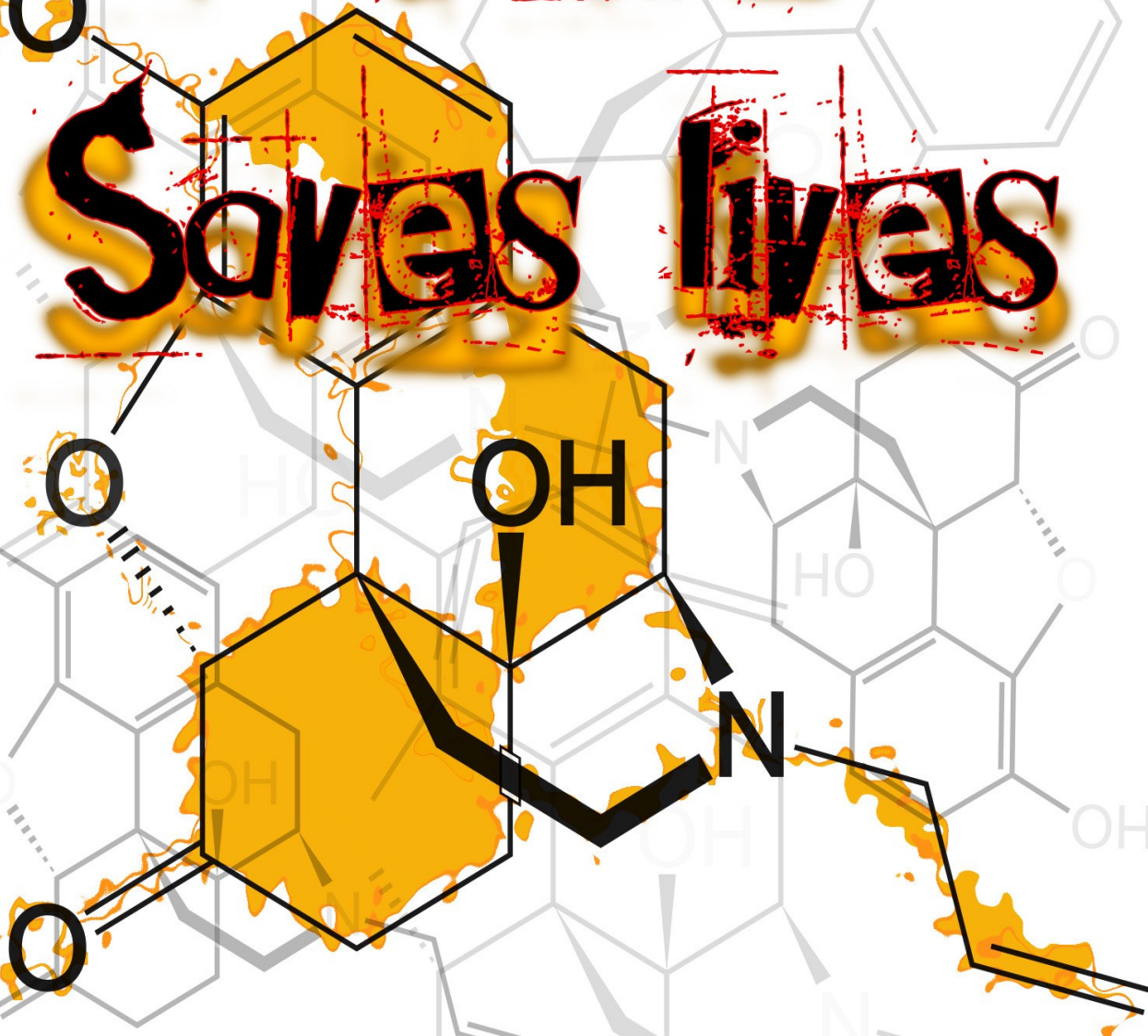


# **D**rug **E**ducation **A**dvocate

**NOWT ABOUT US WITHOUT US**

# Naloxone

# Saves lives



Published by



Issue 1



**"DEA" can be contacted @  
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## **Fair Play To Ya Jo!**

From all your friends in BEBE and DOT, Congratulations to Joanne Brannigan, who has recently been appointed Service User Network Project Coordinator (based in CHNI).

All those years of activism are starting to pay off. Now, don't turn to the dark-side Jo. We knew ya before ya were famous and respectable (lol).

Joanne has been a member of BEBE since the early years and her commitment and dedication is an inspiration to us all (see article by Joanne on page 4&5 of the mag).

## **Welcome to our first issue!**

DEA magazine is produced by the Belfast Experts By Experience (BEBE). We are a service-user group set up by individuals who have experience of addictions. Supported by the Drug Outreach Team (DOT), the group has been operating in various forms (and under various different names) for almost 10 years.

This is not a support group but a group set up to challenge negative representations of drug users, promote harm reduction principles and to ensure that people with addictions have a say in their own treatment.

BEBE has been heavily influenced by the Vancouver Declaration (2005) and its slogan "Nothing About Us Without Us" or in Belfast-speak 'Nowt About Us Without US.' This declaration states that drug users 'are among the most vilified and demonized groups in society.' Drug-users are often looked-down upon by the very services that are charged with helping them. Adopting the slogan 'Nowt bout Us Without US' we argue that service user's should have a say in our own treatment and in decisions being made about our lives.

After many years of lobbying, members of BEBE now sit on a number of Steering Groups and Panels dealing with issues that directly effect the lives of drug-users. Members of BEBE currently sit on the following steering groups: Naloxone, Substitute Prescribing, Needle Exchange, Regional Service User Network, Bamford and BDACT. Being part of these steering groups ensures that service-users have a representative and can contribute in some way to decision-making.

Over the years BEBE has applied for, and received, funding from the Public Health Agency (PHA) to which we owe a great deal of thanks. This funding provided training and hospitality for our service users, which helped us develop a range of skills. Our service-users have also attended and presented at a number of international conferences, including the Drink and Drugs News (DDN) conference in Birmingham and HIT's Hot Topics conference in Liverpool. More recently the PHA funded BEBE to purchase a computer, printing materials and other supplies in order to produce the Drug Educational Advocate (DEA) magazine.

The DEA magazine did not develop out of thin air. BEBE was inspired by a number of other publications produced by service user activists, such as Morphin produced in Southampton, Black Poppy produced in London and Brass Munkie produced by UISCE in Dublin.

I would like to pay special tribute to **Brass Munkie**, which really is an awesome magazine. 10 members of BEBE visited Ruaidhri, the editor of Brass Munkie, who generously gave up his time to give us a few tips on how to produce a high quality magazine.

So what has the DEA magazine got to say and who is it trying to speak to? The agenda and direction of the magazine is set by members of BEBE. The magazine is in synch with the principles of BEBE and seeks to challenge negative representations of drug users and promote harm reduction principles. It seeks to provide up-to-date information on old and new drugs, explore local and international initiatives which effect drug users, and draw attention to drug policy in multiple contexts. We expect to have a readership from a cross-section of society, including drug-users, addictions specialists, health care workers, hostel staff, and anybody who wishes to be updated on drug related issues.

The articles written in DEA are mainly authored by service-users and professionals in the field of addictions. However, we invite anybody, from any background, who has something to say about drug issues to submit an article to the editor of the magazine ([see back cover for details](#)). The views and opinions expressed in this magazine are those of the authors and do not necessarily (though they often do) reflect the views of BEBE members.

By: Jonty/Jake

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# Service User Involvement: Volunteering & My Road To Recovery

By: Joanne Brannigan

I have a very extensive history of substance misuse, experience of homelessness, been through rehab and substitute prescribing, and had been in and out of jail through most of my 20s. I also knew my rattle inside and out. I have lost family and friends, and unfortunately like so many others during this time became very isolated, lacked in confidence and had low self-esteem, out with this circle.

These feelings had crept up on me, and I tried to combat my addiction many, many times and for periods of times was successful. But relapse was inevitable as changing my lifestyle, my surroundings and my circle of friends was never going to be easy. Nor am I saying “dealing with any addiction” is easy, but I found it manageable, Torture, but manageable. This was the 1<sup>st</sup> step for me and from prior experience was achievable but trying to move smoothly into a “normal lifestyle” was a far more difficult transition for me.

Fortunately during this time of periods of abstinence and relapse I had the good fortune to become involved in a Service User Group, Belfast Experts By Experience (BEBE, formerly SUN) which is based in the Drug Outreach Team (DOT). DOT had workers, I sussed instantly! They knew their stuff and were extremely passionate about all of their clients.

My life started to change at that moment, although I only know it now in retrospect. These workers went over and above what their job required. They would help

each and every individual with whatever the individual, problems they had and this was not just a 9-5 service. Whenever I needed them, and I did on many occasions, they were there.

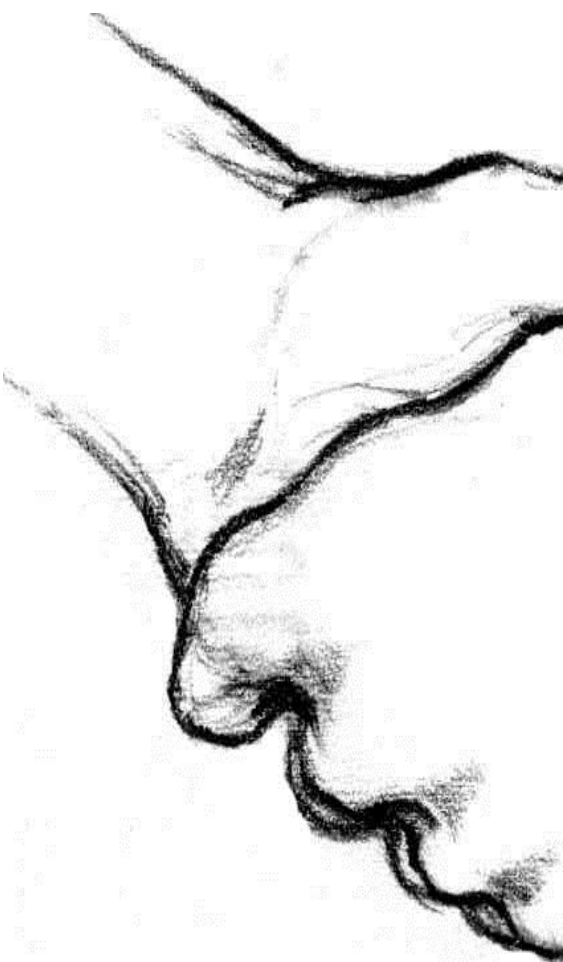
The great thing about BEBE and DOT was that everyone was welcome. Wherever they were in their recovery, or meeting people where they were with their addiction or recreational drug use. A harm reduction approach was always taken, no rules, no regulations. Very Low Threshold, and open to everyone. More services like this would be ideal in encouraging individuals into some kind of service, so they are not missed, left out and vanish under the radar.

Whilst attending the group over many years a variety of opportunities started to open up for me. I undertook as many training courses as possible, from Advocacy Training right through to life skills. I had my first opportunity of doing a presentation at a Service User Conference, here in Belfast. I was stuttering and stammering alongside the seasoned professionals like Michael & Buff (DOT), but the experience was invaluable.

It was about that time I was introduced to Chris (Council for the Homeless, Northern Ireland—CHNI) and I slowly became involved in the Substance Use Training that Chris delivered. During these training sessions I was given the opportunity to speak honestly about my life experiences, where I grew in confidence and gained more and more

experience of speaking in front of other people. It was especially daunting at times but I was learning and growing and was most definitely growing in confidence

I really think things went up a gear



when we undertook the Naloxone Training and the Basic Life Support with the British Heart Foundation. We went onto deliver training all over Northern Ireland. I had also started to attend conferences nationwide where Chris and I delivered presentations (of which I played a small part), all of which was building my con-

confidence and self esteem. Without the training alongside Chris I would never have had the opportunity to put all that I had learned into practice. There was never any pressure, Chris was, and is, an excellent trainer, and I was learning and growing, not only as a trainer but as a person, without even realising it.

I thought the mixed model approach to training that CHNI delivered was a far more balanced

SU alongside the professional at these training sessions, gave an opportunity to break down very real barriers and prejudices against Service Users and how they are perceived.

Again on the 6<sup>th</sup> of Nov 2012 I was given a fantastic opportunity of becoming a Volunteer at CHNI, which has given me the scope to develop my skills one step further. To become part of a team, working together, I was learning from scratch what is required to work in a 9-5 environment -- something that was a world away before participating in the training with Chris.

***Having a Service User and professional gave the trainees the professional knowledge that was required but also gave a Service User perspective that added "realness" to the training. This left individuals, after training, with memorable, powerful and tangible sessions with a real balanced approach.***

way of learning. Having a Service User and professional gave the trainees the professional knowledge that was required but also gave a Service User perspective that added "realness" to the training. This left individuals, after training, with memorable, powerful and tangible sessions with a real balanced approach. Having a

After all my experiences on training, attending conferences and the Harm Reduction Cafes I have a real belief in myself and my past was not a wasted one but one with a lifetime of expertise. Working within the team at CHNI has led onto me now being apart of Steering Groups and being a Service

User representative on BDACT, where I have the opportunity to advocate on behalf of my peers. I can directly voice their opinions and reassure that their voices will not only be heard but acted upon.

Working within this close team has given me a platform to act on behalf of others and hope to be a part of the development of Service User Involvement and all aspects of their care. Whether they are drug free, abstinent or not, I would like to see individuals being met where there at and not where the system would like them to be.

So I would like to see that the opportunities given to me are given to others. CHNI have helped me realise that I really would like to go on and advocate for the most vulnerable individuals in our society, the most chaotic, and individuals, for one reason or another, cannot access services and see they do not go unnoticed and therefore uncared for.

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# **Drug Accommodation Support Project (DASP): A Local Initiative to provide temporary accommodation to injecting drug users**

**By: Jonty in Conversation with Buff**

Most people in the field of addictions and homelessness in Belfast, whether service user or worker, know of the pioneer, social entrepreneur and legend that is Iain Cameron (better known as Buff). Along with Micky Foley (and later joined by Michael Blythman and Shiela McEntee), Buff helped set up the Drug Outreach Team (DOT), which is tasked with providing harm reduction advice, support and advocacy for heroin users, as well as other class A drug users.

It quickly became apparent to DOT that injecting drug users, in particular, were excluded from mainstream hostels as they were deemed too high risk for hostel staff to handle. This led to roundtable discussions between DOT, Extern and various other agencies determined to provide hostel accommodation for this marginalised group.

This eventually led to the establishment of the Drug Accommodation Support Project (DASP), of which Buff is coordinator. I'm a big supporter of this project and I interviewed Buff to find out more about it.

Buff explained that he and his colleagues visited various hostels and initially attempted to challenge some of the stigma around injecting drug users in an attempt to increase their access to mainstream hostels. However, hostel staff kept citing the 'Wintercomfort case' as the main reason that they were reluctant to allow active heroin users stay in their hostels.

## **The Wintercomfort Case, You Say! What's That?**

On 17<sup>th</sup> November 1999, Ruth Wyner and John Brock, director and manager (respectively) of the Wintercomfort

charity Bus Day Centre in Cambridge, were found guilty of "knowingly permitting or suffering their premises to be used for the supply of heroin<sub>1</sub>". Convicted under Section 8 of the Misuse of Drugs Act, Wyner was sentenced to five years in prison and Brock to four years – both had their sentences reduced to 18 months on appeal, though their convictions were upheld.

Wyner and Brock were experienced and respected professionals who dedicated much of their lives to helping the homeless. In order to protect vulnerable service users, the Wintercomfort day centre adopted a confidentiality policy which prohibited staff from disclosing the names of service-users they suspected of engaging in drug-related activity to the police.

This clause provided protection for service-users but also presented a peculiar situation where staff could be accused of failing to act sufficiently to prevent drug dealing. And, it is precisely on this allegation that Wyner and Brock spent several months in prison.

They were arrested in 1998 following a police surveillance operation on the Wintercomfort charity Day Centre. Two undercover police officers pretended to be homeless men and began to drop into the day centre on a regular basis.

They claimed that they visited the day centre 12 times and were able to purchase heroin on 8 occasions. Wyner and Brock argued that they suspected that there was some drug exchanges taking place in the day centre but had no idea of the scale that was revealed by the undercover police.

Wyner insisted that 'When it comes to heroin, we had very firm policies

laid down. Anything we saw we dealt with in terms of those policies. The trouble is we didn't see everything<sub>2</sub>.' Anybody who has ever spent time in a drop-in centre will know that they tend to be chaotic places and it is difficult, actually impossible, to monitor what is going on all of the time.

## **The Impact of the Winter-comfort Case in the Belfast Context**

The prosecution of these dedicated day centre staff sent shockwaves amongst agencies working with homeless people throughout the UK and beyond. The knock on effect means that drug users became further stigmatised and ostracised as hostel managers began to adopt more risk-averse policies and refused to allow active drug users, particularly injecting drug users, to stay in their hostels.

In the context of Belfast, Buff stated that "as with everything it was magnified a million times by the time it reached the shores of here. And the hostels, most of the hostels didn't even know what it was. They just heard that...these hostel workers had been sent to prison because they knew about drug-use in a hostel and they didn't do anything about it."

"Now obviously it wasn't as simple as that. But whenever we spoke to hostels, that's what was coming back every time about why they didn't want to house, or felt they couldn't house active injectors.

And the other issue then was there were all sorts of scare stories around needle-stick injuries and fear of overdose, not being able to manage people who have used -- all of the stigmas that injecting drug users face, all of the time really."

One of the main things that emerged out of these hostel visits was that the hostel staff were not trained to deal with injecting drug users.

Chris Rintoul and other figures in the field of harm reduction identified this glaring gap in knowledge and for the last few years have trained hostel staff and others on drug-related issues (contact the Council for the Homeless for more info).

Anyway, a few years ago a sub-group was formed, which included DOT, Extern, Supporting People, the Housing Executive, the Ormeau Centre, the Salvation Army, the PSNI and the Public Prosecution Service. This diverse array of collectives came together to try and thrash out a plan to house injecting drug users in mainstream hostels.

### **DASP Explained and Evaluated**

The scheme to provide hostel beds for injecting drug users is known as the Drug Accommodation Support Project (DASP) and is funded by the Public Health Agency (PHA). It has been running for over 2 years now and has just been commissioned for another year.

Buff explained that the project has been running relatively well but there are still a number of problems with regard to providing accommodation for injecting drug users. The way things are at the moment, there are 6 beds in 2 hostels (3 in each) allocated for IV injecting drug users — 3 are accessible to women but they are all allocated on need and vulnerability.

On the topic of women's access to hostels and other services Buff passionately states "women are massively disadvantaged...in my opinion that's every treatment agency right across the board...women are massively discriminated against for a whole range of issues" and this remains a challenge to DOT, DASP and a whole host of services.

**"But six beds are not enough. And ease of access is not enough. We need, in my opinion, a specific hostel a specific unit for people who are heroin users or active injectors, and that would remove a lot of the issues that we have in the current centres around positive or negative discrimination, whichever."**

Buff continued to point out some other problems: "...The project has self-developed very, very quickly and we were aware that that was going to be a problem. We don't have appropriate move-on accommodation. The pilot initially was, on paper,...that it would be 6 months, quite rapid. You get somebody in whose quite chaotic, get them on to whatever form of treatment they wish to access (more times, more often than not your probably talking substitute prescribing) get them...stable on a script of their choice and then move them out into mainstream hostel accommodation or their own housing executive property or private rental or whatever."

DASP, along with their partners, are currently working on finding a solution to this issue.

Buff continued "Unfortunately, we just haven't got the access to" move on clients as we would have liked. "We're finding that we have people that have come into the project and are sitting there a year, 2 years in some cases, with no appropriate move on. Unfortunately that means that we have people who aren't on scripts, who are street homeless, who are out there that can't access anything."

Buff also identified an unintended consequence of DASP, as some hostels not only continued to refuse to take injecting drug users, but now

used the justification that it was DASP's responsibility to look after this clientele: "We've also had the problem when the project came online that other hostels then use that as an excuse not to take injectors and that was a very negative consequence of the project."

And, I know DOT and myself and others have tried to do a lot of work around that, to try and explain to other hostels that "No, just because there are these six beds here, you don't have the right to turn people away."

Ideally, yes we would have these people in the project, but if there isn't a project bed available then they need to be working with DOT and this group to accommodate people in mainstream hostel provision. The reality is – mainstream hostel provision has a responsibility and a duty to respond to homeless people whatever their issues are. So we need that to be happening as well"

As Buff states himself, the DASP project is not perfect and is evolving. However, I consider it to be an innovative project that does more than just provide beds for injecting drug users. The project also attempts to challenge negative representations of drugs users and attempts to ensure that their housing rights and their human dignity is respected. In this respect, the project is only a drop in the ocean, but a drop it still is. The multi-agency approach and service-user involvement will, in the long run help to move the project forward.

### **Endnotes**

1. Sally Weale. 'The Unlikely Criminals' in The Guardian, 10 July 2000.
2. Sally Weale (see above)

# Drug Use in the LGB&T Community

By: Sarah

***“In my opinion, LGB&T people are definitely born that way - it’s part of you - it’s who you are. So who, in their right mind, would try to be LGB&T, if they weren’t by nature? People from this community are often tormented and bullied, not always in obvious ways but also in indirect ways.”***

Hi my name is Sarah (not my real name). I am a gay woman and have a long history of drug use (mainly stimulants). Having spent a lot of time socialising in the Lesbian, gay, bisexual and transgender (LGB&T) community I have been struck by the chronic use of drugs amongst this group. This problem concerns me and this article seeks to explore this issue in more depth.

## What Are The Facts?

The Rainbow Project, with offices in Belfast and Foyle, is a health organisation dedicated to improving the holistic health and wellbeing of LGB&T people living in Northern Ireland. In 2012 they produced a well-researched and insightful report on substance use amongst the LGB&T community in Northern Ireland<sup>1</sup>. While the findings of the report may surprise many, they are likely to come as little surprise to members of the LGB&T community.

The report conducted an internet survey of 941 LGB&T people and interviewed a further 37 members of this community. It found that members of the LGB&T community are almost 3 times more likely to have consumed illicit drugs in their lifetime (62%).

The following are some of the most interesting findings from the survey:

- Outside of poppers, cannabis, sedatives and opioids were most popular amongst LGB&T respondents, followed by stimulants.
- 25% of LGB&T respondents indicated using illicit drugs over the last year
- 91% of the LGB&T individuals consume alcohol (compared to 74% of the general population), 57% of which stated that they drink alcohol to hazardous levels.
- 44% of LGB&T respondents smoke cigarettes in comparison to 24% of the general population.

Since the LGB&T community appear to consume more drugs and alcohol than the general population they are therefore more at risk of the physical and psychological impacts typically associated with heavy drug use. The Rainbow Project found that:

- 44% of the LGB&T respondents cited drugs and alcohol as a contributory factor in them having unprotected sex
- 30% claimed that drugs and alcohol was a contributory factor in leading them to think about suicide, with 13% actually attempting suicide

So it appears clear that the LGB&T community are more likely to use alcohol and drugs and suffer the consequences of chronic use. But the big question is Why?

## Why Oh Why?

According to The Rainbow Project’s report “The emotional and psychological distress that results from the stigmatisation of LGB&T people is perhaps the most significant reason for higher levels of drug and alcohol use amongst LGB&T communities.”

This sentiment resonates with my own experience and views. I think LGB&T people are more likely than heterosexuals to use illicit drugs because of stigma, prejudice and narrow mindedness directed towards them. This comes not only from the general public but there is often a lack of understanding from close family and friends. In





my own experience some of my family continue to deny the fact that I am gay and try to convince me that I am straight. So it's not just hurtful but extremely annoying that someone that's as close as your family members and close friends do not accept it and do not believe it.

I also think that LGB&T individuals are more likely to use drugs because we are not only in a constant fight with mainstream society but also in a battle with ourselves. Like most people I just want to fit in but I can't change my sexuality to try to please others. Often LGB&T people are trying to put on a different personality, one that fits "normal society". As a result of this internal conflict people are therefore often unhappy and confused.



In my opinion, LGB&T people are definitely born that way - it's part of you - it's who you are. So who, in their right mind, would try to be LGB&T, if they weren't by nature? People from this community are often tormented and bullied, not always in obvious ways but also in indirect ways.

So many LGB&T people take drugs to feel comfortable with themselves, to sometimes numb the pain of non-acceptance of friends and family, and to forget about sexuality and feeling different. Drugs, at least, help with that (in the short term anyway).

### **What To Do?**

As a way of improving the environment for the LGB&T community and reducing the chronic level of substance misuse, the Rainbow Project made a number of recommendations. The following are the ones I consider most important:

1. Providing more gay-friendly social venues, activities and support groups that operate outside of pubs and clubs.
2. Train addiction services in LGB&T issues.

3. Local and Regional drug and alcohol steering groups should include LGB&T representatives.

Regarding the first point, I speak from experience when I say that most of the LGB&T community congregate in pubs and clubs and are well known for our party-lifestyle. This, I'm sure, is partly due to the marginalisation of our community, but also due to the Northern Irish culture which is notorious for its binge-drinking.

Providing alcohol and drug-free venues would promote a more healthy and holistic lifestyle for our community. Furthermore, I consider that there should be more statutory and voluntary services dedicated to promoting the wellbeing of the LGB&T community. There should be more advice helplines and outreach services with gender specific workers.

This leads me on to the second recommendation that addiction services should be trained to be sensitive to LGB&T issues. I believe that members of the LGB&T community should be invited to share their views and experiences with addiction services. Our community should also be invited to participate in training university students who are likely to work with LGB&T individuals in the future, thus sensitising them to the unique struggles of our community.

Finally, I agree that members on the LGB&T community should sit on local and regional drug and alcohol steering groups. In this way we can help implement change from the top-down. Changing the modus operandi of the institutions charged with serving our society can help change society's attitudes towards minorities. This can contribute to members of the LGB&T community feeling more comfortable in society and more comfortable in their own skin.

### **Endnote**

1. Eoin Rooney. 2012. All Partied Out?: Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community.

# DAMIS - Drug and Alcohol Monitoring and Information System

By: Victoria Creasy

## What is DAMIS?

DAMIS is an “early warning system” which government organisations use to find out about emerging trends in drug misuse, so we can act quickly and provide relevant information or advice to those who misuse drugs.

The kind of information DAMIS collects includes:

- A sudden increase in a particular drug being misused
- Drugs being misused in new ways
- New drugs becoming available (for example new legal highs)
- Contaminated drugs / bad batches available on the streets

The DHSSPS oversee DAMIS with support from the lead partners: the Public Health Agency, the Department of Justice and the Police Service of Northern Ireland.

## Collecting information

Every year, Northern Ireland-wide surveys are carried out to find out what drugs people are using and how much alcohol they are drinking. This information helps organisations decide the priority actions required to reduce drug misuse or drug-related harm.

However, these surveys are not designed to gather localised information on drugs being used by small numbers of people, or information on urgent issues such as contaminated drugs. This is what DAMIS is for. It can identify trends and issues at an early stage and warn people about them quickly.

The information which DAMIS receives usually comes from local drug and alcohol support organisations, or from people who misuse or have misused substances themselves.

These people may have contact with a wide range of individuals who misuse substances and are in an ideal position to tell us what is happening in their local area as soon as it happens. While DAMIS can be used to alert people to emerging risks around alcohol as well as drugs, so

far, all DAMIS alerts have focused on drugs.

DAMIS is confidential – this means that when we collect information, we do not ask about who is misusing drugs. We do not need to know the names of individuals, but it can be useful for us to know general information like where drugs are being used, and the gender and age of users. This can help tell us who is at risk and to which particular groups we may need to give information.

Anyone can send information to DAMIS at [damis@hscni.net](mailto:damis@hscni.net).

## What happens next?

Each lead organisation has identified a named member of staff to coordinate this work. Once information is received by DAMIS, it goes to the co-ordinator of the relevant lead partner

The relevant co-ordinator records the information and agrees the “level” of the information and what kind of response is needed with the other coordinators.

### Level One:

A level one response will be to record the information which may be used to inform policy and practice.

### Level two:

A level two response means that the information will be passed to the DAMIS Advisory Group which includes the coordinators from the lead agencies as well as representatives from the HSCB pharmacy team and the Regional Service User Network.

A decision may then be made to circulate the information to everyone on the DAMIS database, in either an alert or a bulletin. We ask everyone on the database to pass the information on as appropriate.

Alert – an alert is an email sent quickly (usually within 24 hours of receiving information) warning people of a specific risk. An alert may be sent when we still have limited evidence, but the need to inform people of a possible risk out-

weighs the need to collect more evidence.

Bulletin – if we need more information on an issue, a request for information is sent to the DAMIS network. Information received can then be pulled together and sent out as a bulletin. This takes longer than an alert to produce, but can provide a fuller picture of the Northern Ireland situation.

### Level three:

A level three response means that a formal warning letter is issued through Chief Medical Officer procedures, and consideration is given to information/awareness aising with the public.

DAMIS became fully operational in May 2012 and in the last year, alerts have included mephedrone (see page 15 of this mag), and D10s (diazepam). Bulletins have included: caffeine, speedballing, oxycodone, mephedrone and fentanyl . DAMIS has also circulated CMO warnings on anthrax infection and 2c drugs.

## Who gets information from DAMIS?

Information is sent out to everyone on the DAMIS database – primarily drug and alcohol support organisations who work in the community and can get the information out to both those who work in the drug sector and those at greatest risk. One year on from setting up DAMIS, we are seeking to widen the database to include a range of professionals working in healthcare, including mental health and social care staff.

If you come into contact with people who misuse drugs or alcohol, either through your work or in your own life, and think it would be useful for you to be on the DAMIS database, you can let us know by emailing [damis@hscni.net](mailto:damis@hscni.net).

# Take Home Naloxone: The Story So Far

By: Chris Rintoul (CHNI)

## History and Effects of Naloxone

Naloxone hydrochloride is a drug which can be given to a person who is experiencing an opiate overdose. It has been used for over 100 years in hospitals when a patient has been given too much pain relief and their breathing slows down or stops. In more recent decades paramedics have carried it and are able to administer it to people outside hospital settings.

Naloxone is an opiate antagonist drug, that is it quickly reverses the effects of the opiates and allows the person to start breathing normally again. If given before the person dies from respiratory failure it is usually very effective. Therefore it is important to give it to someone quickly. The drug is very safe and will reverse the effects for between 20 and 60 minutes.

In the mid-90s there were calls from the harm reduction community and academics to give naloxone kits to opiate users, mainly those using heroin, and to their loved ones. This started to happen a few years later, most notably in Chicago via the wonderful Dr Sarz Maxwell and her colleagues in Chicago Recovery Alliance (CRA).

CRA found that with naloxone (or Narcan as they call it) and some basic training, the death rates from opiate overdoses started to fall. This is because opiate users are often the first people to discover someone overdosed and therefore can administer naloxone very quickly. Other places have done the same with similar results.

In 2008 there were trials in England which showed the benefits of 'Take Home Naloxone' (THN) and the National Treatment Agency later recommended it be rolled out throughout the UK. In 2010 the Advisory Council for the Misuse of Drugs who advises the UK government on drugs policy also recommended that it is made available to people at risk of overdose and to homelessness services.

## Naloxone in NI

In 2010 the Public Health Agency for NI gathered a number of people including me to look at making naloxone available to opiate users here. 500 packs were

bought the following year and training on naloxone was delivered by Council for the Homeless NI (CHNI) and the Scottish Drugs Forum to a range of people; users, carers, homelessness services, addiction services and pharmacists.

The 5 Trusts in NI were asked to give out the packs after a Patient Group Direction was agreed for NI. Unfortunately these packs were not given out until mid-2012 due to delays with some of the Trusts who had to get internal approval.

Meanwhile our overdose rates rose. **In 2011 there were 17 deaths in NI where heroin was mentioned on the death certificate.** This represents about a doubling of the death rate in 3 years which was roughly 9 each year until 2008. Some of these deaths might have been prevented if naloxone was available. However I don't think all could have been prevented with THN, the circumstances are all unique.

THN was eventually rolled out in the Belfast Trust in June 2013. For more details contact the Drug Outreach Team on 02895047301.

## Naloxone Packs

At the time of writing the naloxone packs we have in NI are made by Martindale Pharma. It comes in a yellow plastic box which is sealed. To open twist each end as if wringing out a towel and you will find a 2ml prefilled syringe on a mount, a Patient Information Leaflet (PIL) and 2 intramuscular needles (23 gauge, 1 ¼ inches).

The barrel is marked at each 0.2ml interval. There are 5 doses in the syringe with each dose being 0.4ml. This is because an overdosed person may need more than 1 dose and it can be given again at 2-3 minute intervals until there is none left.

In order to use it, attach one of the needles and inject 1 dose into a muscle in the buttocks, the thigh or the top of the arm. Naloxone should always be given alongside doing other things like calling for an ambulance and either putting someone in the recovery position if they are breathing normally, or giving CPR if they are not.

## User Involvement

I deliver training on naloxone to a range of groups and individuals through CHNI. **Buff and I also developed an app, 'Opiate Overdose' for iPhones and Android phones** (visit [www.urntraining.com](http://www.urntraining.com)). In these I have been given an amazing amount of help from opiate users in Belfast and elsewhere to develop the app and deliver the training.

The naloxone training is always co-facilitated by someone with experiential expertise i.e. someone who has been or is a heroin user. This has made the experience extremely rich for me and we know from the feedback of participants that it is vital in developing their understanding of opiate use and overdose. My co-facilitators are all British Heart Foundation accredited Basic Life Support trainers and demonstrate huge competence, knowledge and understanding in delivering the courses. I always feel utterly confident in bringing these guys in and in their ability to deliver.

## Future hopes

I would like to see a partnership developed between our vibrant harm reduction community here (which has pushed so hard for naloxone) and our counterparts in the South of Ireland. There are signs that THN will be rolled out there as well and I believe we and you can help them. We have learned valuable lessons which might be useful for them to hear.

I also hope we can give naloxone out to anyone that wants it and that we ease the restrictions on supply. For example I would like to be able to go to my GP or pharmacist saying that I have friends who are at risk of opiate overdose and I would like naloxone given to me. Simple.

The new Martindale naloxone pack with the shrink wrapping and the 'Luer' lock is a much better product than the one we currently have. It is far easier to see the doses so people are able to give the right amount each time.

And most of all I hope that far fewer people die from opiate overdoses as a result of giving out naloxone.

## Action on finding a potential overdose

**Do not**

Person unconscious and unresponsive

**Do**

Shout for help and approach with care

Check airways are clear of loose objects

Open airways  
Tilt head back gently and lift chin

**Not Breathing**

Call 999

30 chest compressions  
then 2 rescue breaths

Inject 0.4ml Naloxone

Repeat 3 cycles of 30  
chest compressions  
and 2 rescue breaths

**Breathing**

Recovery position  
stay with person until  
ambulance arrives

- Inflict pain
- Put in a bath or shower
- Walk them around
- Give them other drugs such as stimulants
- Leave them alone

**Breathing**

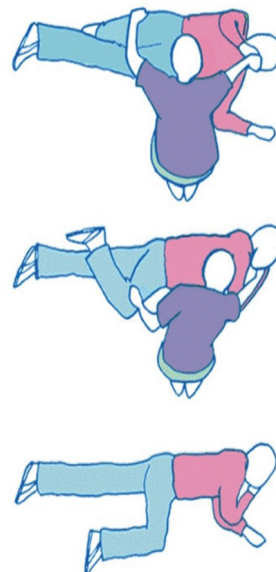
Recovery position

Inject 0.4ml Naloxone

Call 999

Inject 0.4ml Naloxone  
Repeat every 2 mins. If no  
change

Recovery position





### **Action on finding a potential overdose notes**

When you come across a person who has overdosed you should:

Shout for help

Approach with caution and ensure the surrounding area is free from dangerous objects such as discarded needles, glass

Shout and shake the person to rouse them

Check their mouth is clear of loose objects before you tilt their head back otherwise something might lodge in their throat

Check if they are breathing before calling 999

Stay on the phone with the emergency service and give them as much information as possible (*where you are, if the person is breathing or not and what you are doing*)

Carry out basic life support (BLS) if person is not breathing

Inject approximately 1/4 of the Naloxone into outer thigh

\* Repeat 3 cycles of BLS then a further 1/4 of Naloxone \*

Repeat \* \* until ambulance arrives

Once the person has come around advise them not to leave until they have been seen by the paramedics

Advise them not to use any other drugs

*Naloxone only removes opiates from the receptors in the brain and it wears off after a short time. Therefore, there will still be heroin in the body and it is likely that the person might go into unconsciousness again.*

If the person is breathing place them in the recovery position and administer Naloxone into outer thigh. Stay with them until ambulance arrives.

# Speaking from Experience: Naloxone Saves Lives

By: Jake

My name is Jake (not my real name) and I have used drugs, including heroin, for over 20 years. I've got many things to say about drugs and the treatment of drug users but today I want to share my views and personal experience of using Naloxone.

It was about one year ago and the story goes that my mate Gary had been off the gear [heroin] for a couple of weeks. He'd been staying down in his uncle's place, clearing his head. I'm sure his uncle was delighted to see Gary clucking away for a couple of weeks (lol). Anyway, he arrived back to Belfast, and was again tempted by his mistress, heroin. He tried to stay away from it, avoid the obvious locations where he could find gear but like any city, drugs are never far away.

It's an interesting thing about heroin addicts, you can spot another addict a mile away, so all you have to do is follow him for a bit and you'll find a dealer. Anyway, needless to say Gary scored a bag of gear. Now, he hadn't used gear in a couple of weeks so his tolerance had dropped. He used to take up to 1 gram of gear daily (i.e. 4 or 5 bags depending on the dealer) but was wise enough to know that his tolerance had dropped and he was at risk of overdose.

Anyway, Gary picked up his fresh barrel and spikes and knocked around to my gaff. He cooked up half a bag of street gear, sucked it up into the syringe, put the tourniquet on and searched for a vein.

Since he'd been injecting for a few years some of his veins had collapsed and he often found it difficult to find one. However, having stopped using for a couple of weeks, one or two veins had recovered.

So he picked out a vein, inserted the needle, withdrew the plunger to make sure he hit the vein clearly (**If it's pink stop and think! If it's red go ahead.**). Bingo! He injected the gear, released the tourniquet and quickly went into a nod.

I was smoking a joint but was drinking coffee as well. I wanted to stay awake because I knew Gary hadn't used gear in a while so I was watching him to make sure he was alright. We're mates, and we

look out for each other. Anyway, his lips turned blue and I could barely hear him breathe. I knew he was overdosing.

Now, at the time naloxone had not been rolled out in NI but luckily enough a friend of mine just arrived back from Glasgow, and he brought back a few naloxone kits. He knew we were a bit backward here (in terms of drug policy, not in terms of intellect) and the kits would come in handy.

Well, I ran upstairs and grabbed the naloxone kit and injected .4ml, which is 1/5 of a 2ml barrel into his thigh muscle. I know you're supposed to do CPR as well (see pull-out in the centre of this magazine) but I suppose I panicked a bit). Anyway, thankfully the naloxone brought him around this time.

I attended naloxone training with Chris Rintoul in CHNI so I knew that naloxone only reverses the effects of the gear for between 15 and 60 minutes so I phoned 999. I told them that my friend had breathing difficulties. Because I'm not a qualified doctor I can't say that he's overdosed. To be honest, I didn't say he overdosed because I was afraid that the cops would come as well. So, I just said that he was having breathing problems.

When the paramedics arrived I explained to them that Gary had overdosed on gear and I had used naloxone but they didn't know what I was talking about. When I said Narcan, which would be the brand name, that's when they went "ok".

I got talking to the paramedics and they said that they were called out to a heroin overdose last week and there were packets of citric acid lying about and they didn't understand what they were for.

I explained to them that brown heroin, which we get in most of Europe, is really meant to be smoked on the foil – it's not meant for injecting. In order to break it down you need to use citric acid (not too much though) and then add sterilised water to turn it into a liquid to inject. So I showed them some safer injecting techniques (lol). I knew I missed my calling – I should have been a medic (free drugs – yippee).

So that's the story of how I used naloxone to save my mate's life. Now, would you believe that he overdosed again 2 weeks later and I had to use the naloxone again (different kit). At this stage I'm on first name terms with the paramedics and one of them has asked me to be godfather to his new born baby (lol).

Anyway, you can see how important that naloxone is and how important it is for all opioid users to have a naloxone kit handy.

As well as rolling out naloxone I also think that condoms and clean syringes should be given out in any chemist anywhere free of charge - not on needle exchange - not on needle return - just free needles and condoms.

This is harm reduction and benefits the user and society more generally. If they're shooting heroin give them a pack of 10 syringes (and a naloxone kit), if they're shooting cocaine give them more barrels and spikes because coke users tend to inject more. As long as they're compos mentis and over 21 years of age, the pharmacist should give them what they ask for and then guide them in the direction of some sort of outreach team or some sort of harm reduction service if they want help.

I am not a medic or a drugs counselor, so what qualifies me to talk about these issues? I am an expert by experience. The first friend I buried from a heroin overdose was 16 years ago and in 2011 alone I buried 13 people in 12 months. If naloxone kits had been there who knows how many would still be alive today. Give naloxone to all opioid users and stop the needless deaths.

# DAMIS Bulletin on Mephedrone (May 2013)

This bulletin follows on the Legal Highs Bulletin 1 issued in April 2010 by the Public Health Agency. Bulletin 1 provided information on mephedrone which at that time had just been classified as an illegal drug. This follow-up bulletin has been prepared in light of continued use of mephedrone despite its illegal status, and emerging reports that mephedrone may be linked to self-harm and suicide.

## **What is Mephedrone? (also known as Meff, Drone, Plant Food, Magic or Monkey Madness)**

Mephedrone is one of a group of synthetic drugs called cathinones which have chemical structures similar to amphetamine. It can come in powder, crystal or pill form and is usually snorted, though sometimes ingested orally. It acts as a stimulant to produce euphoria, alertness, talkativeness and feelings of empathy. There are emerging reports that mephedrone is also being injected by a small number of people across Northern Ireland.

## **What are the health risks of Mephedrone?**

Mephedrone users face similar risks to those associated with both amphetamine and ecstasy type drugs. These include overstimulation of the cardiovascular system, with risk of heart and circulatory problems; and overstimulation of the nervous system, with risk of fits and of agitated and paranoid states and hallucinations<sup>1</sup>.

Users have also reported palpitations, seizure, vomiting, sweats, chills, cold extremities (blue fingers), pain and swelling in nose and nosebleeds, and psychosis<sup>2</sup>.

## **Higher risk mephedrone use**

The risks may increase significantly if mephedrone is:

- used with other substances, i.e. other stimulants; prescription drugs (e.g. benzodiazepines);
- alcohol or other depressants taken in large amounts
- injected

Using mephedrone may be particularly

hazardous for people with a history of mental health problems, cardiac problems or neurological disorders, or those currently taking medication for these conditions.

## **Is mephedrone addictive?**

Because mephedrone is similar in chemical structure to amphetamine, and amphetamine carries a risk of addiction, it is likely that mephedrone can also be addictive.

Reports from users suggest it can be compulsive to use, resulting in them using more and more in one session (increasing tolerance), which increases the risk to health. Some users have also reported developing cravings after use. An increasing number of users have reported a quick progression to regular mephedrone use and/or uncontrolled bingeing behaviour<sup>3</sup>.

## **Can mephedrone cause death?**

The most recent figures indicate that in 2010-2011 there were three deaths in Northern Ireland for which mephedrone was listed on the death certificate<sup>4</sup>. Death is more likely to occur if mephedrone is taken in larger amounts, or in combination with prescription drugs, other illicit drugs or alcohol<sup>5</sup>. Recent reports suggest that mephedrone may be linked to self harm and suicide<sup>6</sup>.

## **Is mephedrone legal?**

Mephedrone is a Class B drug under the Misuse of Drugs Act making it illegal to possess or supply<sup>7</sup>. The penalty for possession is up to five years in prison or an unlimited fine (or both), while the penalty for dealing is up to 14 years in prison or an unlimited fine (or both).

## **Where can I get more information or help?**

If you think you may have a problem with drugs, your GP can provide help and advice and refer you to other relevant services. Information and advice on mephedrone or other drugs can also be obtained by ringing the National Drugs

Helpline (Frank) on 0800 77 66 00. I

If you or someone else has immediate serious health concerns relating to mephedrone use, emergency services should be contacted immediately. If you or someone else is in distress or despair, Lifeline's counsellors are available 24 hours a day, seven days a week, to listen in confidence. Contact Lifeline at 0808 808 8000.

## **Endnotes**

1. Chief Medical Officer, Dr Michael McBride. Mephedrone update. Belfast: Department of Health, Social Service and Public Safety (DHSSPS); 1 April 2010.
2. Advisory Council on the Misuse of Drugs (ACMD). Consideration of the cathinones. London; 2010.
3. Cited in Corkery et al 2012, see endnote 6
4. Northern Ireland Statistics and Research Agency <http://www.nisra.gov.uk/demography/default.asp30.htm>
5. John M. Corkery et al, Mephedrone-Related Fatalities in the United Kingdom: Contextual, Clinical and Practical Issues, [http://cdn.intechopen.com/pdfs/32134/InTecMephedrone\\_related\\_fatalities\\_in\\_the\\_united\\_kingdom\\_contextual\\_clinical\\_and\\_practical\\_issue.s.pdf](http://cdn.intechopen.com/pdfs/32134/InTecMephedrone_related_fatalities_in_the_united_kingdom_contextual_clinical_and_practical_issue.s.pdf)
6. Ibid
7. Department of Health, Social Services and Public Safety. Press release: Mephedrone ban in UK. 15 Apr

# Making 'When the Drugs Don't Work': A Documentary on the Drug Outreach Team (DOT)

By: Robbie Meredith (BBC Northern Ireland)

In retrospect, if I'd been in Michael Foley's position, I'm not sure I would have been quite as open as he subsequently was. I first met Michael, the head of Belfast Trust's Drug Outreach team, at the start of December 2012. I'd found out a little about the team and its work around six months earlier, and had wanted to shadow them for a radio documentary for BBC Northern Ireland since.

Turning an idea like this into reality often involves time and negotiation. In the BBC, I had to run the idea past my editor in the newsroom. He was very interested and encouraging, which then meant I could approach the Belfast Trust.

After several phone calls and e-mails to the Trust's press office and others, I found myself sitting in a small office in the Trust's addiction services centre off the Lisburn Road in Belfast on a cold winter afternoon. In truth, I'd already got further than I had originally thought I might.

Michael and I, and Paula, the manager of addiction services, talked for an hour and thrashed out some of the issues that he was concerned about. He was understandably wary about client confidentiality, and also implicitly that I might stitch him, the team and their clients up. The meeting was friendly and open, however, and I left a little more confident that the documentary would actually go ahead.

The next step for me was to meet other members of the team and some of the service users themselves. My timing could have been much better.

I called into the old base in the Crescent in Belfast while the team were in the midst of a move to better offices in the city centre, and the service user group were about to head out for their Christmas dinner. However people again gave me time to explain what I

wanted to do, and asked me plenty of questions in return.

These early meetings were vital, in that they gave me the time to gain some trust. Although I was itching to record material there and then, I was very aware that I was dropping into a world I knew little about and that I would be asking people to give intimate details about their lives and experiences even though they had only known me for, at most, a couple of weeks. Only by establishing some sort of relationship with me would they do that.

Things really got going in mid-January 2013. By then I had a mid-February deadline to broadcast the programme and had had the chance to sit down with Michael and the rest of the Drug Outreach Team – Jonathan, Michael, Sheila and Linda – to plan out what I wanted. They would have to put up with a lot of stupid, and fairly obvious, questions from me in the coming weeks, and also with me shoving a radio microphone under their noses at every opportunity. Despite this, they couldn't have been more helpful.

Just how open and helpful became apparent on the first full day I spent with them. Michael Foley let me sit in on, and record, an assessment he had with Jane. That wasn't her real name. We had decided that, to offer some confidentiality and protection to drug users that I'd be interviewing, we would call them by 'alternative' first names. That's fairly standard journalistic practice if your interviewee's identity needs to be kept secret, for whatever reason.

Their voices would be broadcast but I could re-assure them that little else about their identity would be revealed, beyond their stories and experiences. Some of the users spent a fair bit of time choosing a new name – it's

not often in life you get a chance to pick a name for yourself other than the one you were given at birth – but most settled for fairly common names, like Jane, Stephen or Johnny. Looking back to that first interview, I was very naïve about drug use.

As Jane detailed to Michael the number of different substances she took in order to become, in her words, “comfortably numb,” I had to keep asking what drugs she was referring to. Heroin and cocaine I knew a little about, but I'd never heard of blues or yellows – different measures of diazepam – and I also had to ask Jane to stop and explain to me what exactly 'Budweisers' were. I knew the beer, but not the slang-name for the prescription drug sold on the street.

Still, I had something. Every journalist feels better when they finally get something recorded that they can use, and the material built quickly from then on. The following day, Michael Blythman drove me to meet Johnny in his home. The trust and affection Johnny had for Michael was immediately obvious, and he welcomed us by pouring us huge glasses of lemonade and then spent half an hour sitting beside me, telling me, with astonishing frankness, about how he'd begun using heroin through work colleagues and how it had affected his life and his family.

As he described how his son had found him following an overdose I realised that I was holding my breath.

“I was lying unconscious on my bathroom floor,” Johnny said. “My son kicked the door in. I was meant to pick my son up that day from the picture hall, and because I never turned up and he had to make his own way home and him finding me like that I had to try to sit him down for an hour or two because it was breaking his heart, because he found me uncon-



scious with a needle hanging out of my arm.”

From then on, the interviews kept coming, the material kept building, and with each one I learnt something more about the world I'd been living in, but ignorant of until then. I visited one of the few pharmacies in Belfast to provide a needle exchange, one I'd used many times before as it was close to where I lived, but noticed the amount of information and help for injecting drug users for the first time. Michael Foley took me to an airy flat in a pretty area of the city where Simon, an injecting heroin user, was concerned for my safety enough to make sure that he searched the sofa for syringes before he let me sit down.

Dawn, another heroin user, opened my eyes to the scale of the 'black market' in prescription drugs in Belfast; Stephen showed me his damaged arms and talked frankly about how easy it was for him to buy heroin here, while Jake, funny and smart and immensely likeable, talked about dealing to fund his own supply of drugs and railed against the 'head in the sand' attitude he felt many in authority had for drug users.

There were, naturally, some frustrations. Some users, under paramilitary threat, didn't want to speak to me – understandably – while some of Sheila's clients, sex workers or drug-using mothers with children, just couldn't make interview times we'd arranged. Again, this was understandable. These women had more important priorities than talking to a journalist.

Ironically, it was one of my final interviews which proved to be the most haunting. By any measure, Joanne Brannigan is a remarkable woman. A former multi-drug user, culminating in injecting heroin for a number of years, she now works as an advocate and lobbyist for better services for both drug-users and the homeless in Belfast, and is one of the leading voices in the Belfast Experts By Experience service user group, which is facilitated by Jonathan from the Drug

Outreach Team. She was happy for her real name to be used in the programme, and, in response to a question I asked her about what it was like to overdose, she gave me an answer which I knew then would conclude the documentary.

“It's the best feeling in the world and that is the hardest part of your recovery,” she told me. “There's no trouble in the world, life is as good as it gets, and you're going into a warm cosy sleep. That's how it feels, but you don't wake up.”

When I called a halt to recording interviews, I had over seven hours of material to edit down into twenty-nine minutes of radio. This is the most laborious aspect of making a programme: you listen to everything you have, transcribe the interviews and then begin to 'cut' clips and extracts – on a computer audio-editing system – which you think you might use. You then have to try to develop a narrative and an order to tell the story you want to tell, and begin to place the clips in a rough order before writing a script. In effect, you have to cut all the jigsaw pieces yourself before you can even begin to make the jigsaw.

I was immediately aware that I wouldn't have room for some important parts of the story. The service user group, who had been so welcoming to me, didn't really feature, while I just couldn't find room for a couple of interviewees who had been very open about their lives. I was acutely aware that I'd be letting some people down, and had to struggle to maintain some journalistic distance and objectivity at times.

The finished documentary, called 'When the Drugs Don't Work' and broadcast on BBC Radio Ulster and BBC Radio Foyle on a Sunday afternoon and again on a Thursday night in February, was also rather darker than I'd initially envisaged. I had heard stories of redemption and recovery from some users, but had ordered the jigsaw in such a way that I just couldn't fit them into the story I

wanted to tell. As a result, some users were unhappy with the programme – I got a text from one just after it was broadcast wondering why I'd concentrated on, in his words, 'doom and gloom.'

I understood his point of view. Others might have made a very different programme with the material I'd gathered; I might even make a very different programme if I did it again today.

However, most members of the Drug Outreach Team, and service users, were reasonably positive about the programme, even if I did make Michael Foley headline news for a day, due to his view that some Class A drugs should be de-criminalised. If I'd told him that might happen at that first meeting in December, I'm not sure he'd have agreed to the project and I'm not sure he's entirely forgiven me yet! My colleagues in the BBC newsroom who listened also said to me that they felt that they'd learned something about people, and a world, they knew little about, which showed me that I'd at least achieved something of what I'd set out to do.

I won't pretend to be an expert in the work of the Drug Outreach Team and the drug users they work with. After all, I dropped into their world and their lives for only a couple of weeks. However, I know much more now about that work and that world than I did at the beginning, and I'm full of admiration for the team, and for many of the users themselves that I met.

Everyone was extraordinarily friendly, welcoming, open and articulate; any stereotypes I may have had in mind about heroin users were utterly dismantled. Indeed, making the programme has been one of the best and most worthwhile experiences of my career as a journalist.

# Fraternal greetings from Dublin

By: Ruaidhri McAuliffe

I work for UISCE, the Union for improved Services, Communication and Education. We've been on the go since around 1998, although there were many attempts at engaging with drug users to counter lack of services going back to the 1980s. The issue of drugs became more newsworthy in the 1980s and 1990s, although drugs had been around a long time before that.

Like many towns and cities across the water, the late 70s and early 80s saw a significant rise in the use of heroin in Dublin. Social historians point to the Islamic revolution in Iran as a very significant event. Wealthy people fled Iran quickly, some of them converting their assets into heroin for export.

Of course, other social factors were perhaps more important such as the huge unemployment that followed the de-industrialisation of Britain under the Thatcher governments. A turning point in Dublin was in the late 1970's when the supply of opiates from prescriptions and burglaries from factories and chemist shop dwindled and was replaced by imported heroin.

Before this, while there was some small scale use of pharmaceuticals, hash and LSD. At this time, there was a considerable drugs scene in London, a popular destination for generations of Irish migrants. The bright lights of London had an increased allure by the late 60s with Carnaby Street, the Kinks, the Stones, and what was described as the 'counter-culture'.

London was like the centre of a new world. It was in this environment that many young Irish people got into drugs. Drugs were a big part of that scene, and there wasn't a clear distinction between 'hard' and 'soft' drugs. Hash and LSD were popular of course, as were amphetamines and downers. Under what became known as the 'British System', those with serious drug habits could register with specialised doctors and receive prescriptions for heroin and cocaine. At the time of the repeal of this system, there were less than 2000 registered addicts in the UK.

It took many years before a half decent response to drugs was developed here.

People with drug habits had to be 'cured'. They were offered rapid methadone detoxes, but not maintenance. There were no needle exchanges.

The emergence of HIV provoked some improvements: needle exchange was allowed, and methadone maintenance was introduced, initially for people with the HIV virus only. It took another 15-20 years to organise services to adequately meet the demand for methadone treatment in the Dublin area.

Many of the current responses put in place to deal with the drugs problem date back to the mid 1990s. A key moment for many was the shooting dead of investigative journalist Veronica Guerin in 1996. She achieved some notoriety from her writing about the underworld of drugs kingpins for the Irish Independent newspaper.

A less publicised event in 1996 was the killing of drug user Josie Dwyer by 'anti-drug activists' in the South Inner City. This indicated the severity of the hostility directed towards drug users, but also a failure of conventional policing in less privileged communities. There were claims that anti-drug activism and vigilantism was a front for republicans who wanted to discredit 'Free State' forces as well as establishing power in disadvantaged communities. A nadir had been reached.

The government's response was to recommend the establishment of local drugs task forces in the areas most affected by drugs. These task forces would oversee the responses to drugs at a local level, and emphasised the community dimension.

Some parts of Dublin City, including the North Inner City where we're based, had a poor relationship with the agents of the state. Whether it was the police, or the city council, or the education services, some areas of the city had been very let down. There was a lack of trust that needed to be addressed.

The new Drugs Strategy that established the local Drugs Task Forces was explicit in making the connection between problematic drug use and social disadvantage. Some areas, like where we're based in the North Inner City have a strong history

of community development and activism. So it was important from the outset to have the community centrally involved. In some instances this meant the co-option of anti-drugs activists...

So, these task forces brought all the main local stakeholders together: service providers, associated government agencies, elected local representatives and community representatives. At the beginning, drug users were not directly represented, and our group UISCE was founded to fill that gap.

Our organisation was founded to provide a voice for drug users at drugs task force level. It had been assumed that 'the community' could speak for the drug users, or that the services could authoritatively speak for their clientele.

While it is important to acknowledge the support UISCE has had from its allies in services and among community people, many drug users felt alienated from their communities, and services, particularly treatment services, which were characterised by conflict and mutual distrust.

While services have improved greatly, there remains a legacy of distrust best illustrated by the punitive nature of some treatment regimes. A lot of our work is with the HSE (Health Service Executive) who oversee all the drug treatment in the Republic. It's great that we have our feet under the table, and there are plenty of dedicated and hard working people there. However, there is still I believe subtle resistance to drug users.

Many people UISCE represent are on methadone maintenance programmes. Among the public, it is still a controversial drug, but it is largely accepted as a 'treatment'. However, there is some way to go in really convincing people that it is primarily a 'harm reduction tool'.

There is still the assumption that methadone is only ok if it stops illegal drug use, and that you eventually give up the methadone also. It is accepted as a way of getting 'drug free'. Of course methadone can be used as a bridge towards abstinence, but sometimes abstinence is not a realistic goal. The real value of methadone, or any other substitution drug is in its ability to reduce the harms of expensive, impure, illegal street drugs, and to

engage people with appropriate support services: welfare, housing, general health, and further drug treatment supports if required.

I suppose the key message is that there are many ways to support drug users that don't necessarily have to do with getting off drugs. People have important rights to health, housing, education and basic freedoms whether they use drugs or not, and whether they want to give up drugs or not.

The Celtic Tiger years saw a lot of resources being thrown at the drugs issue. Communities developed programmes for their drug users, treatment places multiplied, and the issue was given quite a high priority in government. In the early years of the National Drugs Strategy, from the late 1990's to 2005, the 'Minister for Drugs' sat at the cabinet table where the key decisions were made. There were high level committees overseeing the implementation of the drugs strategy plus a national advisory group, both of which had a strong community input. The community dimension of drugs policy in the Republic is seen as a key feature of our response to the drugs issue.

Unfortunately, following the bail out of the banks, the demands of the 'Troika' (European Commission, European Central Bank, International Monetary Fund) have seen funding cut to the overall drugs budget.

Since resources became tight, the drugs issue has become less of a priority. The post of the 'Minister for Drugs' was given the additional responsibility of the Housing Strategy, and is no longer part of the cabinet table. The Community representatives were not best pleased with the government scaling down its commitments to them and the Drugs Strategy, and have withdrawn from a process they see as increasingly tokenistic, while maintaining a 'watching brief'.

These days there are less young people presenting at needle exchanges, although steroid users have become a significant sub-group in this regard. We are seeing a 'greying of methadone', with the average age of people on methadone is increasing year on year. People with HIV have seen treatments improve a great deal in the last twenty years, which may result in a shift in focus onto Hepatitis C, where we can learn much from what has happened in Scotland where Hep C strategies were given high priority and were well resourced.

The main reason we came together to form UISCE was the discrimination faced by people who were branded 'drug addicts'. Access to decent treatment was severely lacking in the mid 90s, but this was underpinned by the assumption that 'drug addicts' didn't deserve treatment, especially if that treatment meant giving them free drugs to maintain their addiction.

Although UISCE is first and foremost a rights organisation, we have been central in bringing a 'service user' perspective to the service providers. While there is a plethora of organisations in what is termed the 'community and voluntary sector', the state oversees the provision of methadone, which has been the most important development in the response to drugs in the last twenty years.

The HSE (Health Service Executive), have been supportive to us, not least in terms of funding. We have been part of an oversight group regulating methadone provision. It is clear that because of the autonomy afforded to doctors, there is quite a bit of variance in how people are treated. There are still instances of punitive treatment, often linked to an over-reliance on regular urine testing. These are vestiges of the old regime, and thankfully treatment has become more humane and responsive to the needs of patients. Policies and practices come from many years' experience and lengthy discussions by committees meeting regularly over years and years. People on those committees can be reluctant to change what took so long to establish. While change can be slow and difficult, where there has been a lot of investment in and attachment to the current state of affairs, I still believe we are certainly moving in the right direction, but by engaging with our allies we can speed up that change.

There are other areas with 'service user' representation. When we first sat down together, it was apparent that many people in these groups were not keen on the term 'drug user organisation', preferring the term 'service user'. Much of this had to do with the fact that many of the people involved were no longer using any drugs, or were no longer using illegal drugs. We established a network of people involved in representing service users: SURF (Service User Representatives' Forum). SURF includes representatives from some other areas of Dublin, as well as Dublin Mid Leinster (Kildare, Wicklow, South County Dublin) and the North Eastern Region (Cavan, Monaghan, Louth, Meath). All SURF members

are recognised as representatives by their local drugs task forces.

We have frequently met with drug user activists from the North, and hope that we can develop our links and improve the lot of drug users.

Thankfully, that public resistance to treatment has lessened over the years, as substitution treatment has become accepted as a valuable response. Outside Dublin that resistance is still a problem, preventing people from accessing proper treatment.

The quality of treatment is variable. At its worst, it is little more than an exercise of humiliation and social control. These are human rights issues that we must continue to challenge.



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# Poetry Corner

## Cluckin' in Hydebank

By: Kat

As I sit in the horsebox on my way to hell

I think about prison life in a cell

So much for the detox, so much for a new life

But who's fault is it that I'm in such strife

Did I think of my children, my family, my friends

Surely I knew this is where it ends

As I make my way up to the committal landing

My legs are like jelly, How am I still standing

As I sit in my cell it all becomes real

I have to accept it, to know how I feel

I talk to the walls, deep in conversation

So much for detox and rehabilitation

See stress led to drugs, drugs led to crime

Crime led to court, and now I'm confined

I talk to the girls, they all seem ok

Their own cross to bear, each in a different way

I'm settling in and I'm knuckling down

Aware of the officers, they're always around

Are they here to help or are they here to get me

If I ask for assistance how will it affect me

I must talk to someone or my head will bust

But the fact of the matter is who do I trust

As I let my guard down, the real me comes out

I find out who I am and what I'm about

I pick up my troubles, pour them in a funnel

Suddenly I see light at the end of the tunnel

I'm certainly not cured, not fully right

But I know I can make it, if I put up a fight

And if I do it, who will I thank

All the circumstances that led to Hydebank



# Poetry Corner

## When Heroin Was My Heroine

By: Jake

Five o'clock in the morning, this is my time of day  
Time to squeeze the filters dry  
Time to tease the chills away

Then get me head down for an hour or two  
Before it all starts again  
Scrimp up the paper, as ye do  
Then just pump it in a vein

Me arms and hands went years ago  
Legs and feet all gone  
So now I've upped the ante  
And started to crank fermoral

Hitting up the aul' pound coin  
Twenty year or more  
Used me arm, me neck, feet and leg  
Bought it, sold it – what for?  
Even went on the beg

I thought I reached the point of no return  
Me veins were all like glass  
Then I turned on the aul' pound coin  
Got it first time  
Jez that's bleedin' class!

I know the dangers – oh so well,  
Got mates that lost their lives  
But when it gets right down to it  
The turn on always prevails

I'd love to say I've seen the light  
And saw god's will first hand  
But that just ain't the case  
I'm trapped in no-man's land

A point of transition  
For good or for bad  
So I've put my trust in REAL friends  
And let them take me by the hand

They've pointed me, directed me  
But never once did they dictate to me  
Simply thought, and put me on me own path  
HANX LADS, for the pushes and sometimes shoves  
To escape me personal hell  
HANX LADS – you know who ye are  
I don't have to tell.

## Anger And Fear

By: Debbs

Anger and Fear is all i see,  
Anger and fear of what might be.

Will i go or stay  
What do i do  
Hope or pray  
That history doesn't repeat  
That i don't see  
That hurt is still in me.

Destiny or without control  
The choice to change  
Or a chance to fall  
To enjoy the pain  
Of the past again  
With yet another poor lost soul.

Strong enough to say no  
If i meet him in a different form  
That the strength will come  
To tuck tail and run  
Not to repeat the past  
To move into the light  
And away from my darkest plight.

# Did Ya Hear The One?

## Not So Funny Jokes

### (But the Jokes on You Because You're Reading Them)

#### BAD JOKES

I know a guy who's addicted  
to brake fluid.  
He says he can stop any time.

How does Moses make his tea?  
Hebrews it.

A dyslexic man walks into a bra...

Why were the Indians here first?  
They had reservations.

I didn't like my beard at first.  
Then it grew on me.

How do you make holy water?  
Boil the hell out of it.

Did you year about the  
cross-eyed teacher who lost  
her job because she couldn't  
control her pupils.

Yes I am a drug abuser  
I regularly go into chemist  
shops and scream at the aspirins.

My son passed his hepatitis exams today  
He got A, B and C.

#### WORSE JOKES

Jokes about German sausages are  
the wurst...

When chemists die, they barium

I stayed up all night to see  
where the sun went.  
Then it dawned on me.

Im reading a book about  
anti-gravity.  
I cant put it down.

Did ya hear about the sausage  
that walked into a chipper.  
He got battered.

When you get a bladder  
infection, urine trouble.

Broken pencils are pointless.

What do you call a dinosaur  
with an extensive vocabulary?  
A thesaurus.

# Addiction Support Groups in Belfast

## Narcotics Anonymous Belfast Meetings

Day	Time	Location	Additional Notes
Monday	12.30pm	Ballynafeigh Community Centre, Ormeau Rd.	
	8pm	Clonard Monastery, Clonard, Clonard St.	
Tuesday	7pm	Fitzroy Presbyterian Church, 26 College Green	
Wednesday	7pm	Malone Place Clinic, 31 Malone Place, Lisburn Rd	Beginners Meeting
Thursday	12.30pm	McQuiston Church, Castlereagh Rd	
	7.30pm	Ballynafeigh Community Centre, Ormeau Rd.	Topics Based
Friday	8pm	Prison Fellowship Building, 39 University St	12 Steps Based
Saturday	12pm	Prison Fellowship Building, 39 University St	“Just for Today” Based
	7.30pm	Prison Fellowship Building, 39 University St	
Sunday	11.30am	The Peace People, 224 Lisburn Rd.	
	5pm	Ballynafeigh Community Centre, Ormeau Rd.	Open to addicts and non-addicts 1st Sunday of each month.

## Life Ring Meetings Belfast

Day	Time	Location
Tuesday	8pm	Quaker Meeting House Fredrick St.
Friday	8pm	Quaker Meeting House Fredrick St.

## Belfast Needle Exchanges

McGregor’s Pharmacy, 30 Botanic Avenue, Belfast – BT7 1JQ

- Monday to Friday: 9pm—5.45pm
- Saturday 9.30am– 5.30pm

Boots Pharmacy 35-47 Donegal Place, Belfast -- BT1 5AD

- Monday to Wednesday 8am — 7pm
- Thursday 8am — 9pm
- Friday 8am — 7pm
- Saturday 8.30am — 7pm
- Sunday 1pm — 6pm

**DEA** can be contacted at:

Drug Outreach Team  
Ground Floor  
Glendinning House  
6 Murray St  
Belfast, BT1 6DP  
Tel: 07788234054  
Email: jonathanlacey7777@gmail.com



# DEA - Empowering You!

Do you have a yarn to tell?  
Do you have a point of view you want to express?  
Do you have a poem or joke to share?

**Well get your arse in gear!**  
contact Jonathan at the Drug Outreach Team or on 07788234054

## Get Involved!

Are you interested in Service User involvement?  
BE BE holds a weekly Service User meeting -

Wednesdays at 2pm in the Drug Outreach Team  
(address above)