Ana Liffey Drug Project

Annual Report 1990

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Presented at the
Annual General Meeting
of the project
held on
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At the Launch of the Ana Liffey Drug Project Annual Report 1990. Left to Right: Dr. Maeve Hillery *(Patron)*, Mr. Joe O'Rourke *(Chairperson)*, Mr Chris Flood TD *(Minister of State)*, Mr. Barry Cullen *(Director)*

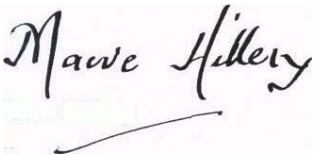
Foreword . . . . . .

Developing a Vision

The publication of this report comes at a significant time in the growth of the Ana Liffey Drug Project. The project has developed out of a vision first articulated by its founders, Frank Brady SJ and Mara de lacy when it was first set up in 1982, and which has remained solidly in place since. This is a vision of hope, of a determination to respond to problem drug users first and foremost as individuals. It is a belief in the capacity of drug users to engage positively in a change process and to be the architects of their own recovery. When the Ana Liffey Drug Project was first set up there were few enough people who shared this vision. But, while few in numbers it was these people who provided it with the space to develop a service. Without their determination and sense of purpose we would not be here today to celebrate the project's most recent achievements. To the project founders, to the voluntary workers in its early years, and to the individuals and companies who funded the work, we owe a great debt. Their contribution will always be remembered and respected.

This report speaks volumes of the progress made by the Ana Liffey Drug Project in recent years. In this regard I refer to progress made in service delivery, policy developments and new initiatives, all of which are detailed in the report. One of the new initiatives - the setting up of the parents support group, Le Cheile - has particular significance. I first met members of this group during a visit to the project in November 1990.1 was deeply touched by their courage and by their willingness to share their sense of loss and bereavement. These parents, meeting and acting together, can provide genuine support and reassurance to others who share their predicament. I sincerely hope they continue to be encouraged in their endeavours.

The project is now at a stage where it can present itself with a new confidence. Its service is quite clearly both challenging and attractive to those who use it. It operates in an environment where there is policy support to its objectives. As patron I congratulate the project on its achievements and promise it continued support for the future.



Dr. Maeve Hillery
Patron

Minister's Speech . . . . . .

Speech by Mr. Chris Flood T.D., Minister of State at the launch of the 1990 Annual Report of the Ana Liffey Drug Project May 20th, 1991.

Ladies and gentlemen, I am very pleased to accept your invitation here this evening to accept the Ana Liffey Drug Project's Annual Report for 1990 and I look forward with interest to studying the report in detail.

As many of you are aware my colleague, the Minister for Health, Dr. Rory O'Hanlon T.D. this morning officially launched the Government Strategy to Prevent Drug Misuse.

This comprehensive strategy is based on the recent report of the National Coordinating Committee on Drug Abuse, which I now chair, and reflects the widest possible consultation with all bodies - both statutory and voluntary - involved in the area of drug misuse including of course, the Ana Liffey Drug Project. The Government Strategy document falls into five main areas:

Chapter 1 charts the development of the drug problem in Ireland, looks at our current data gathering capabilities and calls for the development of a national database which will gather data from the widest possible sources nationwide on the trends and extent of drug misuse.

Chapter 2 looks at the current legislation provisions in the area of supply reduction and sets out the further action which the government propose to take.

Chapter 3 deals with drug demand reduction policies under the general headings of education, outreach and treatment and rehabilitation.

It deals with proposals regarding:

- the provision by the health boards of a mechanism for coordination between the statutory and voluntary services in their areas;
- increased involvement of the statutory training and occupation rehabilitation services such as FAS, NRB, VECs, etc, in the rehabilitation of drug misusers;
- a strengthening of the role of the Drug Treatment Centre Board, Trinity Court and an expansion of the Board membership the coordination of programmes in the related areas of drug misuse and AIDS;
- an extension of the existing outreach programme and the introduction of Community Drug Teams in specific areas.

Chapter 4 sets out the training requirements to be put in place to facilitate an expanded role for general practitioners in the treatment of drug misusers.

Chapter 5 deals with the question of coordination of our international efforts. I would like at this point to focus on one particular element of the strategy which I feel is worthy of special attention in the context of tonight's meeting.

The strategy introduces for the first time in Ireland the concept of Community Drug Teams drawing on the expertise of general practitioners and other health and social service professionals working in targeted communities and serious drug misuse problems. *(Contd.)*

Minister's Speech (contd) . . . . . .

I am convinced of the need to decentralise drug treatment services, as far as is practicable, to ensure the maximum accessibility of services and continuity of treatment. This, of course, cannot be done without ensuring the maximum level of support to drug misusers and to their families in terms of counselling services, and the provision of laboratory back-up and other specialist inputs as a support to general practitioners. This plan provides for such support. Nor can it be done without providing the general practitioners concerned with specialist training in the field of drug misuse. This is also provided for in the report

My department is asking the Irish College of General Practitioners in conjunction with the Drug Treatment Centre and the other relevant training bodies to develop specific training arrangements to meet these requirements.

The important role of the voluntary agencies in the field of drug misuse has been recognised in the Government Strategy and cannot be overstated. I look forward therefore, in my capacity as chairman of the National Coordinating Committee, to seeing a development and enhancement of the good working relations which already exist between the voluntary and statutory services in this most important field.

In conclusion I would like to thank the Ana Liffey Drug Project for the work they have done in tackling the problem of drug abuse, for their constructive input into the Government Strategy and wish them every success in their endeavours in the future.

At the launch of the Ana Liffey Drug Project Annual Report 1990. The Minister of State with some of the parents involved in the project's family support programme

Introduction to Report . . . . . .

1990 - A year of Changes

The year 1990 will be seen as a year of major and significant changes in the drugs field. It was a year in which drugs issues were debated openly, perhaps for the first time since the problem first escalated in the late 1970s. There was the seminar on Drug Treatment Policies which this project organised in April, in Trinity College, and which over 150 people attended and heard of new, more community-oriented approaches to the drug problem. There was the setting up of the Drug Workers' Forum and its unique objective of uniting in the one forum persons who both work with and/or are affected by problem drug use. This and other similar developments have facilitated drug users coming forward to express their views on the drug problem and drugs services. Many of these views have not been heard before and it is important that according as we hear them, we take them on board, and where appropriate, we make the adjustments in our services.

It was the year in which the National Coordinating Committee on Drug Abuse was reconvened to consider a new drugs policy. It is indeed timely that the details of this new policy are being published on the same day as the launch of this Annual Report. The Minister and his department deserve our congratulations for producing this document. It is the first comprehensive statement on drugs policy to be issued since the problem escalated in the late 1970s.

It was the year in which the Liam Brady Testimonial Match, and his "Give Drugs the Boot" campaign stimulated a renewed public interest in the drugs issue. In conjunction with this campaign RTE's, "Gay Byrne Show" broadcast a 90 minute live programme from the Ana Liffey premises in which drug users and parents shared their experiences and feelings of loss to a wider audience. In the south inner city a number of people who came together to organise children's sports for the Liam Brady campaign, stayed together and last November organised a hugely successful seminar on local drug problems. This group, now known as Community Response have since, produced a very important report on drug problems in the south inner city and recommendations for dealing with it.

It was also the year in which the Le Cheile support group for parents began to expand. This support group now consisting of 24 parents has found a unique format for both sharing their grief and losses, and socialising through song and dance. We certainly hope this group expands in the coming year.

Within the project itself we have gone through a number of important and significant changes. We have reviewed our service, strengthened certain components of it, and restructured the way we deliver, support and supervise this service. In recent months we have also lost to new employments two workers

- Mara de Lacy and Brian McNulty. We wish them well for the future and welcome their replacements
- Karma Harty and Ray McGrath.

It was a year in which the project relied yet again on the non-statutory sector for substantial funding. This situation we know, cannot continue indefinitely. For the coming year we will be applying for and expecting to receive, core funding from statutory sources in relation to the work we do.

It was sadly, a year in which yet more young people died as a result of HIV and AIDS. Over the last twelve months we have shared this grief and loss with their parents, families and friends. As we reflect on another year of the project, we think of them and remember their strength, courage and willingness to share.

Barry Cullen
Director 9

Stating the basics . . . . . .

Definition

There is no simple definition to any social problem and the drug problem is no exception. In defining the drug problem there is a tendency to focus on the drug itself as being evil, as symbolising degradation and horror, and to focus on the drug users as persons who have rejected society and its values, or as deviants and criminals. This approach is far too simplistic and there is a need for a more rational definition of the drug problem.

In the Ana Liffey approach to the drug problem we operate from a pragmatic definition. Problem drug users are people for whom the continued use of psychoactive drugs creates profound difficulties for themselves or others. These difficulties include: addiction, in relation to drugs which create a psychological craving; withdrawal symptoms in relation to drugs which create a physiological dependence; financial hardship and an involvement with crime in relation to drugs which cannot be bought at a price which the user can afford; court appearances and imprisonment in relation to drugs which are illegal; isolation from family and community in relation to drugs which are not socially approved; serious illness and the risk of HIV infection in relation to drugs which have been adulterated with impurities or administered intravenously with unclean syringes and needles; and, the prospect of being permanently labeled as "junkie", "alcoholic", "unemployable", "outcast" and "deviant" in relation to drugs which have caused problems over a prolonged period.

Problem drug users are people for whom the continued use of psychoactive drugs creates profound difficulties for themselves or others.

Analysis

To respond to a social problem effectively it is necessary that we be equipped with an analysis - a sense of understanding the problem from a particular perspective and using this to inform our work objectives and our methods.

Problem drug use is fundamentally a "social problem". In the Irish experience it has been principally a "community problem". Its causes and effects are most apparently social in those small geographic areas where opiate use and a variety of activities associated with it have been most prevalent. The first escalation of opiate use in the late 1970s- and its continuation since - was, and is, clearly confined to a small number of flat complex communities in the inner city of Dublin and a number of local authority housing estates in its suburbs. These areas are characterised by high unemployment and generalised deprivation.

This social problem is indicative of a breakdown in community and of a limiting of social, recreational, education and employment choices. We cannot respond to the drug problem in isolation from these factors. It is not enough to say that "we need only to remove the drug user from a socially threatening environment." The environment is their home, it is is their community, and it is the place where the problem is most manifest. Inasmuch as it is a community problem it is in a community-oriented approach that answers to this problem may be found.

The problem is indicative of a breakdown in community and of a limiting of social, recreational, education and employment choices

Stating the basics . . . . . .

Methods

Our assumptions about drug users will inform the methods we use while working with them. If we constantly stereotype drug users or perceive them only in terms of negative labels, then our methods of work will be pitched at a low level of achievement. We and they will end up frustrated, disillusioned and unable to make any real sense of the problem.

Underlying the Ana Liffey Drug Project's methods of work is our belief that drug users can make realistic assessments about their situation, they can act responsibly, they can cooperate with services, they can take on advice and information, they can make changes in their lifestyle, they can look at important issues in their life and they can reassess their progress.

What is crucial in relation to whether or not they do these things while in contact with drugs services is whether the services *believe* they can. Our positive support and attitudes are fundamental to these changes happening. So also is our accessibility. From the time the project was founded in 1982 we have had a major emphasis on being accessible -on being available. A rigid, institutional approach to problem drug use reinforces the stereotypes, it distances the service-user from service-provider, and contributes further to the mystification of the problem. The Ana Liffey methods of work which incorporate user-friendly and harm-reduction approaches are oriented to commencing work with the drug user where they are at and not where we think they should be.

Harm Reduction

The underlying principle of harm reduction is one of saying that if we cannot get drug users to focus on immediate, short-term abstinence as a way of dealing with their drug use, that we focus instead on reducing the harm associated with such drug use. Within this approach drug treatment personnel continue to work with drug users even though the latter continue to use drugs and/or demonstrate no commitment to stopping use.

Harm reduction involves making a commitment to working with drug users no matter what the stage or level of use - i.e. including persons who still use drugs; persons who are going through some kind of treatment; persons who are exploring a drug-free option, and so on. With each of these and at every stage, there is a harm reduction message.

The most fundamental component to harm reduction is the provision of basic advice and information. If a person insists on using drugs advice/ information on non-injectables, safer injection practices (non-sharing, safer preparation, cleaning/sterilisation), etc is provided. If a person has HIV or at risk of HIV advice/information on safer sex practices is provided.

Harm reduction also involves making available a wider range of treatment options - the provision of a range of treatment services including stabilising doses of methadone and methadone maintenance programmes (both centrally and community based) as well as drug-free rehabilitation.)

From the time the project was founded in 1982 we have had a major emphasis on being accessible - on being available

Harm reduction involves making a commitment to working with drug users no matter what the stage or level of use

Stating the basics . . . . . .

Being User-Friendly

The underlying principle of user friendly services is that they should incorporate a positive, non-judgemental, non-directive attitude to work based on empathy, self-determination of need and the protection of confidentiality. With a user-friendly approach a service is consciously pointing out to service users that it (the service) does not have the answers, it does not have the solutions and that it is prepared to work together to search for these.

There are important implications to adopting a user-friendly approach. Firstly, the only basic assumption we can make about newly referred drug users is that they have recognised the service as a place to come to for help in dealing with their problems.

Secondly, it is necessary to show empathy with drug users. We need to have an openess to understanding their situation and seeing it from their point of view. We should attempt to accept drug users as they are; to understand that if they say they want to continue to use drugs that this is an honest statement of their being; and not have unrealistic expectations of their motivation, capacity or perceived necessity to change their current situation. There are many positive changes which drug users can make even while they continue to use drugs.

Thirdly, we need to accept their own own perception of their needs. We need to understand that if a drug user identifies material, medical, and therapeutic needs not related to drug-use, that

Being User-Friendly (Contd.)

these may be valid and should not be superseded by what we perceive as being most important. We have often found within our service that many drug users present for counselling on relationship issues. We find that by responding to these needs we reach a stage, somewhat further down the road, where they want to look at their drug use and deal with this also.

Fourthly, we need to be non-directive in relation to advice/information on options leaving it to the drug user to make an informed decision about these options. There is no point in us insisting that a drug user must engage in a particular form of rehabilitation if they are not prepared to. At best they will undertake the rehabilitation programme with reluctance which often transforms to resentment. At worst, they will reject completely helping services.

Fifthly, we need to openly demonstrate our commitment to confidentiality. Drug users need reassurance that their information is protected. Information should not be shared with other agencies without informed consent. Wherever possible access to recorded information should be agreed and procedures for setting this up should be clarified.

These are key, fundamental attributes of a user friendly service. The only purpose served by departing from them is to marginalise drug users even further.

There are many positive changes which drug users can make even while they continue to use drugs

There is no point in us insisting that a drug user must engage in a particular form of rehabilitation if they are not prepared to.

Staff at the Ana Liffey Drug Project. Left to right: *back row* - Marguerite Woods*(Team Leader)*, Ray McGrath (Project Worker), Bríd Nic Aodha Bhuí (Secretary); *front row* - Rev. Frank Brady SJ *(Project Worker)*, Karina Harty *(Project Worker)*, Sr. Ethna O'Donovan *(Project Worker)*, Barry Cullen *(Director)*

Reporting on work 1990 . . . . . .

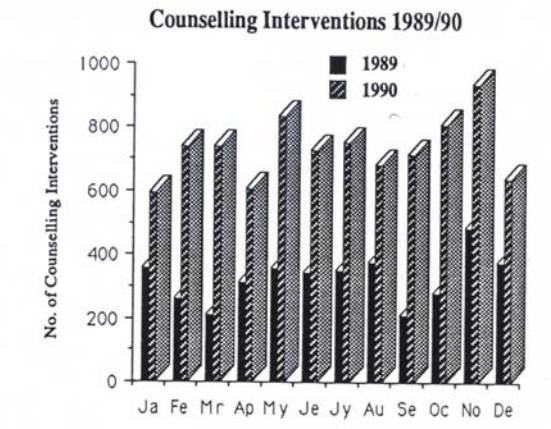
General

Over Ac past two years the Ana Liffey Drug Project has undergone a process of evaluation, review and change. During this period there has also been a marked increase in people using the services of the project and in the cumulative attendances of project users. (A detailed breakdown of service attendance is provided in accompanying graphs). Attendances during 1990 have almost doubled each month over the previous year and the indications so far this year are that this pattern will remain.

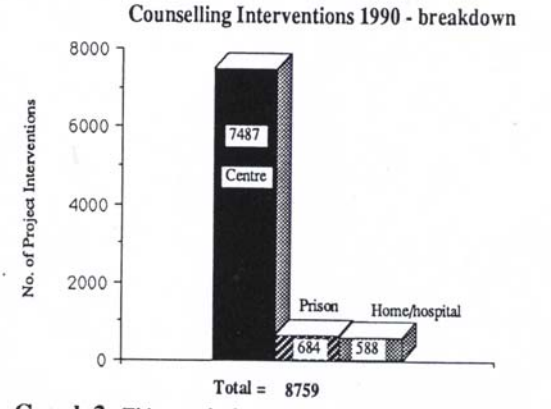
There has been a renewed commitment to a team approach to the work. Various mechanisms such as regular weekly team meetings, support meetings and counselling supervision have been introduced to facilitate and resource the staff. This allows for ongoing staff input and involvement in the decision making processes and the role of each Project Worker in the development of the service is thus valued and respected.

The appointment of a Team Leader in November 1990 indicates the Project's commitment to a coordinated, trained, informed and supervised service. Some staff changes occured in early 1991. Mara de Lacey left in early March to take up a position as Addiction Counsellor in St Patrick's Hospital, while Brian McNulty left in April to join the Probation and Welfare service. We value the contribution which they have made to the Project over the years and we wish them well in their new positions. We are happy to welcome Karina Harty and Ray McGrath as new Project Workers.

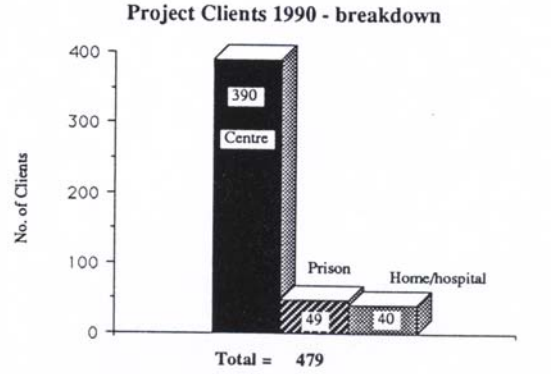
Attendances during 1990 have almost doubled each month over the previous year and the indications are that this pattern will remain



Graph 1: *This graph shows the total number of counselling interventions, per month, in the years 1989 and 1990*



Graph 2: *This graph shows the breakdown of counselling interventions according to centre, prison, home and hospital visits, 1990.*



Graph 3: *This graph shows the breakdown of project clients according to centre, prison, home and hospital visits, 1990*

Reporting on work 1990 . . . . . .

Drop-in Centre

The Ana Liffey Drug Project was first set up to initiate informal contacts with drugs users who had no meaningful relationship with other services. Initially these contacts were developed in outreach and streetwork and efforts were made to engage drug users in their own environment. The drop-in centre developed out of these efforts.

Through its drop-in service the project maintains informal contact with problem drug users. This is the baseline service of the project where first time attenders meet the Project staff and where people drop in on a regular basis. It presents an opportunity for informal and unstructured, but meaningful, contact with Project users. This facility enables drug users to attend without having to make specific commitments to formal counselling and it includes a tea/coffee service and space to have informal discussions. The drop-in service is a safe place for the people who use the service. The only rule which applies is that no one attending the Centre should make it unsafe for others.

In April 1990 we reviewed the activities of the drop-in and evaluated its importance with regard to the overall service. Consequently a decision was taken to increase the resources in the drop-in. Two members of staff are available to drop-in at all times. This provides increased interaction and a counsellor is always available should any crisis of an attender occur. Following a further review in September a decision was made to structure the drop-in opening hours. We now open our drop-in facility for two hours morning and afternoon.

Drug users attend without having to make prior commitments to more formal programmes

Counselling Programme

The project provides a professional counselling service with an emphasis on supporting the drug user to reach a level of management and/or control of their situation. Drug use is only one of a number of issues addressed in counselling. Others include health and issues around primary health care particularly in the context of drug use and HIV; safer drug use; safer sex; child care issues; pregnancy; family and other relationships; child sexual abuse; sexuality; social and life skills.

Prior to counselling there is an intense assessment interview and the person is then allocated a key worker. Counselling intervention is based on pragmatism; it is oriented towards the achievement of attainable goals and focuses on motivation, support, reassurance, information and advice.

There are two types of counselling interventions: structured appointment counselling on a weekly or fortnightly basis and informal counselling interventions at a crisis intervention, once-off or informal level. Sixty five per cent of clients attending the centre are availing of appointment counselling, 30% are using once-off counselling when they feel they need it and 5% are using the drop-in service exclusively.

We will work with people at whatever level of motivation they present. A fundamental objective is to empower problem drug users - to give them basic information and advice, and to equip them with the knowledge and skills to set realistic goals and to evaluate their own progress.

Counselling is oriented towards the achievement of attainable goals and focuses on motivation, support, reassurance, information and advice

At the launch of the Ana Liffey Drug Project Annual Report 1990. Dr. Maeve Hillery with some of the parents involved in the project's family support programme

Reporting on work 1990 . . . . . .

Prison Counselling

The Ana Liffey Drug Project's involvement with prisons began in 1985 and has been built up since. Currently, a project worker attends Separation Unit/Basement three mornings per week to provide counselling and group work. A Project worker also attends each of the prisons - Mountjoy Main, Mountjoy Womens, and the Training Unit - one morning per fortnight, to provide counselling.

Over the years we have developed a sound professional relationship with prison management, the prison welfare service, the psychology service, the school, and the prisoners themselves. Our current work in the prisons is done under the auspices of the Probation and Welfare Service.

Our prison counselling service has developed to respond to the problems of addiction, and stress and family-separation, among long-term prisoners. Many of these issues are focused on particularly through utilising groupwork methods. We also work closely in preparing prisoners for temporary release, or in arranging for prisoners to attend special family counselling sessions in our centre.

Many temporary release prisoners attend our services and maintain the contact with us that was initiated within the prisons. Indeed our work in the prison is an important outreach service. Often drug users are brought into contact with services through contacts made within the prisons and will as a result of these contacts continue to address their problems when they leave prison.

Our prison counseling service has developed to respond to the problems of addiction, and stress and family-separation, among long-term prisoners

Family Support

The drug user should not be seen in isolation from his/her family. For every drug user there is a whole extended family network who have been affected by the trauma of neighbour disapproval, visits by the Gardai and court appearances. Many families also provide care for children whose drug-using parents are in prison, hospital or indeed one of whom may be deceased. The persons who invariably bear the brunt of this trauma are the mothers of drug users.

In 1988 the project initiated a family support service and allocated a worker specifically to duties in this area of work. The worker contacts families at their direct request or the request of the drug-using son or daughter attending the project. Thereafter, family contact is not linked to any direct counselling or other programme within the project. The work we do with the families is quite separate to that we do with drug users who directly attend the service. Essentially our work with families is around responding to *their* needs and usually takes the form of information-giving, clarification, reassurance, and support. Where appropriate, communication between family and drug user is also undertaken, particularly in instances where the latter is imprisoned.

The family worker also maintains contact with drugs users, known to the project, who are admitted to hospital. In situations of serious illness, further contact is initiated with the families and support, counselling and reassurance is offered, particularly where there might be a bereavement as a result of a drug-related illness.

Our work with families is around responding to their needs and usually takes the form of information-giving, clarification, reassurance, and support

Reporting on work 1990 . . . . . .

Le Cheile

Le Cheile is a support group for parents of adult persons who have HIV as a result of intravenous drug use. This group was initiated by the project in November 1989 and has continued since. The project continues to provide vital funding for premises, refreshments and transport. There are two Ana Liffey workers assigned to working with the group and it also has the support of a number of health board addiction and HIV counsellors.

The idea of setting up this group originated from our work with parents who had experienced bereavements as a result of HIV. Many of these parents became quite isolated within their home and community. By bringing parents together it was felt that a mutual support system could be developed. Eventually the parents may find the resources and energy to speak out on the issues as they see them. Indeed, some parents participated in an RTE programme on drugs and HIV in May 1990 which was broadcast directly from the project's premises.

The group meetings are organised on a monthly basis and they consist firstly of a discussion - a reflection of where people are at and how the group is developing. This discussion is then followed by refreshments, song, dance and general crack (the Irish version). There are now 24 members in the group and between them they have experienced 14 deaths in their families in recent years.

By bringing parents together it was felt that a mutual support system could be developed

Development Group

A Drugs Development Group was set up in the latter part of 1990. The primary objective of this group is to bring together drug-users (both former and current) with a view to setting up a self-organised group which would concern itself with issues they share in common. Ultimately, it is envisaged that this group could become a voice for drug users, that it could work towards improving services - medical, welfare and accommodation - and public attitudes, and that it could provide support to its own self-help groups.

The idea of setting up this group originated within discussions in the Ana Liffey, where it was felt that the absence of such a group had contributed further to the marginalisation of drug users. It was apparent that drug users were not broadly perceived as having a valuable contribution to make to discussing drugs issues, or to the development of services and responses.

In consultation with personnel from other services the project set about bringing together a number of people who were interested in forming this group. The group set up in December and it meets once a week. The focus of its meetings is the acquisition of knowledge and skills around building a self-organised group. The group is trying to evolve a set of objectives that are achievable, a structure suitable to its needs, a system for providing continuous group support, and credibility to attract some external funding.

Ultimately, it is envisaged that this group could become a voice for drug users

Reporting on work 1990 . . . . . .

Groups

Open Forums - The project has in place a number of mechanisms for client participation in its work. Open Forums provide a very real opportunity for those who use this service to raise issues, to evaluate what the service has to offer and to make a constructive input with regard to its development. For the last two years these meetings have been happening in the project. Initially they were resourced and facilitated by members of the staff but a more recent development has evidenced the skills acquired over time by project users as they now have taken on the responsibilities of organising, hosting and facilitating these meetings.

Information Meetings - A number of interesting and stimulating information meetings took place during the year in the project. Attendance varied according to the subject under discussion. When a community welfare officer came to talk about social and community welfare entitlements there was not a vacant seat or indeed floor space in the group room. A General Medical Practitioner visited to discuss general health issues and two workshops on issues relating to HIV and prevention were conducted by a counsellor from the GUM clinic in St James Hospital and an outreach worker from the AIDS Resource Centre respectively. Members of the Irish Quilt Project brought videos and panels from the AIDS Memorial Quilt to the group for a very emotional session and we all felt really honoured to have one of the first panels made in Ireland stay with us on display in the project for a week.

Project users have taken on the responsibilities of organising, hosting and facilitating open forum meetings

Groups (contd.)

In May 1990 we had a sneak preview of "Stories from the Silence" before its first showing on RTE. We would like to thank all those who made these workshops, talks and seminars possible.

Therapeutic Group - In 1990 a short term therapeutic group ran for ten weeks. It dealt with the issues of HIV, illness, interpersonal relationships and methadone maintenance. The depth of the issues, feelings of insecurity, fear of feelings themselves and the issue of inter group confidentiality have lead to an avoidance of therapeutic group work on the part of attenders. To this end an additional information meeting' took place facilitated by project staff on the issue of confidentiality. However the constant demand for one to one counselling coupled with the demand for groups which focus on information, activities and self organisation would indicate the unpopularity and avoidance of therapeutic group work. (our work with the issue-based development group is referred to earlier in this report)

Alive and Free Weekend - In October 1990 12 people who use the service on a regular basis participated in a residential group work weekend. This was a very successful experience which focussed on important issues in relation to communication, trust, fears and the future.

Prisons - The project has also operated a very successful group among long term prisoners in the Mountjoy Separation Unit.

The demand for one to one counselling and for groups on information, activities and self-organisation, indicates an avoidance of therapeutic group work

At the launch of the Ana Liffey Drug Project Annual Report 1990. Dr. Maeve Hillery with staff and some of the women involved in the project's programme

Reporting on work 1990 . . . . . .

Women's Issues

In the main women drug users are largely "hidden" from view. The public perception of a drug user is frequently that of a young man. The issue of women and illicit drug use is rarely addressed even within fora which discuss women's health issues. On the other hand drug use is sometimes presented as evidence of a "type" of woman. There are perceptions of women who use drugs as "unfeminine", "unfit to parent" or "irresponsible". This sort of "deviance" may be regarded negatively but if a woman has already been regarded as "deviant" - if she is an ex-prisoner, if she has worked in prostitution or if she is a lesbian - the knowledge that she is using or has used drugs may only exacerbate the already existing assumptions about her. These attitudes are often internalised by women and frequently prevent women from being open about their use of drugs and may actively stop some women from seeking help or support if they need it. Fears about drug use in relation to pregnancy and child care issues may have the same effect.

Research has shown that many drug users may be well into their drug using "careers" (on average four years) before they present at an agency for medical treatment or for counselling and support. Perhaps future research will support the belief of many drug workers that women tend to present later, if at all. It is widely estimated that approximately 67% of drug users are men, the remaining 33% women. The reasons for this difference are

The issue of women and illicit drug use is rarely addressed even within fora which discuss women's health issues

Women's Issues (contd.)

attributed variously to women's position and role in society, socialisation processes, less freedom, harsher familial attitudes to "deviance" in girls and women, etc.

Interestingly considering the above ratio, the Ana Liffey Drug Project has witnessed an increased attendance of women in the last two years so that approximately 40-45% of the people attending are women. In April 1991 women's attendance at the Project represented 47% of the monthly attendance. This is considerably higher than the usual attendance at drug services, statutory or non-statutory. Some services are reporting women's attendance to be as low as 15% of the total clientele.

In the centre we have not nor do we intend to positively discriminate in favour of women but we attempt to provide a service which meets the needs, requirements and aspirations of both women and men. Informally within the drop in area there is a constant addressing and acknowledging of women's issues. Coupled with a high female attendance at the project there is a strong interest in an ongoing women's group. Currently women attending are discussing this with a view to bringing together a group which will become a "real" group, one which will endure and provide an informative and educational experience while also acting as a support mechanism. We regard this process as an important direction in our work for the coming year.

The Project has witnessed an increased attendance of women in the last two years so that 40-45% of the people attending are women

Reporting on work 1990 . . . . . .

Policy Developments

In reviewing its own approaches, practices and methods of work in the early part of 1990 the Project staff and management decided to initiate a wide discussion on drugs policy and to formulate proposals for developments in overall government policy. Essentially, the project was concerned that while it was making changes in its own work, and adapting to other developments in relation to drugs, HTV and AIDS, progress in delivering a more effective, coordinated service was limited, *unless* there was a wider reexamination of social policy in relation to problem drug use. From our own experience it had become clear that the drug problem was essentially a community-based problem yet services, and treatment responses tended to be specialised and located outside the community. Essentially, the overall thrust of drugs policy needed to be changed if we were to be successful in pursuing our development priorities.

Initially, it was decided to introduce some informed debate and in April 1990, in conjunction with the Addiction Studies Course in Trinity College, the Project hosted a seminar in Trinity College on the theme of Drug Treatment Policies. The seminar was addressed by Judy Greenwood, consultant psychiatrist with the Edinburgh Community Drug Problem Service, Fergus O'Kelly, general medical practitioner in the south inner city of Dublin and Shane Butler, director of the Addiction Studies Course. The seminar, which was attended by about 150 people, was very informative and very hopeful in that the mood of those who

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Policy Developments (Contd.)

attended was very supportive to the need for change.

Following the seminar. Project staff and management decided to prepare a comprehensive submission to the National Coordinating Committee on Drug Abuse which was convened in June 1990 for the purposes of preparing a new National Drugs Policy. This submission, along with edited transcripts of the papers which had been delivered at the Trinity College seminar were published in August 1990 in a document which was widely circulated to Government, Department officials, public representatives, professional bodies, academic institutions, trade unions, media and the various personnel who work in the drugs field. Overall the feedback from this document was very positive. In September Project management representatives met the National Coordinating Committee's sub-group responsible for preparing the National Drug's Policy to outline our proposals in more detail.

In November the Project's director, Barry Cullen, along with two representatives from the Irish College of General Practitioners, Dr. Fergus O'Kelly and Dr. Gerry Bury, undertook a visit to Edinburgh to examine the appropriateness of their particular approach to problem drug use. A report on this visit was also submitted to the National Coordinating Committee on Drug Abuse. The main conclusion to this report was that a community based drug treatment service was viable,

Our policy document was widely circulated to Government, TDs, professional bodies, media and the various personnel who work in the drugs field

Reporting on work 1990 . . . . . .

Policy Development (Contd.)

provided the right mix of policy objectives, structures and resources could be achieved.

Eventually, the National Coordinating Committee finalised its policy recommendations and these were submitted to Government and granted Cabinet approval on April 23rd last. The government launched this report as official policy on May 20th.

In the area of treatment and rehabilitation the main development in drugs policy is the shift towards a Community Drugs Team approach, and the greater involvement of GPs and other community care personnel in responding to the needs of problem drug users. This is a radical shift in government policy; it is a shift which we wholeheartedly support and one which we have recommended in our submission to the National Coordinating Committee.

In our submission we also recommended the provision of a Drugs Coordinator for the Dublin area, together with a team of local coordinators, for the purposes of setting up and coordinating community drug teams. We would see this as a vital structure for delivering on the new policy developments. There is a tremendous amount of work involved in consulting with GPs, with the voluntary sector and community care workers, and in putting together a strategy for implementing this new policy. Unfortunately the government's report does not refer to any new structure and we hope that this matter will be reviewed.

The Community Drugs Team approach is a radical shift in government policy and one which we wholeheartedly support

Contact with Other Groups

Since April 1990 members of the staff of the Project have been actively involved with the newly formed Drug Workers Forum. The Forum arose as a result of the interest of drug workers from many different services in cooperating and working together on issues and informing public policy and debate concerning drug users and drug services. The first meeting of the Forum took place on the occasion of the visit to Dublin of Dr. Judy Greenwood, Consultant Psychiatrist with the Community Drug Service in Edinburgh, where she spoke at a seminar organised by the Ana Liffey Drug Project and the Addiction Studies Unit in Trinity College. The Forum continues to meet on a monthly basis. We regard this as an important new development and our participation and commitment will continue in the coming years.

Our contact and cooperation with other agencies and groups is a crucial aspect of our work and as a result we have prioritised ongoing outreach as an important facet of our development, whether it be with community care teams, other non-statutory organisations or small voluntary groups. We have recently undertaken to make contact with and have meetings with community care social workers.

We have also been involved with Community Response - a group of statutory, community and voluntary personnel who are concerned with the drug problem in the south inner city. Recently, Community Response, published a very comprehensive report which quantifies and analyses the local drug problem and sets out clear recommendations for responding to it.

Our contact and cooperation with other groups is a crucial aspect of our work and we will continue to give it a high priority for the future

Reporting on work 1990 . . . . . .

Annual Accounts

Ana Liffey Drug Project

(Company Limited By Guarantee)

Extracts from Audited Accounts For The Year Ended 31/12/1990

	1990
Operating Income	**£**
Statutory Grants	67,375
Non-Statutory Grants	31,500
Donations and Interest	24,837
	123,712
Operating Expenditure	
Staff Salaries & PRSI	100,395
Operating Overheads	30,549
Transfer From Capital Reserves	(7,232)
	123.712
Balance Sheet	
Fixed Assets, Net Book Value	23,495
Net Current Assets	50.343
	73,838
Funded From Cumulative Reserves	73,838

Audited Report
The above is an extract from the accounts on which we reported without qualification

Mahon& Co.
Chartered Accountants
1415191

Reporting on work 1990 . . . . . .

Sources of Funds

Statutory Grants:

Department of Health/Eastern Health Board *(National Lottery)*
Department of Education/Eastern Health Board *(National Lottery)*

Department of Justice
Combat Poverty Agency

Non-Statutory Grants & Contributions

3M Ireland
Abbey plc
Aer Lingus
Algemene Bank Nederland (Ireland)
Allied Irish Bank
Altrusa Club of Dublin
Beck, Smith and Associates
Beecham of Ireland Limited
Brennan Insurances
Brown Thomas Limited
Brownes Ethnic Foods Limited
John D Carroll Group
Cement Roadstone Holdings pie
Cigna Insurance Company
Clondalkin Group plc
Craig Gardner & Co.
James Crean plc
Criterion Press
Marcus de Cogan
Comdt M F de Cogan
Drug Awareness Programme CSSC
The Educational Company of Ireland
E Fanning & Company
Flogas Plc
Gill and Macmillan
Glaxo Ireland
Glorney Charitable Foundation
A & L Goodbody
Gowan Group Limited
Guardian Royal Exchange
Michael Guiney Limited
Heiton Holdings plc
Hodgins Percival & Associates
IBM

Sources of Funds (contd.)

Ireland Funds
Irish Life Assurance plc
Irish Glass Bottle Company Limited
Irish Intercontinental Bank
Irish National Insurance
Irish Youth Foundation
Jesuit Solidarity Fund
Johnson Brothers Limited
Leo Laboratories
Lisney & Son
L & P Financial Trustees of Ireland Limited
Mr. Niall McCarthy
Marks & Spencer (Ireland) Limited
Mercantile Credit Company
Murray Telecommunications Group
Musgrave plc
New Ireland Assurance
John O'Brien Insurance Limited
The O'Brien Press
Odium Group Limited
O'Flaherty Holdings Limited
People in Need
Rev. Brian Power
Press-O-Matic
Quinnsworth
Roscommon Capital
Royal Insurance Limited
R & H Hall plc
B P Shaw Limited
Silvermines Group plc
Smith Kline Beecham
Stanley Trust Limited
Tedcastle McCormick & Co. Limited
Tennents Ireland Limited
Ulster Bank Limited
Walsh Mushrooms Trading House Limited
Waterford Foods
Wellcome Ireland Limited
Willis Wrightson (Ireland) Limited

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