

**Presentation for Conference**  
***Drugs in Dublin, Working Together We can Make a Difference***  
**Dublin Castle, 7th February, 1997. Dublin Corporation.**

**Introduction.**

Towards the end of the 1970s, and the beginning of the 1980s, concern was being expressed in Dublin about the growth in drug misuse in the city, particularly young peoples' drug misuse, and the growth in availability of heroin on the streets. Research studies carried out at the time showed alarming rates of heroin use, particularly among already disadvantaged young people. An account by two journalists, Flynn and Yeates, traced how the supply of heroin had become organised in a way that had not previously been seen in Dublin. Illegal drug use had been discussed since the late 60s, when a series of articles by another journalist had highlighted such activity in the city, and police attention had been drawn to it. (Bushe 1968).

Throughout the 1980s, local communities consistently drew attention to their plight, and to the struggle they were having in trying to control the severe consequences of the drug misuse on their areas. Attempts which were made to engage statutory agencies in a meaningful way in the community proved unsuccessful, and communities set about responding in different ways. In 1981, Ballymun, an area of high unemployment and social deprivation, which was once described as "the most disadvantaged area in the State" by an Eastern Health Board special committee, set up their own response. The Youth Action Project. Those who started it believed that a way forward could be found, and that the community was the best place to develop that way.

In the south inner city area of Dublin, people took action to evict drug pushers from their communities, after major efforts on the part of statutory workers on the ground failed to generate a response from the authorities. This action took on the characteristics of a social movement, involving major participation of people from all over Dublin, and focused on

the supply of heroin in communities. We have seen similar action again in the 90s, and while it is controversial, and open to exploitation, it has at its core “one of the most remarkable expressions of civic responsibility the country has ever seen” (Fintan O’Toole 1996). It has sparked off an involvement in the communities which will develop in other ways. Other groups which were set up include CAD (Community Awareness of Drugs), which has consistently organised awareness programmes for parents throughout the country, and is not concentrated in any one area, and Community Response set up a community led partnership of statutory, voluntary and community, developing ways of responding to drug related problems in the South Inner City.

Problem drug use is a major issue for many of our communities. There is a wealth of support from all over Dublin to “do something” about the problem. A City-Wide campaign was set up. and drew up a strategy for a response which involves health, education and justice issues. People have been organising themselves to play a part in helping. Once again, different actions are taking place in different communities, ranging from parent-to-parent education programmes, to local people engaging doctors and organising structures for the provision of methadone.

The hurt which has been caused to our communities through the downward spiral of problem drug use is extensive. People, already struggling to reach a basic standard of living, coping with unemployment, poor alternatives, overcrowding and lack of facilities, found problem drug use in their areas to be devastating. Theft increased, security became a major issue, people isolated themselves, staying behind their own front doors, local incidents increased, security grills went up, anyone with any resources at all moved out. In many cases, businesses closed, and the media reinforced an image of hopelessness. People felt abandoned by the powers that be, and in some cases dereliction ensued.

Feelings of anger, shame, hatred, fear, hopelessness, guilt, despair, powerlessness, bounced around everywhere; feelings which are usually very hard for us to express and come to terms with. They are usually reacted to, and we have seen some of these reactions

in behaviours which attempt to control, to avoid, which become rigid, judgemental, which are confusing, crisis oriented, and which adopt trial and error techniques.

Collectively, we were ill prepared to deal with the enormity of the spiralling disaster, and we can identify phases we have gone through since drug abuse was first evident. The first was disbelief. People were told this is not happening, it's not that bad, you're exaggerating, etc. Only those who were directly affected in their own families knew how bad it was. Until some research was done. Even then, it was believed that the problem had gone away, that it had levelled off.

Then the search was on to find the reason for this - why is it happening? There are many reasons, and they have all been discussed. They are complex, involving individual, family, community, and society. We know the reasons. But have we worked to change them? Many people believed it was a phase we were going through, that we would grow out of it. But we didn't.

Next we said - let's control this. This reaction still goes on, especially in the minds of those who believe that stronger laws and tougher sentences, more prisons will rid us of this problem.

The problem still grew, and the blame game then went on and on. Every sector blames the other. "It's your fault" is the common cry. The buck is passed, until it can be passed no further. Vulnerable parents, already struggling, are the last dumping ground.

Each section has also tried to find separateness from the problem, like family members who try to get away from it. This is helped by the separateness of our systems, and our departments. It's seen in communities, by people doing things like sending their children out of the area to school, going to shopping centres in other areas, socialising in other areas, etc. We can live in areas without seeming to be part of them. And we have tried to live in spite of it, and get on with our lives. It was not a talking point for a while, it was taken for granted, part of life. It wasn't news! It wasn't on the political agenda.

People stopped talking about it, trusted no one, and went about their business. But the pain spread. It deepened. We couldn't hide it anymore. It has burst open, like a festered wound, and is gaping for all to see.

The community action born out of this agony has once again made drug abuse a media, and political, issue. Because it didn't go away. It never disappeared. Now communities are facing their problems, and accepting ownership of their areas. But this time, the demand is for the involvement of everyone, all of the key players. Now we see a developmental process, with a demand for more say, leading to change that makes a difference. The collective community voice is saying that enough is enough, and that serious action needs to take place, in both supply and demand strategies.

In YAP we believe that, whatever the variables which affect the onset, the responses we make are crucial in determining if someone remains addicted.

During the 1980s, strategies were developed to move from centralised to community services.

However, "community" can be interpreted in different ways.

Models of community response.

Community as a setting. This is seen as a positive alternative to residential care. Services are more accessible, and the person can stay in their own environment. The people living in the area are seen as the receivers of the services, the patients. Community as a resource for central agencies. This approach goes a step further and uses local structures and resources. For example, local people might be trained to deliver certain services. These people are usually volunteers, and can be very effective in reaching people. Other groups, agencies in the area are also used to further the aims of the central agency. Decisions are made centrally, allocations made, and priorities set. Local people and resources assist the central agency to implement their plans.

Community Development Approach. The basic principles of a community development approach are participation, equity and intersectoral collaboration (Jones and Macdonald

1993). It is an approach which encompasses a commitment to a holistic approach to health and recognises the central importance of social support and social networks. It is a way of working which attempts to facilitate individual and collective action around common needs and concerns which are identified by the community itself, rather than being imposed from outside. (Smithies & Adams 1990). The potential benefits of community participation in primary care include improvement in the design of services, increased effectiveness and efficiency, strengthening monitoring and evaluation of services, improving mobilisation of community resources and progressive assumption of responsibility for health care by the community, with technical and administrative assistance from the health authorities. (Quirke et al 1994).

This is a more radical approach, and sees the role of the community as not only supporting and helping operate services, but more importantly as determining priorities and being involved in the allocation of resources.

What do we mean by participation? While this is also open to interpretation, it has been defined as having essential elements:

- participation must be active; mere receiving of services does not constitute participation;
- participation involves choice;
- choice must have the possibility of being effective. (Rifkin, Muller & Bichmann 1988).

It is striking to note the central, fundamental role which is outlined in the literature for communities. It is claimed that this is the major way to achieve health for all, through the identification of needs, the decisions taken to meet those needs, the planning and implementation of responses. Some of the agencies, like the Family Centre Lower Hutt, New Zealand, go so far as to say “Therapy that does not address cultural meaning webs in informal ways simply continues the process of alienation.” In Ireland, Tobin has said that “...not only do such programmes (health and education) have a greater capacity to tackle

social exclusion and inequity but the way in which they operate can actually contribute to exclusion and alienation.” John Hubley (Community Development and Health Education, 1980) observed: “It would seem that current health educational programmes are actually widening social class difference!”

In the drug and alcohol field, the principle of participating in the resolution of serious problems is not new. The fellowship of Alcoholics Anonymous is now 60 years old, and in that time the same principles have been used by family members, people with drug related problems, people with gambling problems, eating disorders, etc. These fellowships were founded to find a way where none existed, and have been attributed with considerable success by many of those who use them.

The Therapeutic Community model of care for those with drug problems has been to the fore, as one of the earliest responses, in responding to the need for help. This model uses as its core, a self-help regime, where everyone who is part of the “community” contributes to the organisation and daily running of the house. Community participation, while it does not just happen, has the potential to improve the quality and scope of drug services. It does not happen quickly, and there is no blue print. This can be very frustrating, especially in an urgent situation. However, many of the basic principles for successful involvement outlined by Quirke et al (1994), are present in our communities in their concern and efforts to protect their children from drug related harm. This can be marched by the health board, and other care providers, by accepting that communities are entitled to participate in service planning; by formally identifying workers who will provide support and technical back up, with approved role legitimacy and adequacy for development work; by accepting that shared care means shared control, and by treating communities as equals in the process of dialogue.

**“The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.”**

(Declaration of Alma-Ata)

The idea of community becoming directly involved in their own health care gathered momentum during the 70s, and into the 80s, as the non-governmental organisations (NGOs) built on community development ideas and related them to health. Health became part of an integrated package that would conquer underdevelopment. 1978 saw the WHO produce the Declaration of Alma-Ata, which clearly identified community involvement in their own health as the major plank in the strategy to achieve 'Health for All' by the year 2000. Primary Health Care "addresses the main health problems in the community, providing promotive preventive, curative and rehabilitative services accordingly;"

In promoting community involvement in health so forcefully in this declaration, WHO was endorsing the approach which had become popular as a development strategy, and which saw health, not as an isolated variable in people's lives, but as intrinsically linked to many other factors, social & economic, which affected the health status of the community.

*"involves, in addition to the health sector, all related sectors and aspects of national and community development, .....and demands the co-ordinated efforts of all those sectors;"*

**Conclusion:**

In seeking to find effective ways to respond to the hurt and pain of our communities, value needs to be placed on the evidence of communities' desperation to have their children treated effectively, of their efforts to make their areas safer for their children, and of their sophistication in employing community development strategies in response to many serious issues facing them.

In taking up the challenges of a community development approach to drug misuse, we can be congruent with Primary Health Care as outlined by WHO, and creative and co-ordinated in our activities.

Previous claims of consensus and intersectoral collaboration in Irish policy making have been “superficial having been achieved and maintained by ignoring many real policy dilemmas...” (Butler 1991 p 230).

The effectiveness of structures at local and national level depend on the debate going beyond superficial levels, on the real dilemmas being faced, and on the required analysis and study being undertaken.

The crisis which drug misuse has presented for our society could yet be the foundation on which to build comprehensive community care. Ignoring the difficulties and challenges runs the risk of deepening the hurt and abandonment even further.

Communities are passing through the nightmares and are coming to see a new hope. How do we respond to that courage? Perhaps this time we can turn and face in their direction. That direction is giving hope, and is finding ways forward, if we are willing to make the changes necessary.

Through this, our “ability to respond” can be increased, healing can happen.

#### **What does this mean for community services?**

- 1) community are prime movers;
- 2) leadership is developed from within, not imported.
- 3) plans are developed locally, not centrally.
- 4) local structures have a say in the allocation of resources, and determination of priorities.
- 5) services are community centered.
- 6) no one agency has all the responsibility.



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