ten times although the overall average, 26.9 times, is much higher.

The same number of clients (102, 85%) also appeared in court for drug-related activities. For more than half of these clients (56, 55%) there have been up to ten court appearances, the overall average being much higher at 25.5 court appearances.

Just under three fifths (71, 59%) of all clients have been held on remand for drug-related activities. The average number of times in which clients have been held on remand is 15.7.

Nearly three fifths (68, 57%) of clients have been in prison for drug-related activities. On average, these clients have been in prison 8.3 times and, on average, each has spent 4.1 years there.

It is clear from Figure 5.6 that few clients have escaped contact with the law for their drug-related activities. This is not surprising given that street drugs are illegal and, for those who use them, their weekly cost is more than three times their weekly income. Accordingly, crime is necessary in order to purchase street drugs. In this way, the negative consequences of drug use extend beyond (the drug user and his/her immediate family to those persons and businesses who are victims of crime and to the State through the substantial resources required to process drug users thorough the criminal justice system. From the perspective of minimising the harmful effects of drug use - and without prejudice to the ultimate goal of helping drug users to become drug-free - there seems little doubt that the introduction of a more comprehensive system of maintaining drug users on prescribed drugs rather than on street drugs would have a major beneficial impact.

5.8 HIV/AIDS Within Clients' Social Network

The emergence of HIV in Ireland in 1982 introduced a dramatic new dimension to drug use because of the potential for spreading this virus through contaminated needles used for injecting drugs. HIV can also be spread through sexual contact although all the evidence to date indicates that the primary mode of transmission in Ireland is through intravenous drug use (see Chapter One). In this sense HIV represents a serious multiplication of the negative effects of drug use and poses yet further hazards for the drug user and the rest of society.

Figure 5.7 summarises information on the perceived prevalence of HIV within clients' social networks. This is measured in terms of the number of persons with HIV who are living with clients, who are brothers or sisters of clients, who are living in their neighbourhood or who have died of AIDS.

The data reveals that the HIV status of most of (the persons living with clients (97, 81%) is either negative or unknown. However nearly one fifth (23, 19%) admitted that at least one person living with them was HIV+. A similar proportion of clients have a brother or sister who is HIV+ and one client has a brother who has died of AIDS.

Within their neighbourhood, the perception among the majority of clients (70, 58%) is that there is an average of 25.7 people who are HIV+. Moreover half of all clients (61, 51%) estimate that, on average, 11.9 persons have died of AIDS in their neighbourhood.

It is not possible, using these figures, to estimate the total number of persons who are known to be HIV+ or who have died of AIDS, because of the possible margin of error associated with the estimates and because of the danger of double counting resulting from clients living in (the same neighbourhood. Nevertheless the figures are a powerful indicator that clients perceive their social network to be populated by persons with HIV and persons who have died from AIDS. These networks, as indicated in section 5.5 above, also feature large numbers of

Figure 5.6 Drug-Related Contacts With the Law By Clients at Merchants' Quay Project, 1992

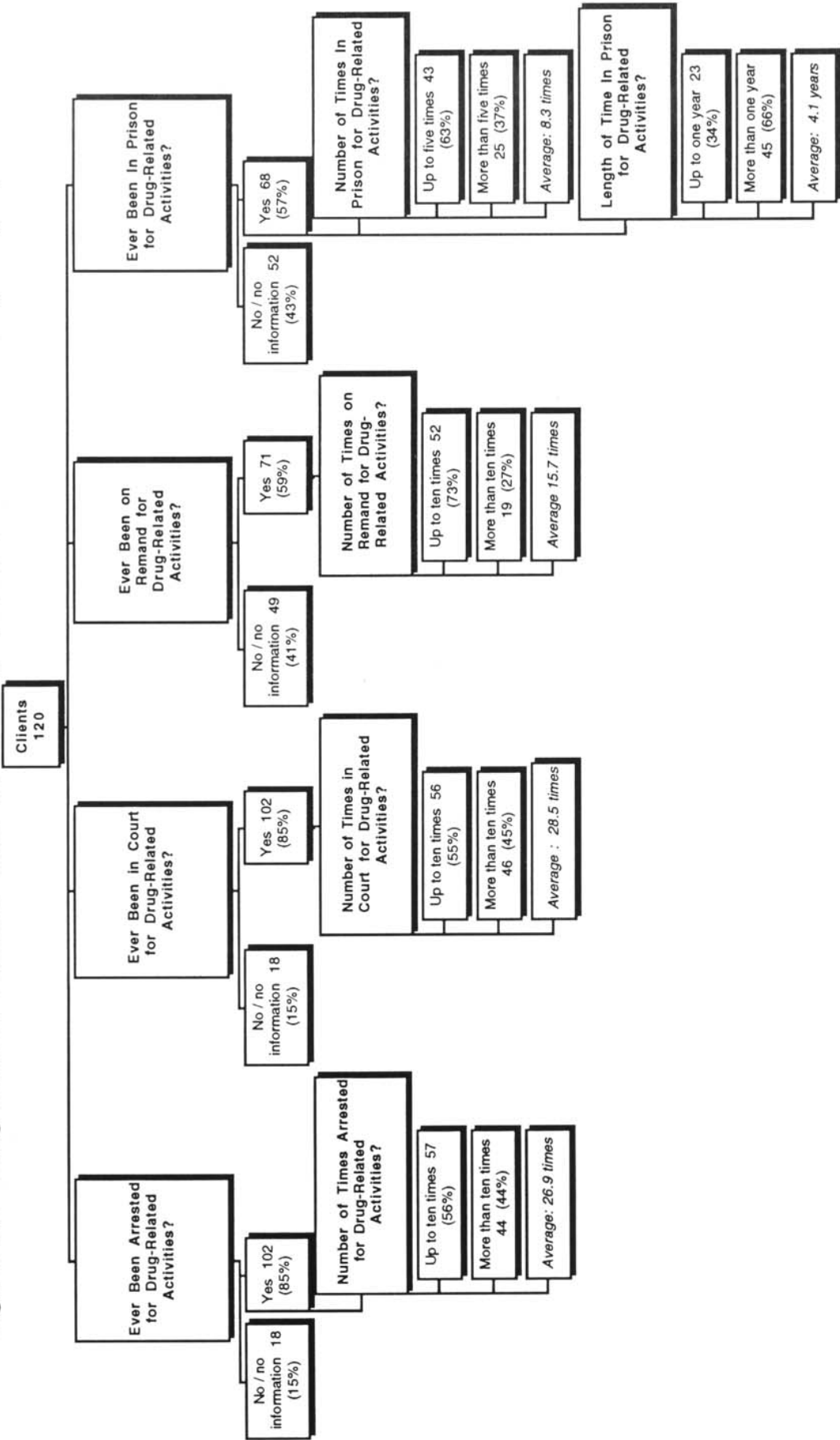
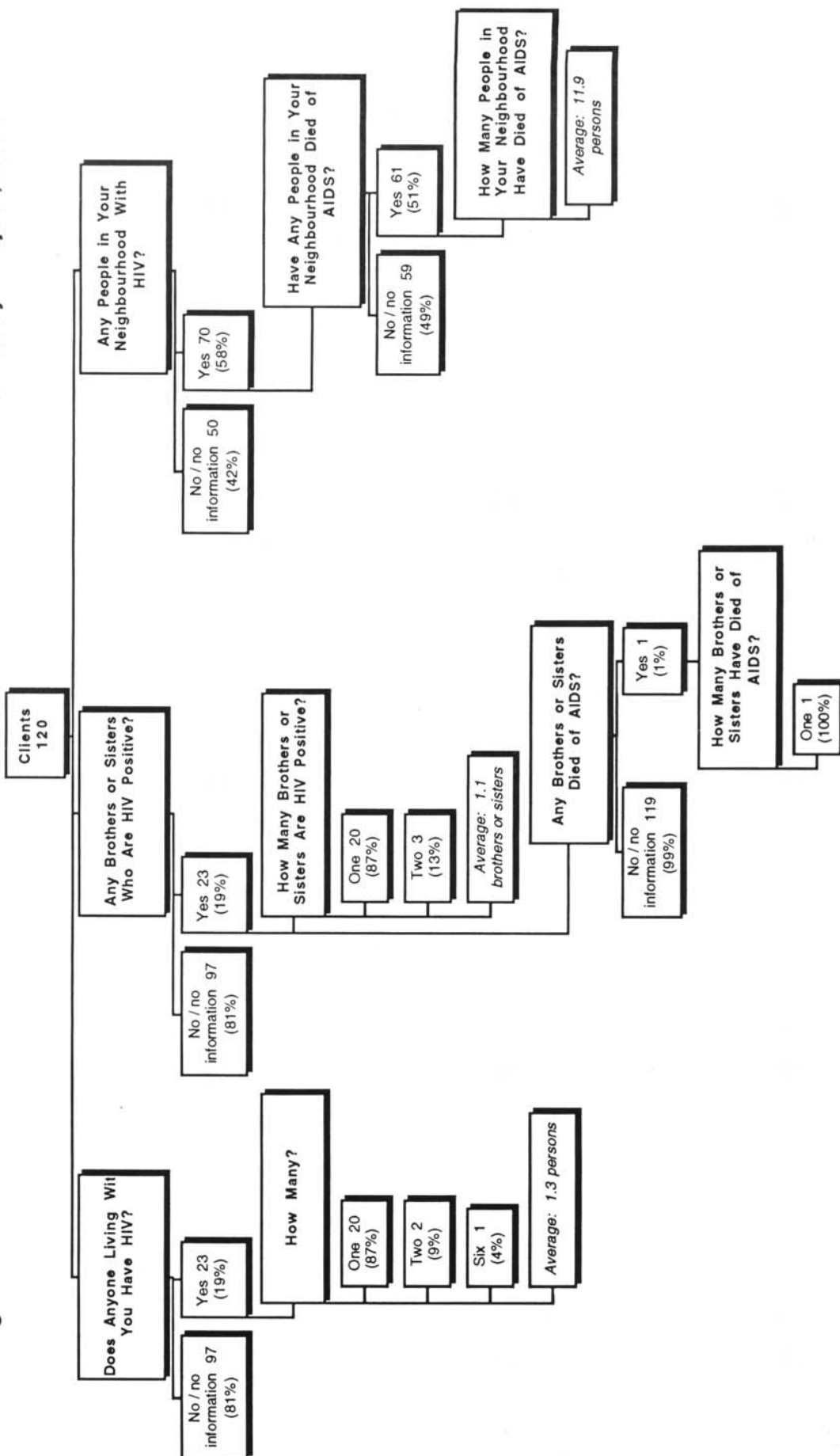


Figure 5.7 HIV / AIDS Within the Social Network of Clients at Merchants' Quay Project, 1992



drug users, including persons who have died from drugs. Overall therefore clients live in social networks which, by the standards of the majority in Irish society, are inhabited by an extraordinarily large proportion of persons who are drug users, are involved in crime, are HIV+ and by persons who have died from drugs or AIDS.

5.9 Sexual Activity of Clients

The emergence of HIV has added a new significance not only to drug use but also to sexual activity, particularly sexual contact between persons who are not regular and faithful partners. HIV can be transmitted through unprotected sex with a person who already has the virus as well as through the intravenous use of needles which have been contaminated by persons with the virus. Accordingly both the injecting practices and the sexual behaviour of clients are important from the point of view of estimating the extent of risk behaviour.

Figure 5.8 summarises information on sexual activity among clients. This reveals that just over half (65, 54%) of all clients are sexually active. Notwithstanding the average age of clients (30.3 years), the relatively high proportion of clients who are not sexually active is probably due to the use of opiates, one of whose side-effects is to reduce sexual desire.

Approximately half (32, 49%) of those who are sexually active are HIV+; more than two fifths (28, 43%) are HIV- and just under one tenth (5, 8%) have not been tested.

More than four fifths of the clients who are sexually active (53, 82%) had only one partner in the past six months. Less than a fifth (12, 18%) had more than one, resulting in an overall average of 1.7 partners in this period.

The vast majority of sexually active clients (61, 94%) are heterosexual. However nearly two thirds (42, 65%) of their sexual partners are drug users.

The risk of HIV transmission is greatest when there is unprotected sex between partners, one of whom is known to be HIV+. Figure 5.8 reveals that, in the past six months, slightly more than a third (22, 34%) of sexually active clients had partners who were known to be HIV+. This is particularly significant in view of the fact that just under two thirds of all sexually active clients (41, 63%) indicated that they do not always use a condom.

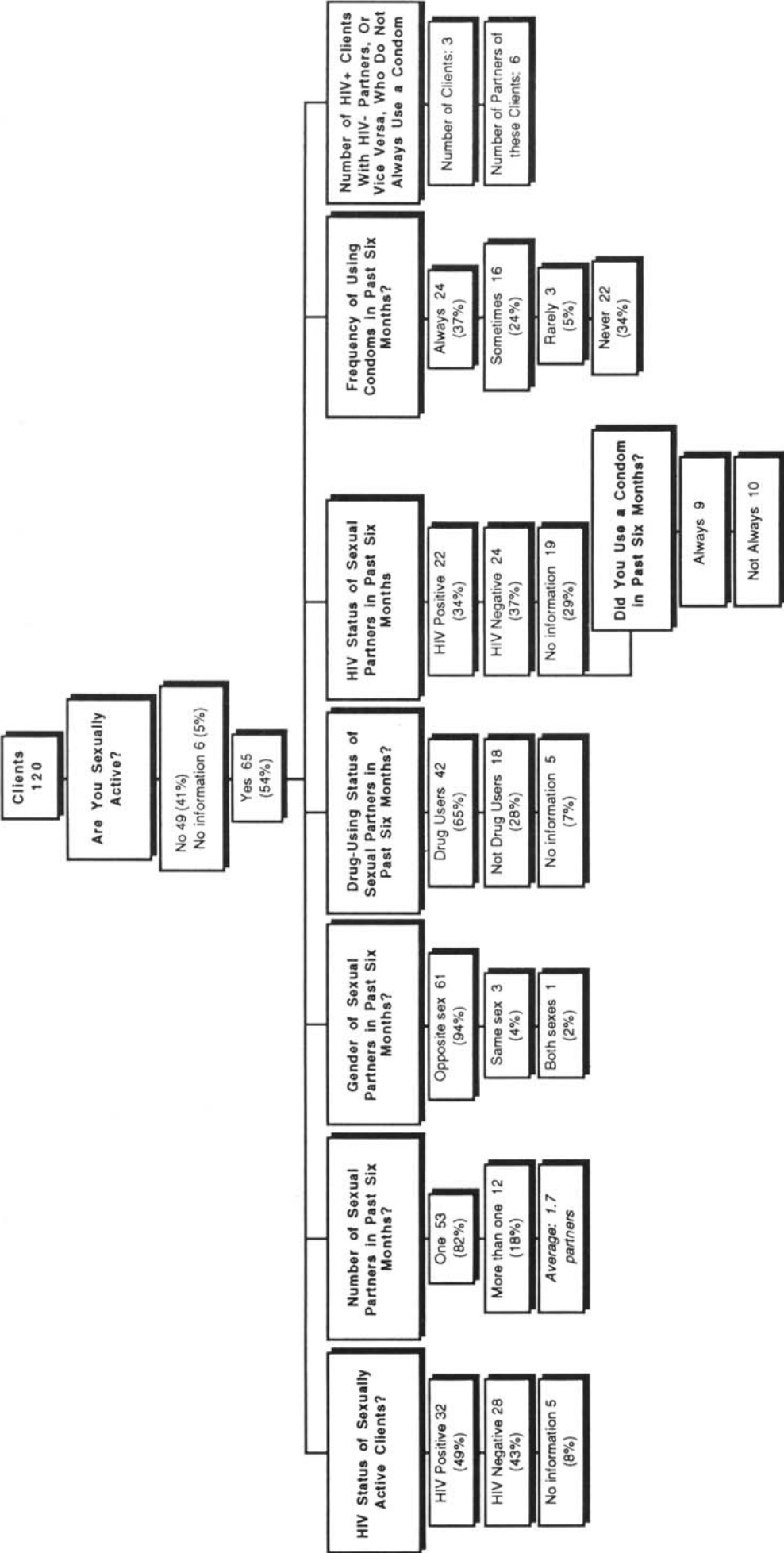
In order to calculate the number of clients whose sexual behaviour is definitely risky from the point of view of HIV transmission it is necessary to calculate the number of HIV+ clients with HIV- partners, and vice versa, who do not always use a condom. From this calculation it emerges that three clients were involved in sexual behaviour which is definitely risky from the point of view of HIV transmission. Together these three clients had sex with six partners.

Some clients are also involved in potentially risky sexual behaviour since the HIV status of over a quarter of partners (19, 29%) is unknown. Further analysis of this group reveals that 10 clients do not always use a condom with sexual partners whose HIV status is unknown. Thus the overall number of clients (13) who are involved in some form of risky sexual behaviour amounts to 11% of all clients but 21% of all sexually active clients.

Combining the two types of behaviour which are risky from the point of view of HIV transmission (sharing needles and unprotected sex), the evidence indicates that 8 clients are engaged in risky needle sharing practices and 13 clients are involved in risky sexual behaviour. In sum, 21 clients are known to engage in risky behaviour from the point of view of HIV transmission. (There was no overlap between clients involved in risky needle sharing practices and clients involved in risky sexual behaviour). From this it is possible to affirm that nearly a fifth (21, 18%) of all clients are involved in behaviours which are risky from the point of view of HIV transmission. Of the two types of risk examined, unprotected sex poses a greater risk (62% of the total risk) compared to sharing contaminated needles (38% of the total risk).

This result is significant given the emphasis placed by the project on informing clients of ways to reduce the transmission of HIV. It is now well known that the provision of information is a necessary condition for

Figure 5.8 Sexual Activity of Clients at Merchants' Quay Project, 1992



changing behaviour but is not usually a sufficient condition. It seems reasonable to infer that, if a significant proportion of drug users who are in contact with services, and have been tested for HIV, are engaging in behaviours which effectively spread HIV, then an even higher proportion of drug users who are not in contact with these services, and have not been tested for HIV, are probably involved in similarly risky behaviour. Risky behaviour is not confined to drug users however and appears to be quite prevalent among non-drug users who are heterosexuals (Murphy, et al, 1992; Foreman, et al, 1992) and homosexuals (Pomeroy, et al, 1992; Foreman, et al, 1992). These results provide no grounds for complacency about the spread of HIV.

5.10 Summary

This chapter has examined some of the key behaviours associated with drug use and the transmission of HIV. The results reveal that four fifths of the clients interviewed are drug users (95), their primary daily drug being an opiate, taken orally. However more than half of all drug-using clients also inject (51) and have been injecting for an average of 12.7 years.

Nearly nine tenths of clients have been tested about four times for HIV and more than half (58, 54%) reported that they were HIV+. This is much higher than the prevalence of HIV among drug users in Ireland suggested by Department of Health statistics.

HIV can be transmitted through sharing contaminated needles and by having unprotected sex with a person infected by the virus. The results show that 21 clients are known to engage in risky behaviour from the point of view of HIV transmission, equivalent to nearly a fifth (18%) of all clients.

Drug use has had a negative impact on the health of clients with two fifths having specific illnesses and more than half having HIV. The previous medical history of clients also reveals that more than four fifths have been hospitalised about five times. The main reason for this among two thirds of clients was overdosing which occurred 3.6 times and brought many of them close to death on two occasions.

Clients live in an environment where they perceive relatively high levels of drug use, both among their brothers and sisters but especially among their neighbours. They also perceive their social network to be populated by persons with HIV and by persons who have died from drugs and/or AIDS. This perception is consistent with the known geographical concentration of drug users in selected areas within Dublin's inner city, and to a lesser extent the geographical concentration of HIV (see Chapter One).

Drug use is an expensive habit. In a typical week in June 1992 the average total amount of money spent by all clients on drugs amounted to IR£14,643. Over a twelve month period, this is equivalent to more than three quarters of a million pounds (IR£761,436).

From a financial point of view, the cost of drug use can be broken into three categories: street (or illegal) drugs, prescribed drugs and doctors' prescriptions. More than four fifths (85%) of total spending is on street drugs, one tenth (10%) is on prescribed drugs and the remainder (5%) is on doctors' prescriptions.

More than half of all clients spend a weekly average of IR£181.30 on street drugs, equivalent to IR£9,428 over an entire year. This is a very substantial amount of money for clients whose main official source of income is social welfare. The average weekly income from social welfare in 1992 (using the Supplementary Welfare Allowance rate) was IR£53.00, which is only about a quarter (29%) of the average weekly amount spent on drugs.

Few clients have escaped contact with the law for their drug-related activities. More than four fifths have been arrested and appeared in court for drug-related activities. On average, this occurred more than 25 times to these clients. Just under three fifths have been held on remand or in prison for drug-related activities. On average these clients have spent 4.1 years in prison.

Chapter Six

Usage and Impact of Services on Clients

6.1 Introduction

This chapter analyses the usage and impact of services on clients using the Merchants' Quay Project: Drugs/HIV Service. As in the two preceding chapters, the data is based on interviews with 120 clients who visited the project in 1991. The analysis begins in section 6.2 with a summary of the main service agencies used by clients. A more detailed description of their use of project services is presented in section 6.3. The impact of project services on selected behaviours of clients is analysed in section 6.4. This is followed in section 6.5 by clients' own assessment of these services. In section 6.6 clients' suggestions for new services are analysed. Finally, in section 6.7, there is a brief summary of the key findings to emerge from the chapter.

6.2 General Indicators of Service Usage

Some general indicators of service usage by clients are presented in Figures 6. 1a and 6. 1b. These indicators include having a medical card, having a General Practitioner (GP), number and name of service agencies ever used, as well as the estimated number of drug users known to clients who do not use any services.

It emerges from Figure 6. 1a that more than four fifths (98, 82%) of clients have a medical card. This is 10 clients less than the number who are dependent on social welfare (108, 90%) and who would have an automatic entitlement to a medical card (see Figure 4.3 above). However the general uptake on medical card entitlements appears quite high, with women clients having a higher uptake (90%) than men (77%). Similarly the number of clients who are registered with a GP is also very high at 90% (108) of the total. Again, a higher proportion of women clients are registered with a GP (95%) compared to men (87%).

The fact of being a client in Merchants' Quay Project is itself an indicator that these clients recognise a need to use services. Many professionals in the area of drug use and HIV/AIDS believe that there exists a substantial proportion of persons in need of services who are not actually using them. The evidence in Figure 6. 1a provides corroborative evidence on both of these points.

In relation to clients' usage of services, the data reveals that all but four clients have previously used an average of 5.5 service agencies each. The main services used, according to Figure 6.1h, are the Drug Treatment Centre (88%-), Coolmine (62%), the Ana Liffey Drugs Project (58%), Narcotics Anonymous (45%), the AIDS Resource Centre (39%), and Cairde (20%). A significant feature of Figure 6.1b is the relatively small proportions of clients who have used these agencies in the past month.

In relation to the usage of services by other drug users, more than half the clients (66, 55%) indicated that they know many drug users who do not use any services. On average these clients know of 31 drug users each who do not use attend any service agency. This figure would probably not be a reliable basis for estimating the total number of drug users who are not using services given that it may contain an unknown margin of error and there may be a double count where clients are referring to the same drug users. Nevertheless it is important as an indicator of the widespread perception among clients that a substantial number of other drug users are not using any services.

6.3 Usage of Project Services

From its inception, the philosophy of the project has been to develop services in response to the needs of clients. As indicated in Chapter Two, the project is committed to a client-led approach to the provision and development of services. In practice this means responding to whatever needs may be presented by the client.

The actual services used by clients are described in detail in Figure 6.2. All clients have used the core services of the project which involve information, advice and referral on each of the following areas: drugs, HIV, AIDS,

Figure 6.1a Usage of Services for Drug Users as Reported by Clients of Merchants' Quay Project, 1992

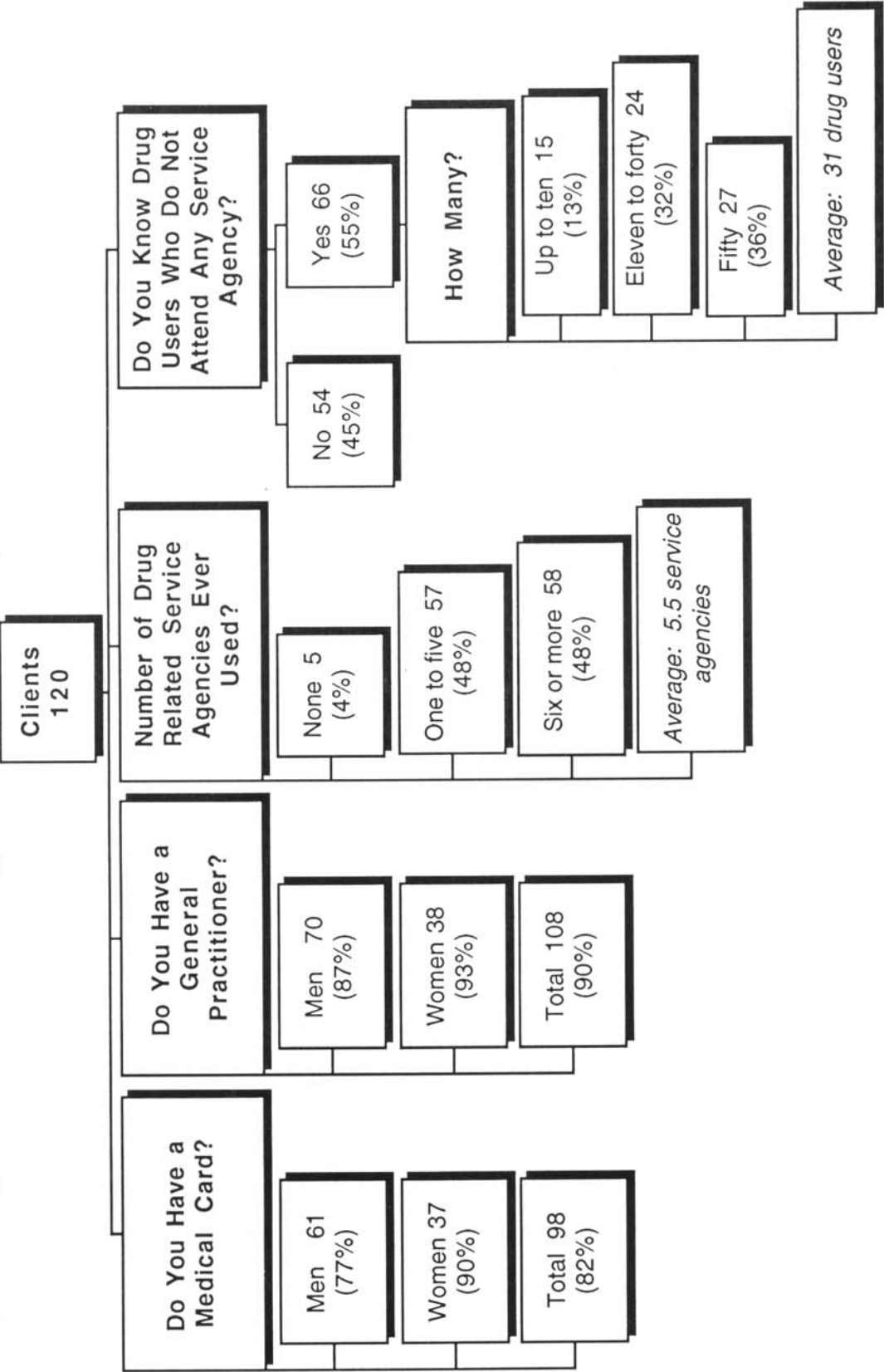


Figure 6.1b Usage of Service Agencies for Persons Who Are Drug Users or Have HIV / AIDS, as Reported by Clients of Merchants' Quay Project, 1992

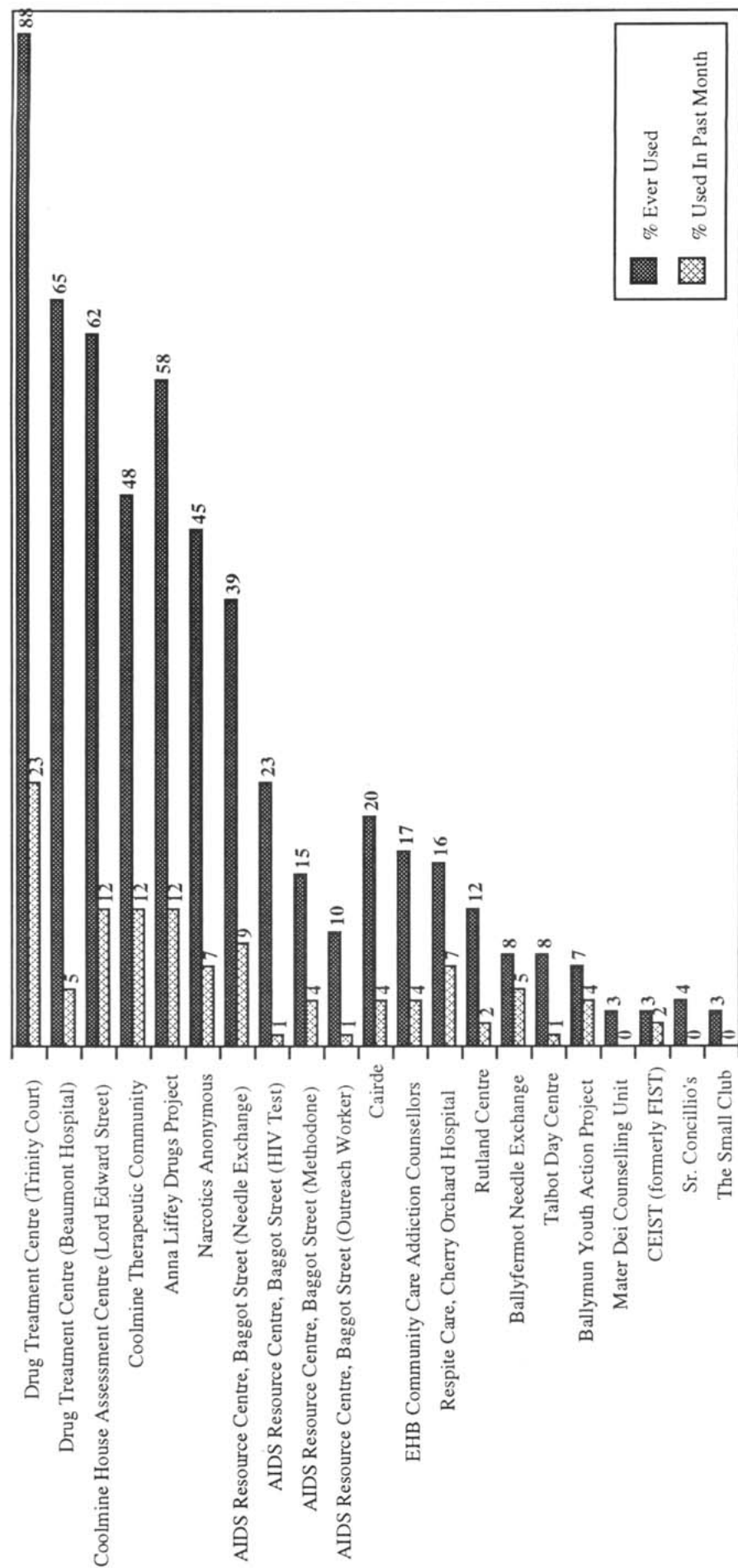
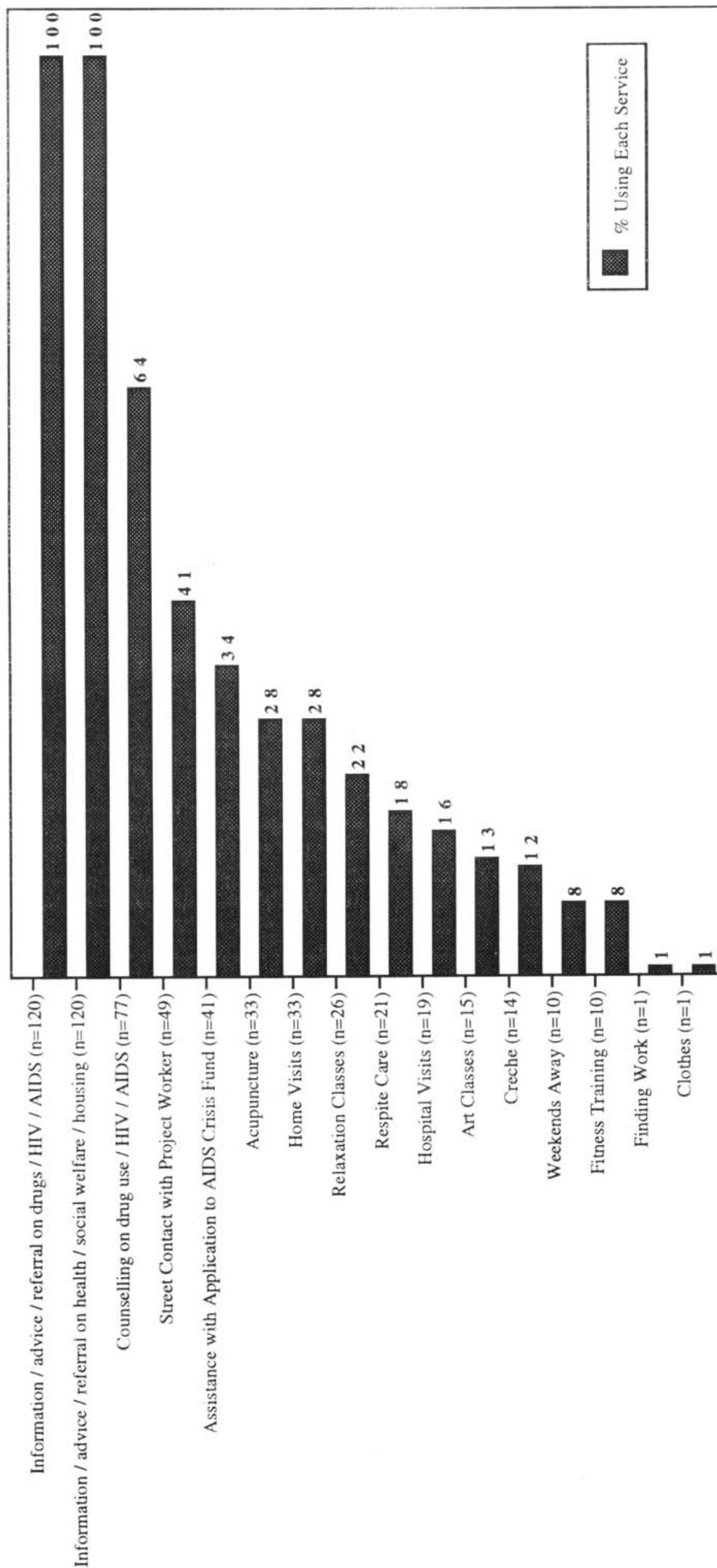


Figure 6.2 Usage of Project Services by Clients of Merchants' Quay Project, 1992



health, social welfare and housing. Counselling on drug use, HIV and AIDS is also a key service of the project and was availed of by nearly two thirds of all clients (77, 64%).

In addition to providing services which are tailored to the needs of clients, the project also endeavours to keep in touch with clients who may not attend regularly. This is evident in Figure 6.2 by the proportions who were contacted by a street worker (49, 41%), or who received visits at home (33, 28%) or in hospital (19, 16%).

The respite centre is an integral part of the project's services (see Figure 2.1 above) and, up to December 1992, has been used by 91 persons (see Table 2.2 above). Among the clients interviewed, a relatively small proportion (18, 21%) used the respite centre. The project also has a crèche next door to the contact centre and this was used by just over a tenth (14, 12%) of all clients. Other services used by clients include acupuncture (33, 28%), relaxation classes (26, 22%), art classes (15, 13%), weekends away (10, 8%) and fitness training (10, 8%).

Overall the evidence in Figure 6.2 indicates that the project has a wide menu of services tailored to the needs of different clients as well as a set of core services around information, advice and referral which are used by all clients. A key evaluation question from the point of view of the project concerns the impact of these services on the behaviour of clients. This question is addressed in the next section.

6.4 Impact of Project Services on Clients

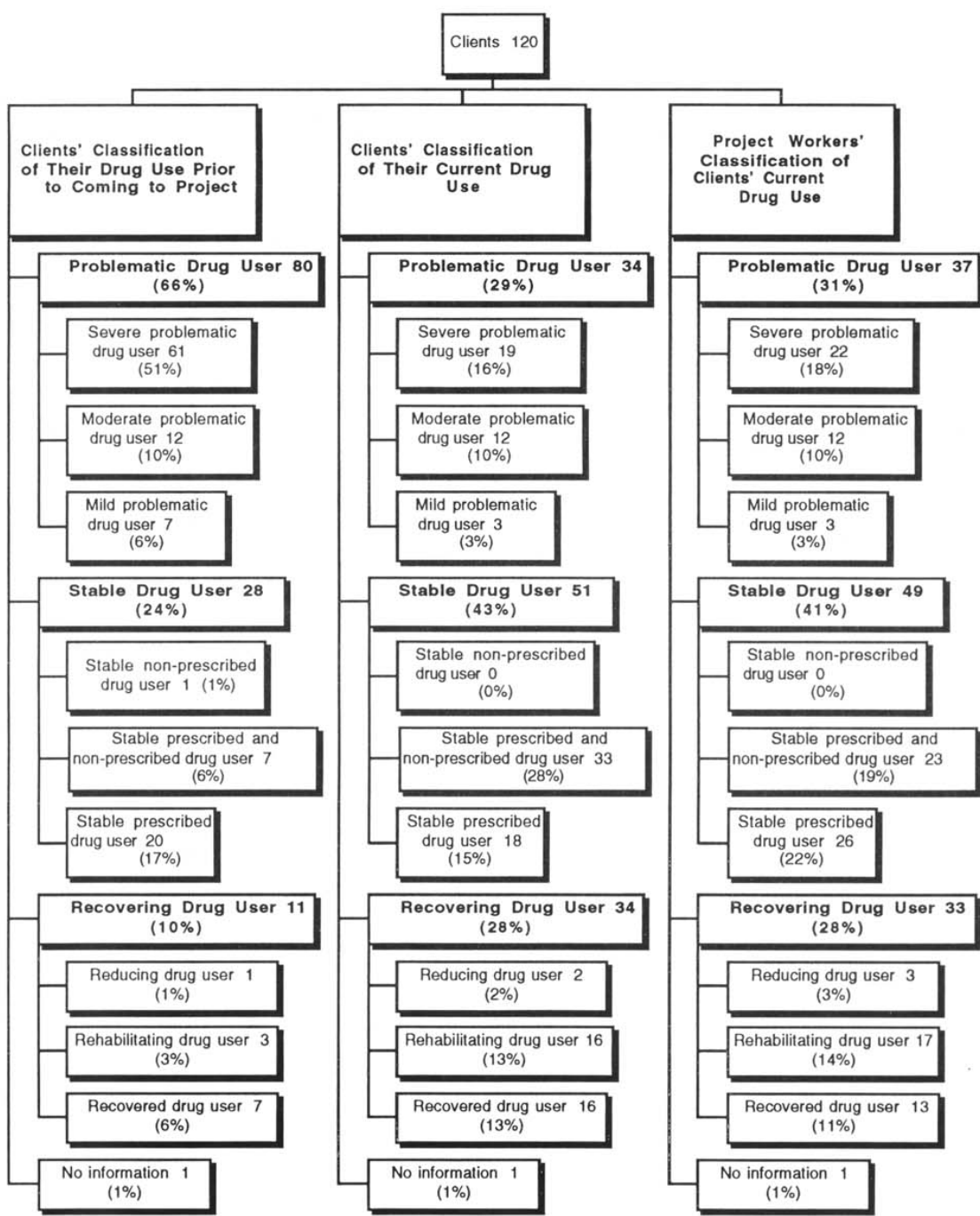
It is difficult to measure precisely the impact of project services on clients since these are likely to vary considerably between clients and to be highly qualitative in nature. In view of this, a number of behavioural indicators were selected to measure some of the possible impacts on clients. These indicators, which are summarised in Figures 6.3a, 6.3b and 6.3c, include changes in the general classification of drug use since joining the project, changes in the amount of drugs taken, changes in the frequency of drug taking, changes in the desire to take drugs, changes in the use of clean needles, changes in contact with drug-using friends, changes in the use of condoms, and changes in feelings of contentment/relaxation.

The classification of drug use presented in Figure 6.3a is based on the categories which are normally used by professionals working in the field of drug use as well as by drug users themselves. These categories provide a useful typology for describing a syndrome of behaviours associated with each drug user. Using these categories, all of the 120 clients surveyed were asked to classify their drug use prior to coming to the project as well as their current drug use. In order to check the validity of responses, the project worker responsible for each client was also asked to classify the client's current drug use. The responses of both the client and the project worker were compared and this revealed that, in nearly nine tenths of cases (105, 88%), there was consensus between the client's assessment of their current drug use and the project worker's assessment. Thus the results presented in Figure 6.3a have quite a high degree of validity.

The picture emerging from Figure 6.3a is that about two thirds of clients (80, 67%) were problematic drug users prior to coming to the project. The term "chaotic" is sometimes used instead of "problematic" to indicate that chaos pervades many aspects of the lives of these clients such as taking dangerous amounts and combinations of drugs, sharing unsterilised needles, having unprotected sex, involvement in crime, problems with health, housing or relationships. Within this broad category, it is usual to distinguish between severe, moderate and mild types, and most of the clients classified themselves as severe problematic drug users prior to coming to the project.

The second broad category is the stable drug user and nearly a quarter of clients (28, 24%) fell into this category prior to coming to the project. The term stable is used in this context to indicate that most aspects of the client's life have a reasonably stable pattern with drug use being regular and involving safer methods and amounts. This category also has three types according to whether the drugs used are prescribed or non-prescribed or a combination of both. It is noteworthy that most of the clients in this category are stable prescribed drug users since the use of non-prescribed, or street, drugs typically requires involvement in crime which can have a highly destabilising effect on users, as well as on the victims of those crimes.

Figure 6.3a Changes in Drug Use of Clients Since Coming to Merchants' Quay Project, 1992

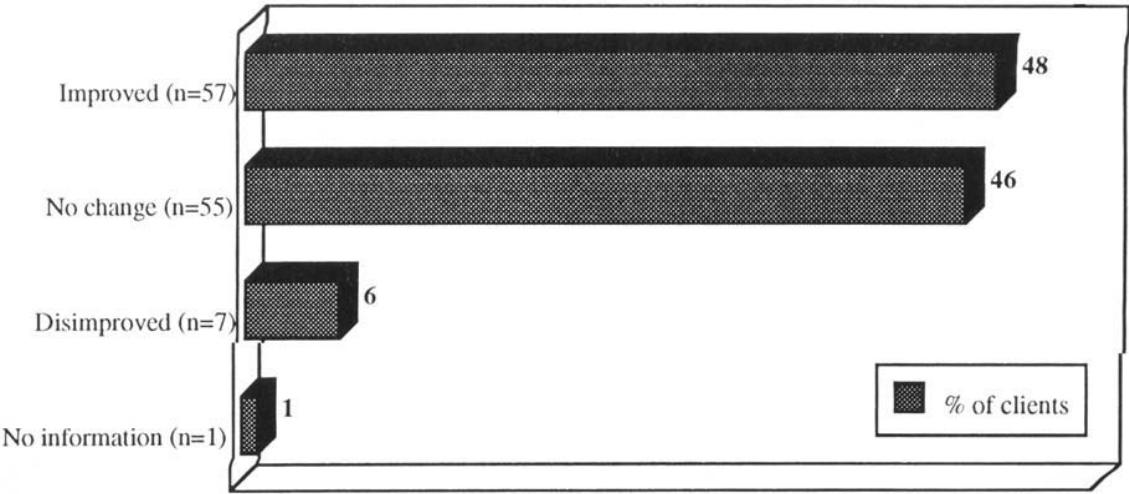


The third category refers to clients who are at various stages in the process of recovering from drugs. The smallest proportion of clients (11, 10%) were in this category which also has three types within it, namely, reducing, rehabilitating and recovered.

It is clear from Figure 6.3a that significant changes have occurred to clients since they first came to the project. From the perspective of their current drug use, the proportion of clients in the problematic category fell from two thirds to under one third (34, 29%), while those currently describing themselves as stable (51, 43%) nearly doubled. Significantly, the proportion in the recovering category (34, 28%) nearly trebled.

These changes are presented in more summary form in Figure 6.3b which indicates the proportions of clients who have improved, disimproved or not changed. In tills context an improvement is judged to occur if a client moves from a more to a less serious form of drug abuse (eg. from problematic to stable) while a disimprovement refers to movement in me opposite direction. Using this criterion, it emerges from Figure 6.3b that nearly half the clients (57, 48%) improved since first coming to the project with a similar proportion (58, 48%) showing no change. Only four clients (4, 3%) disimproved. Improvement in this context effectively means that clients have stabilised their drug use or have begun the process of recovery.

Figure 6.3b Changes in Clients’ Drug Use Behaviour Since Joining the Project, Based on Project Workers’ Assessment, 1992



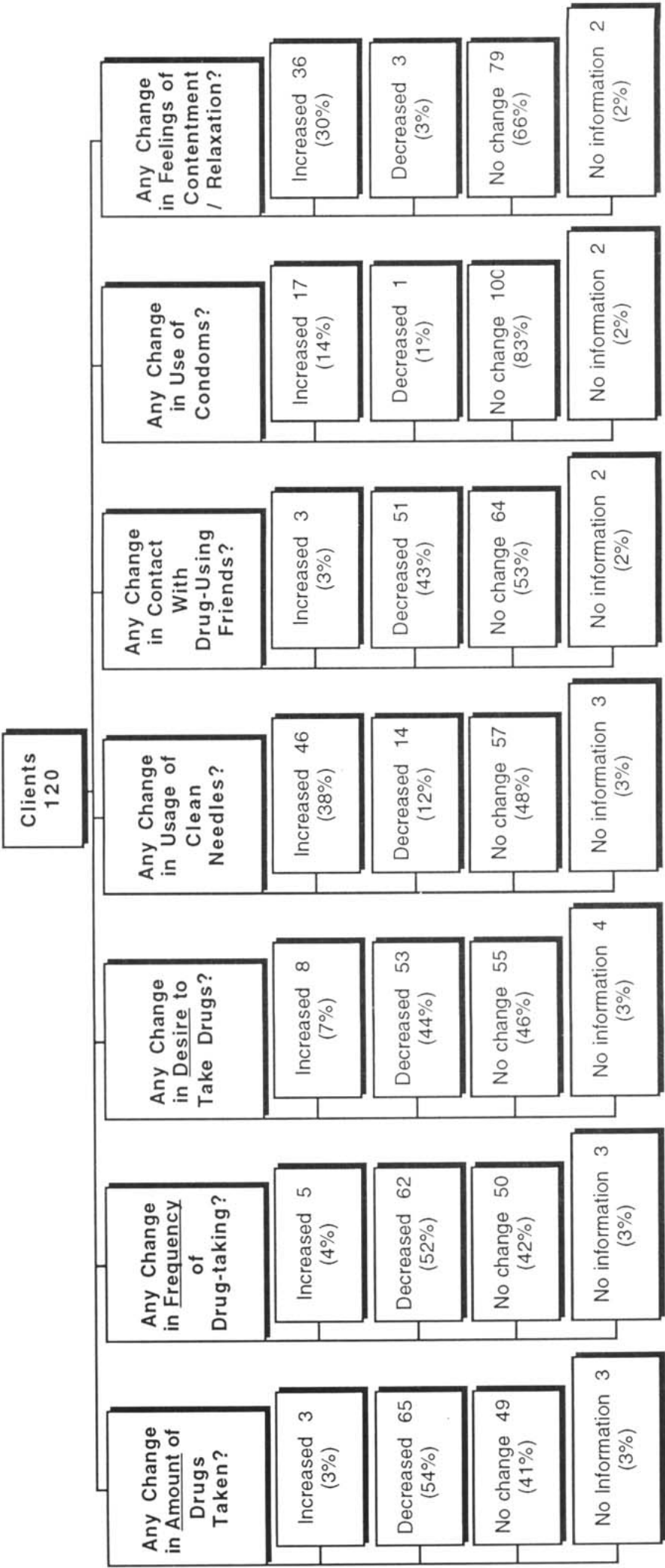
Further information on changes in the behaviour of clients emerged from clients’ responses to the question:

“Has your experience in Merchants’ Quay Project changed your drug-taking behaviour in any way?”. The responses to this question are presented in Figure 6.3c.

In relation to the amount and frequency of drug taking, about half the clients (65, 54%) indicated that this had decreased while approximately two fifths (49, 41%) stated that there was no change. A similar pattern emerged with clients’ desire to take drugs: more than four fifths (53, 44%) indicated that no change had occurred and an equivalent proportion (53, 44%) stated that their desire had decreased. The results on each of these indicators points to the fact that, in the main, clients have either stabilised their drug use or have started on the process of recovery.

In relation to the usage of clean needles, nearly half (57, 48%) indicated that there was no change in this variable possibly because these are no longer injecting drug users (see Figure 5.2 above). However nearly two fifths (46, 38%) indicated that they had increased their usage of clean needles and this may have contributed to the relatively low level of risky needle sharing behaviour from the point of view of HIV transmission, noted in Chapter Five.

Figure 6.3c Changes in Selected Behaviour Since Attending the Project, as Reported by Clients of Merchants' Quay Project, 1992



Drug-taking is often a social activity involving friends. Conversely, the process of recovering from drug use often means severing contact with former drug-taking friends. The evidence in Figure 6.3c reveals that, for more than half of all clients (64, 53%), there was no change in the level of contact with drug-taking friends. However more than two fifths (51, 43%) indicated that they had decreased their contacts with drug-taking friends. As with previous indicators, these results suggest, other things being equal, that clients have either stabilised or are on the process of recovery from drug use.

In relation to safer sex, the vast majority (100, 83%) indicated that there was no change in their use of condoms although this needs to be seen in the context that only just over half (65, 54%) of all clients are sexually active (see Figure 5.8). Nevertheless, one in seven (17, 14%) stated that they had increased their usage of condoms. Given that some clients are involved in risky sexual behaviour from the point of view of HIV transmission, as noted in Chapter Five, it is conceivable that this may have been higher without the intervention of the project.

The final indicator is feelings of contentment and relaxation. The responses to this reveal that two thirds of clients (79, 66%) experienced no change, while just under a third (36, 30%) recorded an increase in feelings of contentment and relaxation.

Overall these results indicate that at least half the clients have improved their drug use and related behaviour since joining the project. The difficult question, from a methodological point of view, is the extent to which this improvement can be attributed to the project. This is a difficult question since it is not possible to control for all the effects which impact on a client's life, including the impact of using the services of other agencies. Detailed information on the usage of other services was not collected although the evidence presented in Figure 6.1b suggests that the proportion of clients using other agencies in the past month was rather small. Equally the data presented in Table 6.1a suggests that, for these 120 clients who were surveyed, the frequency of visiting the project varied considerably. On average, each client surveyed visited the project 39.2 times between February 1990 and June 1990, with two fifths (46, 38.3%) visiting up to ten times only and nearly one fifth (21, 18%) visiting more than sixty times.

More detailed analysis of this visiting pattern is presented in Table 6.1b where it is crosstabulated with changes in clients' drug use behaviour. The results show that, on average, clients who improved made more visits (50.7 visits) than clients who did not change (28.9 visits). However among the clients who improved, the largest proportion (16, 28%) made no more than 10 visits. In other words the frequency of visiting the project does not appear to have a significant influence on changing clients' drug use behaviour. This does not imply that visiting has no effect although it does indicate that improvements in drug use behaviour are not related to the frequency of visits. This suggests in turn that other factors, possibly not even associated with the project, have a crucial influence on changes in drug use behaviour.

Statistical analysis of a number of other factors associated with change in drug use behaviour was undertaken including age, sex, marital status, age on leaving school, and HIV status. None of them had any statistically significant influence on changes in drug use behaviour. This is an area which requires further investigation, possibly using more qualitative data on each client's account of these behavioural changes.

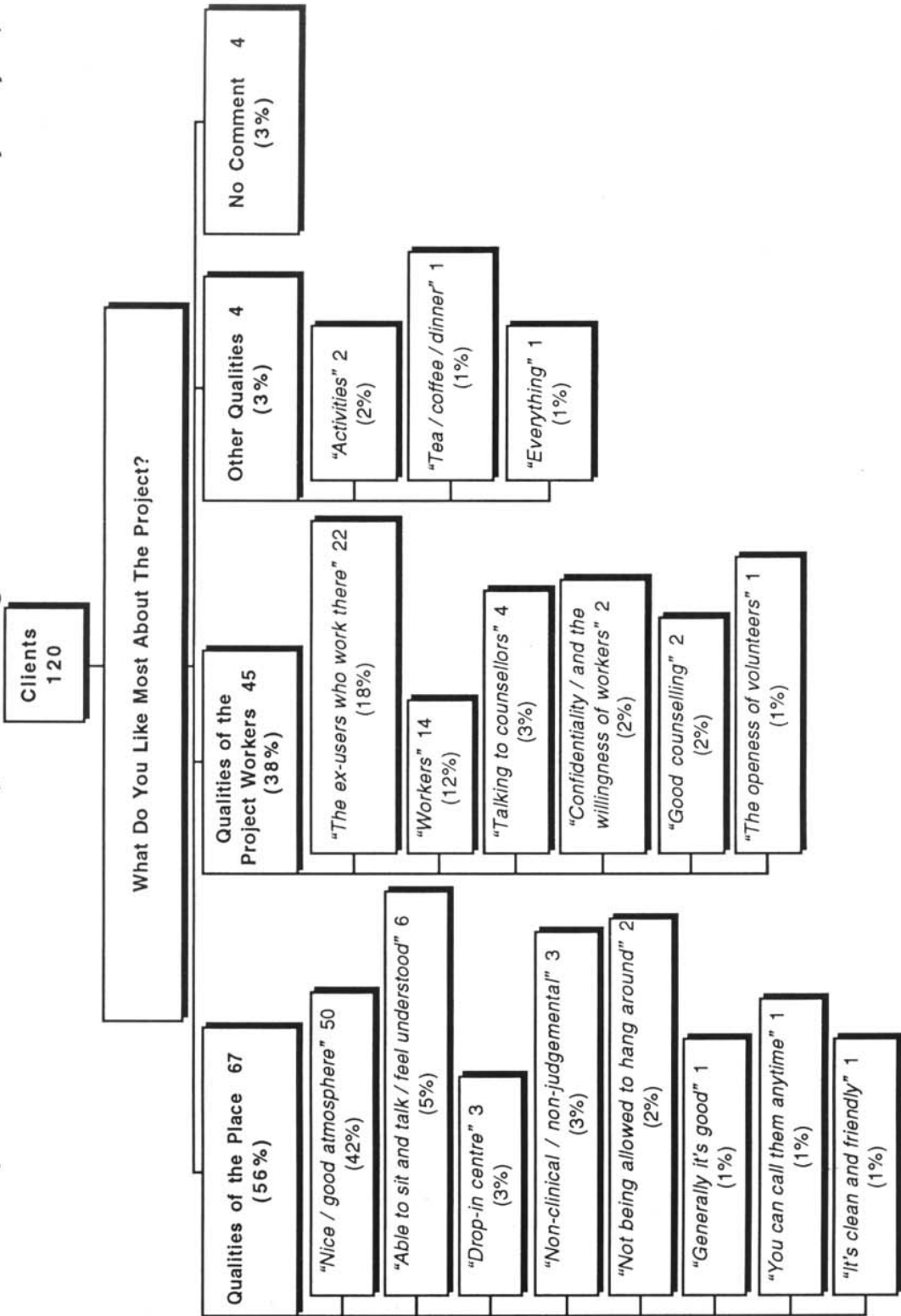
6.5 Assessment of Services by Clients

A number of measures were used to ascertain clients' assessment of services in the project. These include clients' likes and dislikes about the project which are summarised in Figures 6.4a and 6.4b. Clients were also asked to indicate what benefits they obtained from attending (the project) and these are detailed in Figure 6.5. Clients' recommendations on new services for the project were also ascertained and are presented in Figure 6.6. In this context, clients were also asked about their specific views on the provision of a needle exchange within the project and their responses are summarised in Figure 6.7. Each of these indicators will now be examined.

It emerges from Figure 6.4a that the aspects which clients like most about the project can be classified into two main qualities: qualities of the place and qualities of the project workers. More than half the clients (67, 56%) referred to qualities of the place which they liked best including the *"nice/good atmosphere"*, *"able to sit and talk/feel understood"*, and *"non-clinical/non-judgmental"*. Nearly two fifths (45, 38%) mentioned qualities of the project workers which they liked most. Within this context, the most frequently mentioned quality was

Table 6.1a Frequency of Visits to the Project by 120 Clients of Merchants' Quay Project, 1990, 1991, 1992									
Number of Visits to the Project	Feb – Dec 1990		Jan – Dec 1991						Total
	N	%	N	%	N	%	N	%	%
One to ten	98	81.7	71	59.2	74	61.7	46		38.3
Eleven to thirty	8	6.7	29	24.2	26	21.7	25		20.8
Thirty-one to sixty	11	9.2	13	10.8	11	9.2	28		23.3
Sixty-one or more	3	2.5	7	5.8	9	7.5	21		17.5
Total	120	100	120	100	120	100	120		100
Average per Client per period	10.07		15.3		14.7		39.2		
Table 6.1b Changes in Drug Use Behaviour by Frequency of Visits to the Project Among 120 Clients of Merchants' Quay Project, 1990, 1991, 1992									
Number of Visits to the Project	Improved		No Change/No information		Disimproved				Total
	N	%	N	%	N	%	N	%	%
No information	0	0.0	1	1.8	0	0.0	1		0.8
One to ten	16	28.1	26	46.4	3	42.9	45		37.5
Eleven to thirty	13	22.8	11	19.6	1	14.3	25		20.8
Thirty-one to sixty	14	24.6	11	19.6	3	42.9	28		23.3
Sixty-one or more	14	24.6	7	12.5	0	0.0	21		17.5
Total	57	100.0	56	100.0	7	100.0	120		100
Average per Client	50.7		2839		28.3		39.2		

Figure 6.4a Aspects Liked About The Project According To Clients of Merchants' Quay Project, 1992



“the ex-users who work there “, while others simply referred to the *“workers”* as the quality which they liked best about the project. Only four clients made no comment in answer to this question.

The distinction between qualities of the place and qualities of the project workers is not entirely watertight in this context since the latter is likely to influence the former. In this sense the high level of approval for qualities of the place might also be seen as an indicator of approval for the project’s approach and its implementation by project workers.

The aspects of the project which clients like least are summarised in Figure 6.4b. The fact that three fifths of clients (72, 60%) made no comment suggests, other things being equal, that there is nothing which they like least about the project. Three main dislikes were mentioned by clients: aspects of clients, aspects of the way the project is run and aspects of project workers. Nearly a fifth (20, 17%) indicated that they did not like certain aspects of other clients such as the fact that some are *“stoned”*, *“messers”*, *“aggressive”*, *“abusing”*, *“into heavy stuff”* and *“selling drugs on the premises”*. A smaller proportion of clients, amounting to just over a tenth (16, 13%), do not like aspects of the way the project is run including the *“appointment system”*, *“lack of privacy and space “*, *“too near the church”*, as well as the insufficient supply of certain types of services such as home visits, art classes and respite care. One tenth of clients (12, 10%) do not like some aspects of project workers, most notably the turnover of volunteers. Other clients do not like the attitudes of some volunteers and some responded negatively to the fact that some project workers are nuns.

Some of the aspects of the project which clients dislikes may be easier to change than others. For example it may be possible to address such issues as controlling the negative behaviours of clients, increasing the supply of certain types of services such as home visits, art classes and access to respite. Others however may be less amenable to address such as the appointment system or the turnover of volunteers.

The data in Figure 6.5 provides further feedback from clients on the overall benefits of attending the project as well as the their satisfaction with the respite centre. In relation to the respite centre, less than one fifth of the clients interviewed (21, 17%) have used this service although a total of 91 clients have used it up to December 1992 (see Table 2.2 above). All but two of the clients interviewed indicated that they were satisfied or very satisfied with the service received in the respite centre. In addition, four of these clients made suggestions for improving services. Two of them suggested that there could be *“more structure to the days”* within respite. One suggested that drug-free clients should be kept away from drug-users, a factor likely to be particularly important for clients who are stabilising on phsyseptone or going through a detoxification programme in order to become drug free.

All clients were asked the question: *“What have been the benefits to you of attending the Merchants’ Quay Project?”*. More than four fifths of clients (99, 84%) identified some benefits which they derived from attending the project. Figure 6.5 indicates that three main benefits occurred: benefits from specific services, benefits from the general quality of services, and benefits in terms of personal development and relationships.

Benefits from specific services were mentioned by one third of clients (40, 33%) and mainly refer to help, information, advice and support. Benefits from the general quality of services were also mentioned by about a third of clients (38, 32%). The two most frequent comments made in this context were: *“/am able to talk openly about my problems”*, and *“/am made to feel welcome/cared about”*. Benefits in terms of personal development and relationships were mentioned by nearly one fifth of clients (23, 19%). Describing these benefits, clients typically said: *“/started to find myself/become aware of myself* and *“/was encouraged to become and remain drug-free”*.

It is noteworthy that the proportion of clients who indicated that they benefited from the project (99, 84%) is substantially greater than the proportion (57, 48%) whose drug use behaviour improved (Figure 6.3a). This implies that many clients have experienced benefits from the project without changing their drug using behaviour. This finding is not entirely surprising in view of the fact that the project’s approach is to enable clients, in a non-judgmental way, to address their needs as they perceive them. Changing drug-using behaviour may not be the client’s short-term objective and this is respected by the project.

Figure 6.4b Aspects Liked Least About The Project According To Clients of Merchants' Quay Project, 1992

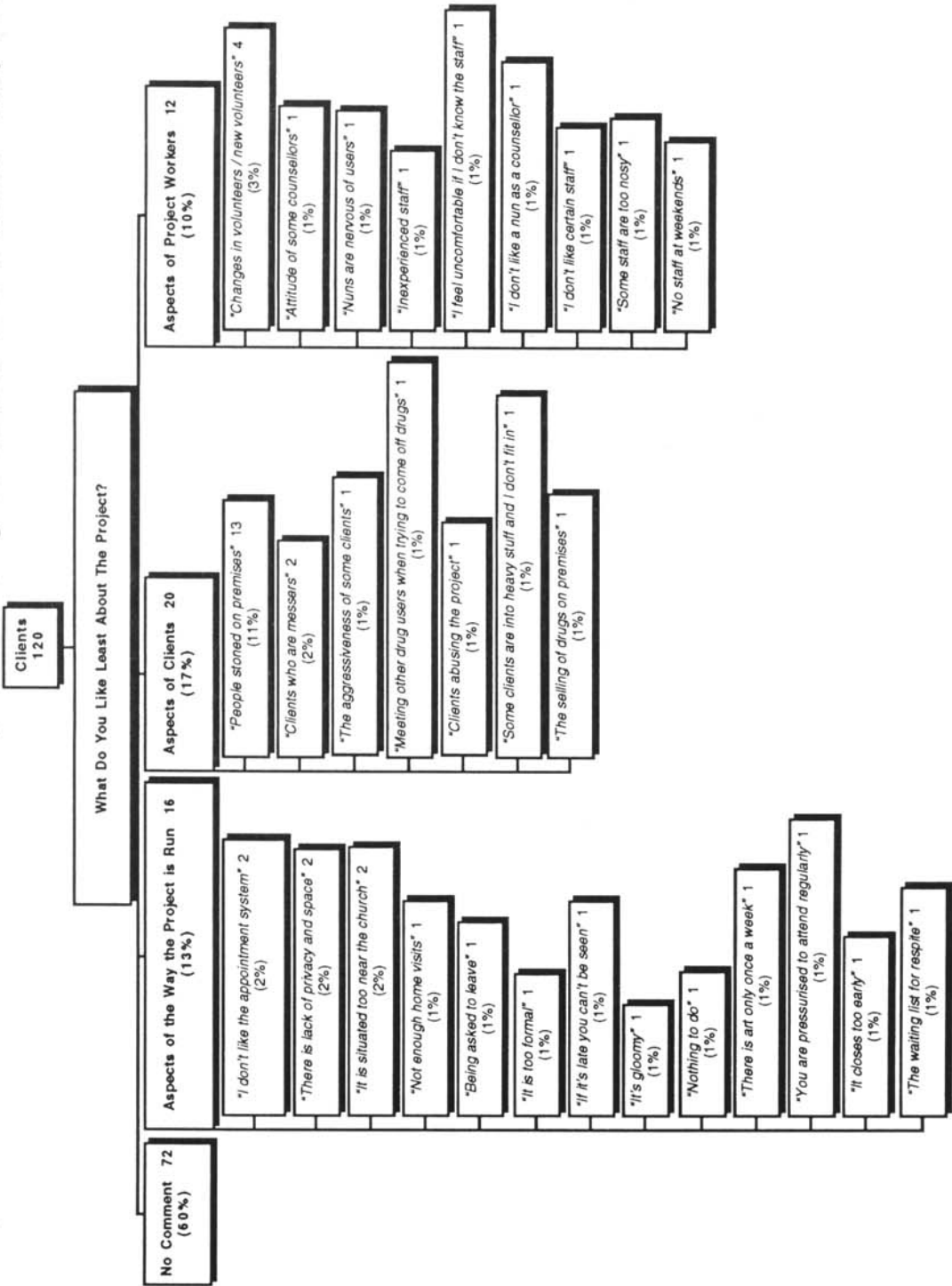
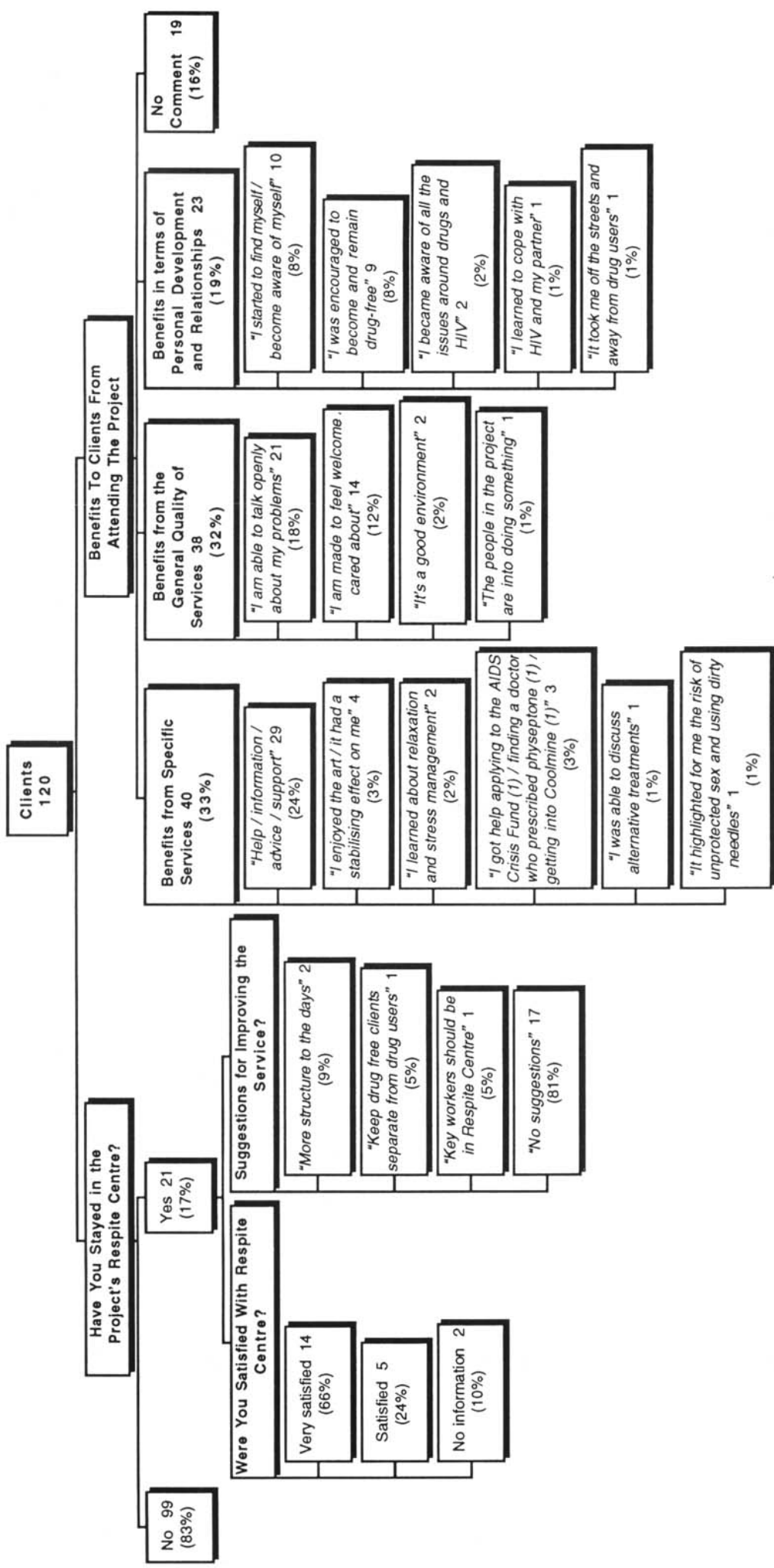


Figure 6.5 Benefits Of Project As Seen By Clients of Merchants' Quay Project, 1992



The data in Figures 6.4a, 6.4b and 6.5 indicates that there is a high level of client satisfaction with the project. This satisfaction derives from qualities which clients associate with the place and with its workers. These qualities, which include openness, friendliness and helpfulness, infuse the overall delivery of services. A small proportion of clients expressed irritation at the behaviour of some clients and at the attitude of some workers but the overall body of opinion among clients is highly favourable to the project.

6.6 Suggestions for Developing New Services

Merchants' Quay project arose in response to a gap in the services for drug users and persons with HIV. However the project is only one agency among many comprising the network of services. Moreover it is generally acknowledged that many gaps still exist in these services. Indeed it was the recognition of such gaps which led to the formulation of the Government Strategy to Prevent Drug Misuse (Department of Health, 1991).

Against this background, all clients were asked the question: "*What, in your opinion, is the biggest gap in services/or drug users?*" Their responses are summarised in Figure 6.6.

The single biggest gap, according to nearly three tenths of clients (35, 29%), is the availability of physeptone. This is noteworthy in view of the fact that the "*lack of enough agencies to provide physeptone*" effectively obliges drug users to depend on street drugs and is a major contributor to drug-related crime as the analysis in Chapter Five.

More than a fifth of clients (26, 22%) identified gaps in all the existing services stating that: "*more of all services are needed*". A broadly similar proportion (23, 19%) were critical of attitudes within service agencies and recommended "*a more caring attitude to the needs of each individual user*". Other comments by clients drew attention to the need for "*more information on agency services*" (8, 7%) and the need for "*more needle exchanges*" (4, 3%). However one fifth of clients (24, 20%) made no comment on what they saw as the biggest gap in services.

Merchants' Quay project cannot respond to all the need which clients present. It is for this reason that referral to other appropriate agencies as well as advocacy on behalf of clients to those agencies, is an integral part of its policy and practice. However there may be specific services which the project could develop, taking account of its competence and resources. With this in mind, all clients were asked the following question: "*What services would you like to see developed at Merchants' Quay Project?*"

The responses are summarised in Figure 6.6. More than half of all clients (67, 56%) made some suggestions for new services which can be classified into four main categories. The first category, suggested by nearly three tenths of clients (25, 29%), involves new services to meet the drug/health/emotional needs of clients. The most frequently mentioned new service in this category was methadone/physeptone and needle exchange as well as an expansion of most of the existing services of the project.

The second category, suggested by more than a tenth of clients (14, 12%), involves new services to meet the social and recreational needs of clients and includes a drop-in centre, a gym, day and weekend trips, social activities and support groups. The third category, suggested by just under a tenth of clients (11, 9%), involves new services to meet the education and training needs of clients. These include FAS schemes, art classes, typing and hairdressing classes. The fourth and final category suggested by just over one twentieth (7, 6%) involve more disparate proposals for childcare facilities when clients are in hospital, a cafe and a newsletter.

The suggestions for new services are a useful guide on where the most pressing needs are being felt by clients. It is clear from this that the drug, health and emotional needs of clients are uppermost, with drug needs being the most important of these.

The project already provides a wide range of services to clients including home visits, professional counselling, group therapy, respite care, etc. The evidence in Figure 6.6 suggests that these may need to be developed further to meet the demand. Similarly the project offers access to a gym and a support group for women although it was suggested that additional activities would need to be developed to meet the social and recreational needs of clients. It is noteworthy that a relatively small proportion suggested services to meet the

Figure 6.6 Suggested New Service Developments According To Clients of Merchants' Quay Project, 1992

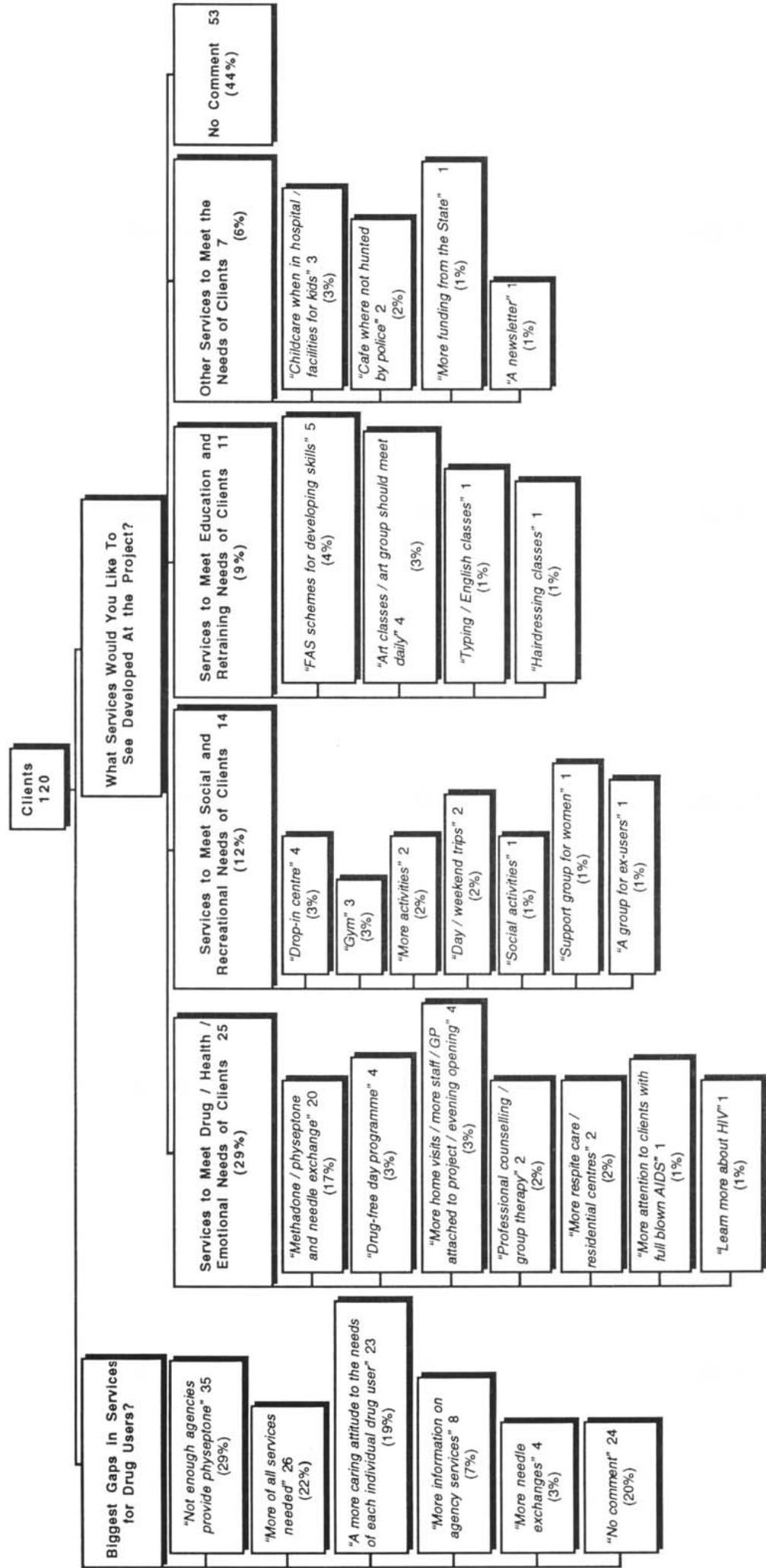
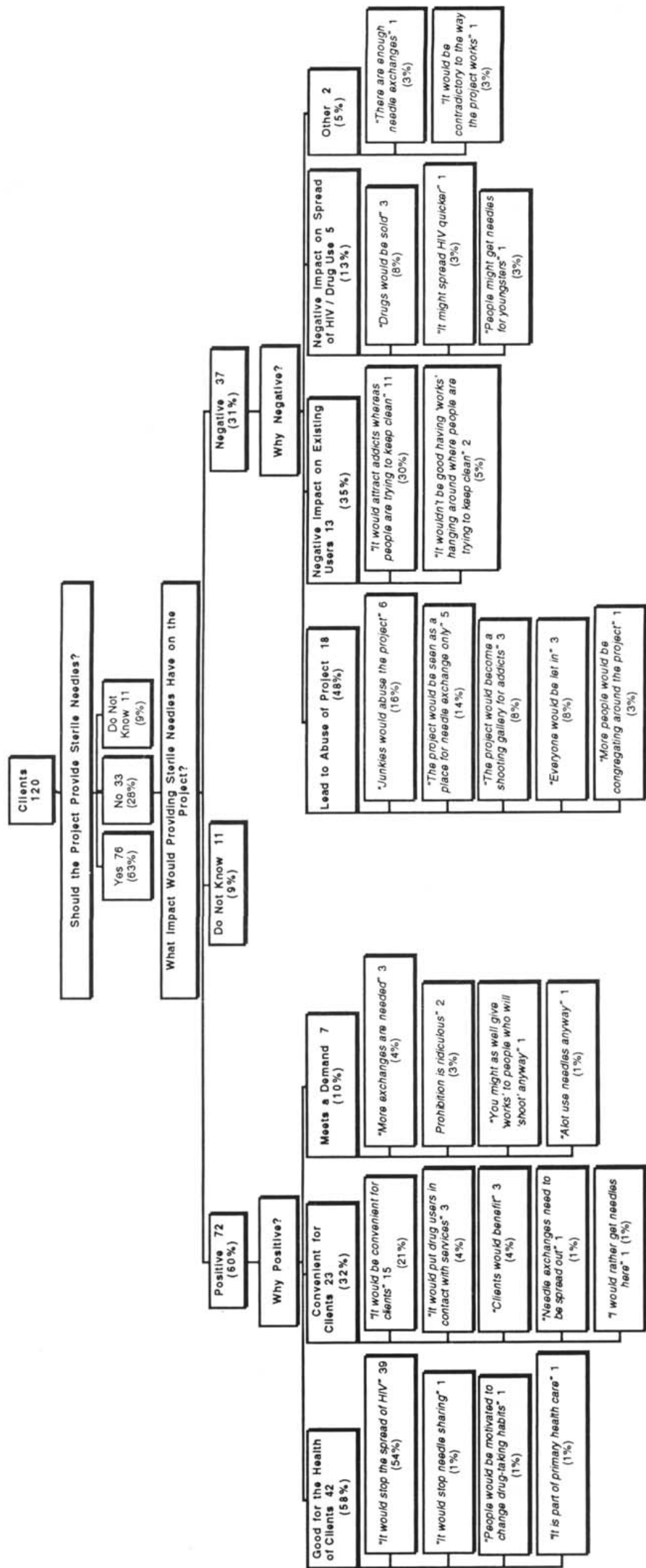


Figure 6.7 Attitudes to Needle Exchange Among Clients of Merchants' Quay Project, 1992



education and training needs of clients notwithstanding the serious deficits among clients in this area, noted in Chapter Four.

One of the new services which the project introduced on a pilot basis between July and December 1992 was a needle exchange programme. This programme was widely debated by the board of management of the project and by its volunteers prior to its introduction. In the light of this, it is useful to obtain the views of clients, some of whom are probably its beneficiaries.

All clients were asked the following question: *“Do you think Merchants’ Quay Project should provide sterile needles to its clients?”*. Their views are summarised in Figure 6.7. A clear majority of just under two thirds (76, 63%) are in favour of providing sterile needles but more than a quarter (33, 28%) are opposed and nearly a tenth (11, 9%) do not know.

Clients were asked about the impact which, in their opinion, a needle exchange programme would have on the project. The responses are broadly similar to the previous question with just under two thirds (72, 60%) believing that the impact would be positive and just under one third (37, 31%) believing that the impact would be negative.

The positive impact on the project of a needle exchange programme would be threefold, according to clients who adopted this view. It would be good for the health of clients by limiting the spread of HIV; it would be convenient for clients to have this service; and it would meet a demand for such a service. The negative impact of a needle exchange programme would also be three fold, according to those adopting this view. It would lead to abuse of the project by facilitating more drug use; it would have a negative impact on existing users, particularly those trying to stay drug free; and it would have a negative impact on the spread of both HIV and drugs.

The experience of the project during its first six months of operating a needle exchange programme is that none of the anticipated negative impacts have occurred. The service is convenient and meets a demand among clients. Moreover it seems reasonable to assume that the greater availability of sterile needles will help to curtail injecting and needle-sharing practices which are risky from the point of view of HIV transmission. As indicated in Chapter Five, approximately 7% of all clients are involved in risky needle sharing practices.

6.7 Summary

The analysis in this chapter has revealed a relatively high take-up of services in terms of the proportions who have a medical card (98, 82%) and are registered with a GP (108, 90%). Nearly all clients have attended an average of 5.5 service agencies each, although very few used these agencies in the month prior to the interview.

All the clients surveyed have used the core services of the project and a small proportion have also used the respite centre.

A significant change occurred in the drug use behaviour of clients between the time they first came to the project and the time of the interview in June 1992. Nearly half of the clients improved their drug use behaviour and a similar proportion showed no change. However more than four fifths indicated that they benefited from the project, substantially greater than the proportion whose drug use behaviour improved. A noteworthy result of the analysis is that changes in drug use behaviour are not related to the frequency of using the project, or using other services. Nor are they related to the age, sex, marital status, age on leaving school, or HIV status of clients. This result suggests the need for further investigation, possibly using more qualitative data based on each client’s account of their behavioural changes.

In general, clients expressed a high level of approval for the project and its services. At the same time they were generally critical of the services available for drug users in Dublin. Their suggestions for new services within the project indicate that the most pressing need is for services to meet the drug, health and emotional needs of drug users. The most frequently mentioned of these (20, 17%) was greater accessibility to physiotherapy and needle exchange.

It is widely believed by professionals working in the area of drug use that a high proportion of drug users do not use any services. This is confirmed by the impressions of clients. Given that the existing demand for services from drug users generally exceeds supply, this situation would be greatly exacerbated if, other things being equal, all drug users were to register a demand for services.

Chapter Seven

Conclusions and Recommendations

7.1 Introduction

This chapter draws together the key findings in the report and proposes some conclusions and recommendations. The analysis begins in section 7.2 with a brief overview of the context in which Merchants' Quay project operates, particularly with respect to drug use, HIV and AIDS. A brief summary of the origin and development of the project is presented in section 7.3. The services of the project are provided mainly by volunteers and some of the findings from the survey of those volunteers are presented in section 7.4 together with some conclusions and recommendations. Section 7.5 summarises some of the key socio-economic characteristics of clients with a view to developing a clearer picture of their diverse needs and the type of services needed to address those needs. There are a number of behaviours associated directly or indirectly with drug use, some of which have important implications for the transmission of HIV, and these are briefly described in section 7.6 together with some conclusions and recommendations. The usage of services and their impact on clients is examined in section 7.7 together with clients' suggestions for new services. Finally, in section 7.8, there is a brief summary of the key findings, conclusions and recommendations.

7.2 Context

The Merchants' Quay Project: Drugs/HIV Service was set up in 1989 to help prevent the spread of HIV through drug-use and related behaviour and to provide non-judgmental care and support to drug users with HIV and their families. Thus the twin problems of drug use and HIV provide the background and context to the project.

The first case of HIV+ in Ireland occurred in 1982. A decade later, at the end of 1992, a total of 65,823 persons in Ireland have been tested for HIV antibodies, of whom 1,313 (2%) are HIV+. Injecting drug use is the highest reported risk category for HIV. They constitute more than half (52%) of known HIV+ cases. More significantly, the large number of injecting drug users who have been tested for HIV (6,012) relative to the estimated total number of drug users in the Greater Dublin Area (4,000 - 7,000) suggests these test results are probably a reasonably reliable indicator of the prevalence of HIV within this group.

The number of AIDS cases in Ireland has increased systematically in each year since the first cases were recorded in 1982. However between 1988 and 1992 the growth in the number of new AIDS cases has fallen precipitously: in 1988 the growth rate was 85%; in 1989 it was 35%; in 1990 it was 10%; in 1991 it was 13%;

and in 1992 the growth rate was 8%. These growth rates need to be interpreted carefully however in view of small number of new cases of AIDS recorded each year.

The majority of AIDS cases in Ireland are male, aged between 20 and 39 years and nearly half of them are injecting drug users. Up to December 1992, a total of 137 AIDS-related deaths were recorded in Ireland, nearly half of them connected with drug use.

The prevalence of HIV and AIDS among other groups in Irish society is still unknown and will not be known until more widespread HIV testing of blood samples is undertaken on the population at large. Accordingly there is a risk that the existing data may seriously underestimate the true extent of HIV in the population.

Most experts agree that "the *problem of serious drug misuse seems to be confined to the Dublin area*" (Department of Health, 1991, p.6). This implies, other things being equal, that the problem of HIV and AIDS is also concentrated in the Greater Dublin Area. The size of the drug-using population is difficult to calculate and estimates of the number of drug users in Dublin vary between 4,000 (Catholic Social Service Conference, 1988, p.21) and 7,000 (O'Kelly, 1990, p.13). In 1990, the estimated number of persons receiving treatment for drug use in the Greater Dublin Area was 1,752 (O'Hare and O'Brien, 1992, p.1).

Informed opinion on drug use in Ireland and in Europe generally suggests that, in the 1990s, drug use may be on the increase, following the peak in 1983. According to the Government Strategy to Prevent Drug Misuse:

“during 1990 there were indications (an increase in the number of drug misusers, in drug related deaths and in seizure of illicit drugs) of an upsurge of drug activity in Europe, including the United Kingdom. There is some evidence of a similar increase here. There has been an upturn in seizures and in persons charged. These, and suggestions of an increase in street availability of cannabis and heroin, need to be carefully monitored” (Department of Health, 1991, p.8).

In Dublin, a disproportionately large number of drug users come from the inner city and is frequently associated with unemployment and poor living conditions. Following her review of all the major studies on drug use in Dublin, O’Hare painted the following picture of the typical drug user: *“... all recent sources show heroin, administered intravenously, as the preferred drug for the majority of drug users - although it should be noted that most are polydrug users. ... The majority are male, single, from a depressed socio-economic background, with low educational achievement and a poor employment record. Many come from problem family homes and have been in trouble with the law often before their involvement with drugs”* (O’Hare, 1987, p.86).

The broad parameters of current public policy in the areas of drug use and HIV/AIDS were set down in the Government Strategy to Prevent Drug Misuse published in May 1991 (Department of Health, 1991). Although drug use and HIV/AIDS are different problems in the sense that each can exist without the other, the position adopted in the Government Strategy to Prevent Drug Misuse is that *“it is impossible to separate policies relating to drugs from those of AIDS/HIV transmission”* (Department of Health, 1991, p.8).

The measures in the Government Strategy to Prevent Drug Misuse fall into three broad categories: measures to reduce the supply of drugs; measures to reduce the demand for drugs; measures to increase access to treatment and rehabilitation, both for drug users and persons with HIV/AIDS. A major innovation in the Government Strategy to Prevent Drug Misuse is the introduction of harm reduction measures for drug users (such as needle exchange, methadone, condoms, etc.) although it is significant that none of the measures radically address the underlying social and economic deprivations which, as all research and experience indicates, are the major contributory causes of drug use.

7.3 Origin and Development of Project

The origins of the Merchant’s Quay Project: Drugs/HIV Service can be traced to the latter half of 1989 when the Franciscan Friars in Merchants’ Quay, Dublin 8 became increasingly aware of the substantial number of persons in the locality who were drug users or HIV+, or both. According to Fr. Sean Cassin OFM, who set up the project, *“;(was local needs which created the project”*.

The model which informs the approach of the project is a medico-psycho-social model. This model is designed to reflect the multifaceted nature of drug user needs. Many drug users have medical problems associated with their drug use such as abscesses, under nourishment, AIDS symptoms, as well as psycho-social problems such as marital and other relationship problems and difficulties in the areas of housing, money, the law, unemployment, etc. The objective of the project is to address these problems directly through the project worker or indirectly by referring them to the appropriate agency and acting as an advocate on their behalf.

The distinctive feature of the project’s approach is that it is client-led. The nature of this approach was explained by Sean Cassin in his address at the formal opening of the project on 27 April 1992: *“Client-led services are simply about having a non-judgmental respect for drug users. We have opted strongly for a client-led approach which encourages respect for the individual’s capacity to change their behaviour; respect for a person’s right to test or not to test for HIV; respect for those who are infected that they will do their utmost to avoid transmission to others.”* (Cassin, 1992).

The project offers services to clients at each stage in the drug-using cycle including crisis intervention, stabilising programmes, detoxification supports and drug-free programmes. The services are offered through two centres: the project’s Contact Centre in Merchants’ Quay and the project’s Respite Centre in County Dublin. The following are the key services offered to clients in the Contact Centre:

- assessing client needs and working out a treatment plan to suit the needs of each
- advice on the safer use of drugs, particularly in terms of reducing the risk of HIV
- a needle exchange programme
- helping clients to access drug treatment and medical services
- helping clients with welfare and housing problems
- helping clients with marital and other relationship problems
- supporting persons who are detoxifying
- preparing court reports for clients and appearing in court to speak on their behalf
- visiting clients in hospital, prison or at home
- providing courses in art therapy, drama therapy, acupuncture, personal development, relaxation and literacy
- providing fitness training in a local gym
- helping clients to decide on adult education courses and in finding jobs.

The annual expenditure of the project for the year ended 31 May 1992 was IR£99,070, resulting in a deficit of IR£52,371, equivalent to 52.9% of total expenditure. The project's deficit is effectively an indirect subvention to the project from the Franciscan community in Merchants' Quay. This level of subvention cannot be sustained by the Friary.

7.4 Volunteers of the Project

The services of the project are provided by mainly volunteers. In December 1992 the personnel in the project comprised: a Director (unpaid), a Coordinator (paid), and 32 volunteers (referred to as Project Workers). Volunteers go through an initial training programme lasting 80 hours over a six week period. Between 1990 and 1992 a total of six training programmes were held for 97 volunteers.

A survey of volunteers was undertaken for this report. Questionnaires were completed by 35 of the 77 volunteers. The analysis of these questionnaires revealed that volunteers, as a group, are mainly in their twenties and thirties, single, have lived abroad and are relatively evenly divided between women and men and between former drug users and non-drug users. They come from families where the father's occupation (mainly skilled manual, self-employed and farmers) suggests that they had a relatively comfortable upbringing. Volunteers have a level of education that is above that of the Irish population in general but may be somewhat below those currently completing their education. Two thirds have worked previously in a voluntary capacity and their career aspirations are mainly towards personal and social services, art, nursing and education.

All volunteers on the project go through an initial training programme which most found useful but inadequate. They suggested three things to improve the project's training programme: (1) change the content of the course to cover such topics as role play with clients, the needs of volunteers as well as information on other agencies;

(2) change the organisation of the course to make it longer, have smaller groups, and use more professionals rather than former drug users; (3) provide ongoing training and more supervision in areas such as stress management, intervention and counselling. Elsewhere in the survey, volunteers mentioned the need for more supervision of their work as a way of improving their skills and learning from their mistakes.

Team spirit is good among volunteers and all but one claimed to have benefited from working on the project, both personally and professionally. However about half are not satisfied with the way the project is run because of their lack of involvement and influence at the level of management. Analysis of the comments of volunteers suggests that there are some problems in the project in the areas of communication and participation which need to be addressed.

A needle exchange programme was introduced into the project in July 1992 and there appears to be widespread support for this development among volunteers. Some volunteers would also like to see more services for clients including a doctor, more treatment and therapy as well as work projects. This would require additional space, as some volunteers pointed out.

The survey of volunteers raises two issues that need to be addressed within the project. The first concerns the provision of training for volunteers, both initial and ongoing training. The second concerns participation and communication within the project.

The provision of training for volunteers has been a priority of the project from the beginning. In addition to the initial training programme of approximately 60 hours, the project also facilitates volunteers to go on courses such as counselling, reality therapy, addiction, aromatherapy, reflexology, acupuncture, group facilitation, etc. The project pays part or all of the fees for these courses which serve to increase the skill level and confidence of volunteers while expanding the range of services available to clients. Training also occurs through the Volunteer Support Group which meets once a week to discuss issues arising within the project, including the management of cases. There are approximately 10 volunteers in each group and these are generally seen to be an integral part of the support structure for volunteers. Individual supervision of volunteers' work by the Coordinator of the project also occurs. The organisation of this supervision is somewhat haphazard and, according to the survey results, is a cause of dissatisfaction for a substantial number of volunteers.

The provision of adequate supervision to each individual volunteer is constrained by the large number of volunteers (32 in December 1992) and by the growing demands on the time of the Coordinator. Previous attempts have been made to allow each volunteer one hour each week to discuss their case load with either the Director or the Co-ordinator. These attempts failed due to the pressures of time and work. More recently the project has established teams within the project corresponding to the different areas of activity: an administrative team, a housekeeping team, a respite team and a drug workers team. The intention is that each team will receive weekly supervision from the Coordinator or a senior volunteer. This innovation has emerged within the project in response to the growing scale of the project and the division of labour between volunteers. It is also seen as one possible way in which the ongoing problems of supervision of volunteers could be managed in a more effective manner. **Accordingly it is recommended that the evolving structure of volunteer teams within the project should be used not only to streamline the work of the project but also to develop a structure for ensuring that each volunteer receives regular supervision. This is probably best achieved by fixing a regular time each week where each team can meet for up to two hours with an experienced member of staff to discuss the management of their cases. The inclusion of clients in some of these meetings should also be given serious consideration in order to maintain the client-led ethos of the project as well as to facilitate the learning of volunteers. Additional requirements for individual supervision and support should be dealt with on a case-by case-basis, given the large number of volunteers, the small number of staff and the growing demands of clients,**

The issue of participation in running the project is also of concern to a substantial number of volunteers. The Board of Management has 10 members, one of which is a volunteer from the project. The Director is also a member of the Board. The Coordinator occasionally attends meetings of the Board if required to do so, but is not a member. Meetings of the Board of Management are held every month and decisions are fed back in an informal way by the Director, the volunteer or, where relevant, the Co-ordinator. Volunteers do not have a right to see the minutes of management meetings on the grounds that some of the material discussed at some of the meetings is confidential. It would appear that the possibility of circulating the minutes of non-confidential parts of management meetings has not been considered.

Improving the system of communication within the project could attenuate some of the dissatisfaction expressed by volunteers at their participation in the project. The oral system of communication which obtains within the project at present is not sufficient to ensure that everyone is fully apprised of developments, given the relatively large number of volunteers, the fact that each is on a different team and may attend the project on different days. Accordingly it is recommended that memos of management meetings should be prepared and given directly to each volunteer or posted on a notice board, as appropriate.

Improved communication will help to ensure that information is passed from management to volunteers as accurately and as efficiently as possible. However it will not address the more fundamental issue of participation. This may require a more fundamental reorganisation of the way in which management currently operates. There is a growing perception among some members of management that it is not sufficiently close to the day-to-day running of the project to be effective. In view of this, the possibility of developing a subcommittee structure corresponding, at least in part, to the team structure among the volunteers may be worth

considering as a way of bringing management closer to the project and facilitating greater involvement of volunteers.

Under a subcommittee structure there is no reason why the level of participation by volunteers could not be increased substantially without becoming cumbersome. The precise number and type of subcommittees would need to be carefully worked out following consultation between management and volunteers although there would appear to be a strong *prime facie* case for moving in that direction. **Accordingly it is recommended that management and volunteers consider the possibility of developing a subcommittee structure for running the project which would have an expanded role for volunteers. The objective of this would be to make the management of the project more efficient and more participatory.**

7.5 Socio-economic Characteristics Clients

The analysis of some of the main socio-economic characteristics of clients was based on interviews with 120 clients who attended the project in 1991 and were contactable. The interviews were carried out in June 1992. Given that these clients constitute more than a fifth of all clients (22%, 549) who ever visited the project between its opening in February 1990 and June 1992 and more than two fifths (44%, 274) of those who visited in 1991, the results of the analysis can be taken as a reasonably reliable indicator of general trends within the client population.

The project has shown rapid growth between February 1990 and June 1992 in terms of the number of clients and client visits. The number of client visits per day is a useful indicator of workload within the project and this has increased from an average of 8.6 in 1990 to 28.3 in the first six months of 1992, an increase of 229%. From the analysis of client visits it emerged that three main types of client use the project. The first type is the "*once-off client*" who comes to the project once and never returns, constituting about 30% of the total. The second type is the "*occasional client*" who makes between two and ten visits to the project and also constitutes about 30% of the total. The third type is the "*regular client*" who visits the project more than ten times. This is the largest category of client constituting 40% of the total.

The analysis of the characteristics of 120 clients revealed that nearly two thirds are men, the average age is 30.3 years, the vast majority were brought up in Dublin, particularly in the inner city and two thirds currently live in a local authority house or flat.

About two fifths of clients are either married or cohabiting. However nearly three quarters have an average of 2.2 children. Moreover nearly half of all the children born of clients are not living with them, a remarkably high proportion of children not living with their biological parents by comparison with the norm in Ireland.

At the time of the interviews in June 1992, four fifths of clients were unemployed. This is nearly five times higher than the unemployment rate in Ireland at that time which was 17% of the labour force. Moreover all those unemployed have been in that position for over a year while more than one fifth have never worked. Accordingly the vast majority of clients are dependent on social welfare for their income.

The vast majority of clients were brought up in a family home but more than a quarter also spent some time in residential care when they were growing up, an extraordinarily high proportion by Irish standards. The reasons why such a high proportion of clients spent some time in residential care may be related to the fact that nearly half of them experienced frequent conflicts/violence in the home when they were growing up and around two fifths experienced substance abuse by parents, the loss of parent(s) through separation or imprisonment, and the physical illness of parent(s).

Clients come from relatively large families, the average being 6.9 children, compared to 4.16 in Ireland. There are strong indications from the occupational and employment status of clients' fathers that most clients grew up in families which were living close to the poverty line.

Nearly half of all clients dropped out of school before the age of 15 years, 1.6 times higher than among the population in Ireland generally. A remarkable feature of the educational background of clients is that nearly a

quarter attended a juvenile detention centre while more than a tenth attended a special school for children with emotional problems/behaviour problems/slow learners/mental handicap.

The educational attainments of clients is generally below the norm when measured by the highest examination passed. More than a quarter of clients passed the Intermediate Certificate/Group Certificate, similar to the proportion in Irish labour force who reported this as their highest educational attainment in 1989. However less than a tenth of clients have a Leaving Certificate, three times lower than the comparable figure for the Irish labour force in 1989 but more than eight times lower than the proportion of school leavers who passed the Leaving Certificate in 1990. The proportion who attended a third level college is about five times lower than the norm among the school leaving population in Ireland in 1991/1992.

The overall picture emerging from this analysis suggests that clients of Merchants' Quay Project are predominantly men from the inner city of Dublin in their twenties and thirties. Most are parents of children but nearly half of the children born of clients are not living with them. The phenomenon of children not being reared by their biological parents, while exceptional in Irish society, is not entirely new to clients since more than a quarter of them spent time in residential care during their upbringing. The vast majority of clients appear to have experienced major family traumas in their upbringing and this may help to explain not only the high proportion who spent some time in residential care but why a similar proportion spent some time in a juvenile detention centre. In terms of education and employment, clients are a seriously disadvantaged group and this is further compounded by their family background experiences and their current drug use and HIV status.

The converse of this profile is that the needs of clients are complex and multifaceted. In addition to providing support, counselling and treatment for the problems associated with drug use and HIV, clients would also appear to have acute needs in the areas of education, training and personal development. The project is aware of the multifaceted needs of clients and is endeavouring to address those needs in different ways, either directly or by referral to an appropriate agency. The balance between providing services directly and referring to other agencies is central to developing the mix of services that is best tailored to the needs of each individual client. This is an area that needs to be kept under constant review by the project to ensure that the client receives the best service available. **Accordingly it is recommended that the project's response to each client is continually monitored to ensure that there is maximum access to each type of service as required by the client. In tandem with this, the project needs to continually assess its overall strategy of service provision in order to ensure that the mix between providing services directly and referring to other agencies is in the best interests of the client and uses the project's resources and expertise to best effect.**

7.6 Drug Use and Related Behaviours of Clients

In order to respond to the needs of drug users, as drug users, it is also essential to have a clear picture of the specific behaviours and lifestyle associated with drug use and of the broader context in which they are formed. Many of the key elements of that picture emerged in Chapter Five. These elements will now be summarised briefly and used as a basis for making further recommendations on policy and practice.

The survey of 120 clients of the project revealed that four fifths are drug users (95, 79%), their primary daily drug being an opiate, taken orally. However more than half of all drug-using clients also inject and have been injecting for an average of 12.7 years.

Clients live in an environment where they perceive relatively high levels of drug use, both among their brothers and sisters but especially among their neighbours. They also perceive their social network to be populated by persons with HIV and by persons who have died from drugs and/or AIDS. This perception is consistent with the known geographical concentration of drug users in selected areas within Dublin's inner city, and to a lesser extent is also consistent with the geographical concentration of HIV (see Chapter One).

Drug use has had a negative impact on the health of clients, with two fifths having specific illnesses and more than half having HIV. The prevalence of HIV among the clients interviewed is much higher than the national prevalence among drug users suggested by Department of Health statistics which indicates that 11.8% of drug users who have been tested are HIV+ (see Table 1.1 above). The previous medical history of clients also reveals that more than four fifths have been hospitalised about five times. The main reason for this among two

thirds of clients was overdosing which occurred 3.6 times and brought many of them close to death on two occasions.

HIV can be transmitted through sharing contaminated needles and by having unprotected sex with a person infected by the *virus*. The evidence indicates that both types of risky behaviour occur among clients.

In relation to needle sharing, about half those who inject also share needles (27) and about a third of these share contaminated needles because they do not always clean them properly (11). Of those who share contaminated needles, seven are HIV+ and one has not been tested so that approximately 7% of all clients are involved in risky needle sharing practices from the point of view of HIV transmission.

In relation to sexual behaviour, the evidence indicates that just over half of all clients are sexually active and have had only one sexual partner in the past six months. Approximately half of these clients, and one third of their partners, are HIV+, although nearly two thirds indicated that they do not always use a condom. Closer analysis revealed that three clients are involved in sexual behaviour which is definitely risky from the point of view of HIV transmission since either they or their partner is known to be HIV+ but they do not always use a condom. An additional 10 clients are involved in potentially risky sexual behaviour because they do not always use a condom with sexual partners whose HIV status is unknown. In other words, a total of 13 clients are involved in some form of risky sexual behaviour, equivalent to 11% of all clients.

Combining the two types of behaviour which are risky from the point of view of HIV transmission, the evidence indicates that 8 clients are involved in risky needle sharing practices while 13 clients are involved in risky sexual behaviour. In sum, 21 clients are known to engage in risky behaviour from the point of view of HIV transmission, equivalent to nearly a fifth (18%) of all clients.

This result is significant given that these clients are probably more aware of the dangers of HIV transmission than persons who have not been tested, or other drug users who are not in contact with any services. Accordingly it may not be unreasonable to infer that the extent of risky behaviour from the point of view of HIV transmission may be substantially higher among drug users who have not been tested or who are not in contact with any services.

From the perspective of the project, this result reinforces the need to maintain its commitment to promoting safer drug using practices, as well as the issuing of condoms and needles. However it also suggests that the project may need to explore other ways of helping clients to adopt less risky behaviour. One way in which this might be done is to target those clients who are placing themselves and others at risk of HIV infection. Currently this is not possible within the project given its reluctance to ask clients about their HIV status. This is an area of considerable sensitivity for many clients and needs to be handled with great care. However the failure to tackle it typically means that the number of clients who are HIV+ is routinely underestimated by the project. A further consequence is that a comprehensive audit of the client's behaviour and lifestyle is not undertaken. Such an audit could be used to give the client more precise information on how to avoid specific behaviours and situations which place them and others at risk of transmitting HIV. **Accordingly, it is recommended that the project examine again its effectiveness in the area of HIV prevention and try to identify new ways of encouraging clients to adopt less risky behaviour.**

Drug use is an expensive habit. In a typical week in June 1992 the total amount spent by all clients on drugs amounted to IR£14,643. Over a twelve month period, this is equivalent to more than three quarters of a million pounds (IR£761,436).

From a financial point of view, the cost of drug use can be broken into three categories: street (or illegal) drugs, prescribed drugs and doctors' prescriptions. More than four fifths (85%) of total spending is on street drugs, one tenth (10%) is on prescribed drugs and the remainder (5%) is on doctors' prescriptions. Given that most clients have a medical card and can reclaim their outlays on doctors' prescriptions and prescribed drugs, it is useful to distinguish three different groups of clients from the point of view of the amount of money spent on street drugs.

The first and smallest group (16, 13%) are drug-free clients who, by definition, do not spend any money on drugs. The second group, constituting more than a quarter of the total (35, 29%), are active drug users who spend nothing on drugs either. The reason for this is that they obtain their drugs from the Drug Treatment Centre in Pearse Street, Dublin 1 or the AIDS Resource Centre in Baggot Street, Dublin 2, the only two centres at the time of the interview (June 1992) where drug users could obtain free drugs; alternatively they may receive doctors' prescriptions and prescribed drugs on their medical card. The third and largest category (77, 64%) are drug users who pay for their drugs. This category spend a weekly average of IR£181.30 on street drugs, equivalent to IR£9,428 over an entire year. This is a very substantial amount of money for clients whose main official source of income is social welfare. The average weekly income from social welfare in 1992 (using the Supplementary Welfare Allowance rate) was IR£53.00, which is only about a quarter (29%) of the average weekly amount spent on drugs.

The fact that street drugs absorb the largest proportion of total resources spent on drugs is not surprising given the peculiarities of the drug market arising from its illegality and the limited access of clients to medically prescribed and legally controlled drugs such as physeptone. The net effect of this limited access is that drug users have no other option, other things being equal, than to purchase street drugs. This requires substantially more resources than most clients have available and, other things being equal, requires them to resort to crime in order to get money. In other words the lack of medically prescribed and legally controlled access to physeptone (and other substitutes to street drugs) contributes directly to the high cost of street drugs and to the high level of crime associated with them.

In view of this it is not surprising that few clients have escaped contact with the law for their drug-related activities. More than four fifths have been arrested and appeared in court for drug-related activities. On average, this occurred more than 25 times to these clients. Just under three fifths have been held on remand or in prison for drug-related activities. On average these clients have spent 4.1 years in prison.

The effect of this level of crime is to spread the negative consequences of drug use beyond the drug user and his/her immediate family to those persons and businesses who are victims of crime and to the State through the substantial resources involved in processing drug users through the criminal justice system. From the point of view of reducing the amount of harm caused by drugs to users, their families, their communities, society and the State, there seems little doubt that a more comprehensive system of maintaining drug users on prescribed drugs rather than on street drugs would have a very beneficial effect. Moreover such a system is not necessarily prejudicial to the ultimate goal of helping drug users become drug-free.

The Merchants' Quay project operates within a broader system of services for drug users and persons with HIV. This system is currently in an important developmental phase as the Government Strategy to Prevent Drug Misuse (Department of Health, 1991) and the National AIDS Strategy (National AIDS Strategy Committee, 1992) are being implemented. A key innovation being introduced into the system is the adoption of harm reduction methods to help drug users cope with their addiction and to limit the spread of HIV infection. These harm reduction methods include the issuing of condoms, needles and physeptone.

It is clear from the amounts of money being spent by clients on street drugs and from their involvement in crime that the a substantial increase in the amount of medically prescribed and legally controlled alternatives to street drugs is required to reduce some of the harmful effects of drug use. Such an increase in supply would be consistent with existing national policies on drug use and HIV and are compatible with the basic philosophy of Merchants' Quay project. **Accordingly, it recommended that the project, through the various fora of which it is a member, promote the case for an urgent increase in medically prescribed and legally controlled alternatives to street drugs.**

7.7 Impact and Development of Services

The analysis in Chapter Six indicated that the uptake of services among clients of Merchants' Quay project is generally quite high. This is reflected in the fact (hat more than four fifths (98, 82%) of clients have a medical card and a higher proportion (108, 90%) are registered with a GP. Nearly all clients have used other services, although few reported using them in the month prior to the interview. The main services used are the Drug

Treatment Centre (88%), Coolmine (62%), the Ana Liffey Drugs Project (58%), Narcotics Anonymous (45%), the AIDS Resource Centre (39%), and Cairde (20%).

There is a widespread perception among professionals in the area of drug use that only a relatively small proportion of drug users are using any services. This view is strongly corroborated by more than half the clients (66, 55%) who indicated that they know many drug users who do not use any services. On average, these clients know of 31 drug users each who do not attend any service agency. This figure would probably not be a reliable basis for estimating the total number of drug users who are not using services given that it may contain an unknown margin of error and moreover there may be double counting if some clients are referring to the same drug users. Nevertheless it is important as an indicator of the widespread perception among clients that a substantial number of other drug users are not using any services.

It is probably reasonable to assume that drug users who are not using any services do not perceive the need to do so. Moreover it is doubtful if the existing network of services could cope with a significant increase in the demand for their services given that many of them are operating at full capacity. The experience of Merchants' Quay project is instructive in this context which has experienced a significant increase in the number of visits and in the number of clients during the first half of 1992 by comparison with the previous two years, (see Table 4.1 above). This has necessitated a corresponding increase in the number of volunteers working in the project and a generally increased workload for all project workers. In view of this it may not be prudent for the project to endeavour to reach out to other drug users who may not be in contact with other services since this could risk jeopardising the existing services to clients. However it is an issue which the project should explore further through the various fora of which it is a member.

All clients have used the core services of the project. The analysis revealed that significant changes occurred in the drug use behaviour of clients between the time they first visited the project and the time of the interview in June 1992. These changes can be understood in terms of the categories normally used by professionals working in the field of drug use to classify drug users' behaviour. These categories are:

- problematic drug user (severe, moderate or mild)
- stable drug user (prescribed, non-prescribed or both)
- recovering drug user (reducing, rehabilitating, recovered).

Applying these categories to clients at the time they first came to the project, the analysis showed that two thirds were problematic drug users, a quarter were stable drug users and one tenth were recovering drug users. By June 1992, the drug use behaviour of clients had changed radically with three tenths in the problematic category, four tenths in the stable category and three tenths in the recovering category. In more summary form, just under half the clients improved their drug use behaviour and a similar proportion recorded no change. Only seven clients were assessed as having disimproved.

Other indicators of changed drug use and related behaviours - changes in the amount of drugs taken, changes in the frequency of drug taking, changes in the desire to take drugs, changes in the usage of clean needles, changes in contact with drug-taking friends, changes in the use of condoms - were found to be in line with this result.

A noteworthy result of the analysis in Chapter Six is that changes in clients' drug use behaviour are not related to the frequency of client visits to the project, or to the usage of other services. Nor are they related to the age, sex, marital status, age on leaving school, or HIV status of clients. None of these variables had a statistically significant influence on changing drug use behaviour among clients. This finding suggests the need for further investigation, possibly using more qualitative data on each client's account of these behavioural changes.

In general clients expressed a high level of approval for the project and its services. Virtually all the clients indicated that they liked certain qualities about the place such as the good atmosphere and qualities about the project workers, particularly the ex-drug users who work there as volunteers. Equally more than four fifths of clients indicated that they benefited from attending the project.

It is noteworthy that the proportion clients who indicated that they benefited from the project (99, 84%) is substantially greater than the proportion (57, 48%) whose drug use behaviour improved. This implies that many clients have experienced benefits from the project without changing their drug use behaviour. This finding is

not entirely surprising in view of the fact that the project's approach is to enable clients, in a non-judgmental way, to address their needs as they perceive them. Changing drug-using behaviour may not be the client's short-term objective and this is respected by the project.

About two fifths of clients expressed some dislikes about the project. These related to the behaviour of other clients, aspects of the way the project is run and the attitude of some project workers. From the perspective of the project, some dislikes may be easier to change than others. For example, it may be possible to address issues such as controlling the negative behaviour of clients, increasing the supply of certain types of services such as home visits, art classes and access to respite. Others however may be less amenable to change such as the appointment system or the turnover of volunteers.

The number of clients who spent time in the respite centre (21, 17%) is quite small. However this is an extremely important service for some of the most vulnerable clients in the project. It is significant therefore that all but two of the clients interviewed indicated that they were satisfied or very satisfied with the service received in the respite centre. In addition, four of these clients made suggestions for improving services. Two of them suggested that there could be "*more structure to the days*" within respite. One suggested that drug-free clients should be kept away from drug-users. This latter suggestion would seem to be particularly important for clients who are stabilising on physeptone or going through a detoxification programme in order to become drug free. Another suggested that "key workers" should be in respite, i.e., the workers who normally liaise with each client.

The high level of client approval for the services of the project needs to be understood in the context (hat the overall level of services for drug users in Dublin is generally perceived to be inadequate. To a large extent it was this inadequacy which led to the formulation of the Government Strategy to Prevent Drug Misuse (Department of Health, 1991).

Clients are critical of the services available for drug users in Dublin. In answer to the question, "*What, in your opinion, is the biggest gap in services/or drug users?*" the most frequent response, from nearly three tenths of clients (35, 29%), was the availability of physeptone. Conversely, the most frequent response (20, 17%) from those clients who made suggestions on the development of new services within the project was the provision of physeptone and a needle exchange. This suggestion is quite understandable in terms of the large number of clients who rely on street drugs. It is also consistent with the recommendation above that the project should endeavour to promote improved access for drug users to medically prescribed and legally controlled drugs such as physeptone and other substitutes to street drugs.

Clients also recommended that most of the existing services in the project should be expanded to meet clients' social and recreational needs as well as their education and training needs. Developments in each of these areas would be of great benefit to clients but it is doubtful if all of them could be developed within the existing resources of the project. Nevertheless, in view of the client-led nature of the project, it is important that the type of services offered within the project is kept under regular review.

One of the new services which the project introduced on a pilot basis between July and December 1992 was a needle exchange programme. This programme was widely debated by the board of management of the project and by its volunteers prior to its introduction. In (he light of this, it is noteworthy that a clear majority of clients (76, 63%) are in favour of or providing sterile needles but more than a quarter (33, 28%) are opposed and nearly a tenth (11, 9%) do not know.

The overall outcome of this analysis provides a strong endorsement of the services being provided by the project. Clients like the project and claim to have benefited from its services. In addition, the drug use behaviour of about half the clients improved since first coming to the project although there is no connection between their improvement and the frequency with which the visited the project.

Merchants' Quay project emerged in response to a gap in the services for drug users and persons with HIV. At the same time the project is only one agency among many comprising the network of services for drug users. In general, drug users perceive many gaps in the network of services, most notably the lack of medically prescribed and legally controlled access to physeptone.

It is clearly not possible for (he project to meet all of the demands of existing clients, even without taking into account the larger population of drug users many of whom, in the opinion of professionals and drug users alike, are currently not attending any services. This is already acknowledged by the project in its policy and practice of referring clients to appropriate agencies and of advocating with agencies on their behalf. Nevertheless **the project should examine ways in which additional resources may be obtained in order to sustain and, if possible, expand existing services. In addition, the project should continue to promote the development of new services for clients through the various fora of which it is a member.**

7.8 Summary

The Merchants' Quay Project was set up in 1989 to help prevent the spread of HIV through drug-use and related behaviour and to provide non-judgmental care and support to drug users with HIV and their families. In 1992 the estimated number of drug users in Dublin was about 7,000. In August 1992 there were 1,265 persons in Ireland with HIV+, more than half of whom were injecting drug users. These statistics define the target group of the project.

The project is one of a network of agencies endeavouring to meet the needs of drug users and persons with HIV. It is generally acknowledged that the services available to this group are inadequate although they are currently being developed under the auspices of the Government Strategy to Prevent Drug Misuse (Department of Health, 1991) and the National AIDS Strategy (National AIDS Strategy Committee, 1992).

The background characteristics of clients who visit the project confirms the picture of drug users which has emerged from previous studies. Clients have experienced major problems in their family background, they have been failed by the education system and are almost totally excluded from the labour market. A notable feature of clients is that most of them are parents but nearly half of their children are not living with them. This phenomenon is exceptional in Irish society but it is not entirely new to clients since more than a quarter of them spent time in residential care during their upbringing.

Since its first diagnosis in Ireland in 1982, HIV appears to have spread rapidly among injecting drug users. More than half of the 120 the clients interviewed are HIV+. At the same time, 21 of these clients are known to engage in risky behaviour from the point of view of HIV transmission, equivalent to nearly a fifth (18%) of all clients. This finding underlines the need for the project to examine again its effectiveness in the area of HIV prevention and to try and identify new ways of encouraging clients to adopt less risky behaviour.

In 1992 clients spent more than three quarters of a million pounds (IR£761,436) on drugs. This, in turn, necessitated widespread involvement in crime given that the average weekly amount spent on street drugs is about four times the average weekly income of clients. The core problem here lies in the fact that clients do not have access to medically prescribed and legally controlled alternatives to street drugs. This is an issue which the project should endeavour to address either directly or through the various fora of which it is a member.

All clients have used the core services of the project and about half improved their drug use behaviour since first coming to the project. However this improvement was not related to the frequency of visiting the project nor to the usage of other services. Nor was it related to the age, sex, marital status, age on leaving school, or HIV status of clients.

In general, clients expressed a high level of approval for the project and its services and indicated that more such services were required. The evidence suggests that the demand for services from existing clients greatly exceeds supply, even without taking into account the larger population of drug users many of whom, in the opinion of professionals and drug users alike, are currently not attending any services. In view of this, it is necessary for the project to examine ways in which additional resources might be obtained in order to sustain and, if possible, expand the existing level of services. It should also continue to promote the development of new services for clients through the various fora of which it is a member.

Finally, the evidence in this and other studies on drug use in Ireland all point to its roots in social and economic disadvantage. None of the current policies directly tackle these root causes of drug use. This is an issue which should be taken up by Merchants' Quay Project through the various fora of which it is a member and should be part of an ongoing campaign to promote policies which address the root causes of drug use.

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