COMMUNITY DEVELOPMENT
AS A MEANS OF
DRUG PREVENTION

An exploration of the contribution community development principles and strategies can make to the development of an effective drug prevention model.

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A huge thank you to Nina (my mother), and Eimear for stepping into the breach in my hour of need.

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1:   Introduction

The idea of community development is not new. The notion of community development is not new. Both are, however, dynamic areas of work evolving rapidly and creating new systems and strategies for tackling some of the difficulties modem society finds itself dealing with.

This study aims to explore the principles and strategies involved in community development and their potential as methodologies for working in drug prevention.

In order to achieve this aim, the study will review a variety of issues central to the themes involved.

Section One will provide a snapshot of the progressive marginalisation of certain communities which are currently experiencing enormous difficulties related to drug use. This section will also describe the methodology utilised in this study.

Section Two will focus on the topic of drug use and drug prevention.

Section Three will explore the concept of community development, focussing on principles and strategies involved. This section will also delve into community development approaches to drug prevention.

Section Four highlights the work of the Drug Awareness Programme, Crosscare, and examines its work in the light of a community development approach to drug prevention.

Section Five will review the issues covered and summarise with reference to the emergent themes and ideas.

Section Six will entail conclusions on the basis of this study and the issues involved.

1.1:   The Development Of Marginalised Communities

> "Deeply entrenched problems, for which there are no obvious or easy answers test our systems to the limits of endurance. Systems can respond by a) changing and growing to meet the challenges or b) falling back on techniques of survival, rationalising, minimising, projecting and denying the extent of the harm."

> (Urrus, 1996)

The development of marginalised communities does not occur accidentally. Any review of an area experiencing severe drug-related problems will expose a consistent and concerted neglect of duties and responsibilities on the part of the State. This negligence continues as long as the community in question is not given a voice and not listened to.

Contemporary Irish society is commonly described as one which has undergone a very rapid period of modernisation economically and socially since the 1970s, changing from a larger agricultural base to a large service-industry base (Murphy-Lawless 2000). This progression, however, has had a markedly different impact on people with lower skills and educational levels, and has led to high levels of unemployment for them. A landmark study of Dublin's urbanisation by Bannon (1981) found that over 10, 000 jobs were lost from the inner city during the 1970s. In Dublin as a whole, unemployment was four times greater in 1994 than in 1974, compared with only a doubling of that figure nationally (Drudy and McLaren, 1996).

From the early 1970s, rehousing of a substantial proportion of the population from unrehabilitated tenement dwellings managed by Dublin Corporation to the newly built local authority estates to the north-west, west and south west of Dublin city led to a decline in population in the north inner city leaving a predominantly eldely group behind (Murphy-Lawless, 2000). Between 1966 and 1993 land use patterns in the north and south inner cities combined saw a decline in industrial space from 20 per cent to 6.5 per cent, a decline in wholesale space from 10 per cent to 5.3 per cent, and an increase in derelict space from 2 per cent to 13 per cent (Connolly, 1997).

The tradition of early school leaving because of the previous accessibility of entry level work in the labour market continued in an uninterrupted trajectory with tragic results for young people who faced into a lengthening future of unemployment, along with older men whose jobs had been shed and who would never regain an economic foothold (Murphy-Lawless, 2000). By 1991, 47% of the working age population had left school by the age of fifteen; in four wards, over 66% of the population had left school before the age of sixteen (Murphy-Lawless, 2000).

As early as 1981, the Garda were recording that one sixth of all crimes committed in the Republic were carried out in Area C of the north inner city (Murphy-Lawless, 2000).

Moran et al (1997) notes the electoral areas of residence in Dublin of those presenting for Drug Treatment, with the north inner city accounting for roughly 1 in 10 in 1990 and 1 in 6 in 1996.

Cox and Lawless (1998) highlight that drug use in Ireland is not a new phenomenon either. However, since the 1980s there has been a steady increase in the number of individuals involved in illicit drug use. To give some indication of the escalation of heroin use in Dublin, it is worth noting that in 1980 the main drug treatment centre, Jervis Street, treated 213 heroin users and this rose to 417 in 1981 (Butler, 1991). In a 5 year review of treated drug users, O'Higgins and Duff (1997) reported that in 1995 the total number of treatment cases in Dublin was 3, 593, the overwhelming majority of whom

were opiate users. In 1996 the total number of treatment contacts in Dublin increased to 4, 283 (Moran et al, 1997). The figures from the Health Research Board clearly indicate that drug misuse, in particular, heroin use, is primarily an urban problem. For example, in 1996, the number of reported treatment contacts ranged from none in the North Eastern Region of the country to 281 in the South East Region. These figures are significantly lower than the reported contacts in the Dublin area.

Cox and Lawless (1998) comment that while recognising that drug misuse is a largely urban problem, research in the UK has illustrated that it is highly scattered and localised, not only with distinct regional variations, but also with a tendency for heroin misuse to be densely concentrated in certain neighbourhoods and not in others (Pearson, 1991; Parker et al, 1986). These neighborhoods tend to exhibit very high unemployment rates, limited social mobility, and other indices of social deprivation. This is not to suggest that there is a simple causal relationship between drug misuse and unemployment; the relationship is complex and many factors have a general significance in shaping the geographical clustering of heroin use alongside social deprivation (Pearson, 1987).

This localisation of heroin use in disadvantaged communities has also been recognised within an Irish context (McCann, 1997). Cullen (1998) argues that the Irish 'drug problem' disproportionately effects certain communities within Dublin. He believes that it makes more sense to see the drug problem as a collection of local drug problems that differ across space and time and often require different policy responses and strategies. The main drugs of use differ across communities, across groups and across generations; and drug policies need to reflect this.

In response to the ever developing drugs problem, the Government, in the 1996 Ministerial Task Force on Measures to Reduce the Demand for Drugs, recommended that a small number of areas be targeted and that local task forces be instituted to support the process. In response, thirteen local Drug Task Forces were established, one for each of the localities identified as having the most acute drug problem, 12 of which are in the greater Dublin area.

These Task Forces aimed to generate a collaborative and participative intersectoral response to the issues their locality was experiencing. However levels of true collaboration and equity of authority between statutory and community sectors has been criticised.

> "A more radical approach is needed if we are to pay attention to the way health is sociologically structured, and avoid the trap of attributing problem drug use in our poorest communities as issues of individual choice only".

> (McCann, 1999, p.57)

The focus of this study will be to explore the area of community development, and to examine the principles and strategies involved in order to assess its efficacy as a means of drug prevention.

1.2:   What Works?

Sometimes the simplest of questions can prove to be the most difficult to answer. A most fundamental question of this piece of research is "what works?". A vast amount of information is available outlining a multitude of projects and their responses to drugs. Innumerable manuals, packs, books, reports and guides outline what to do, to whom, how and when, each purporting to meet admirable objectives and achieve glorious aims. However, the question still begs....... "what works?".

> "Lacking clarity about basic assumptions, we could be pulled in several directions at once with no basis for choosing among our sources of advice". (Blume, 1994, P.2)

Different categories of theories exist. They can be deductive or inductive, mathematical or phenomenological. Theories can operate within certain orientations, or world views. Thomas Kuhn (1970) proposed that all alternative theories prevailing at a given time tend to operate within a certain framework or world view; a paradigm.

There is much discrepancy in the efficacy of different theories. A good theory, Blume maintains, operates like map;

> "useful because it can be carried around, reproduced in multiple copies, and examined while one sits in one place" (Blume, 1994, p.2)

He uses this analogy to describe how some theories fall short of their goals:

> "Some are replaced because they are oversimplified, like maps with significant areas of terrain left blank. Others fail because of the opposite error, like maps with so much detail that they cannot fit in anyone's map case. Still others have been insufficiently abstract, proving useful only under limited circumstances. Furthermore, theories may lack validity if the are based on incorrect assumptions or faulty data, developed on faulty logic, or designed to serve a political ideology". (Blume, 1994, p.3)

This research, then, will identify and outline a broad spectrum of theories relating to drug prevention. Each of these theories can serve as a map, which, depending on its efficacy, may help or hinder us in reaching our destination... a clear understanding of "what works".

1.3:   Methodology

1.3.1: Qualitative Research

The methodology employed in this study is a qualitative methodology.

> "Qualitative inquiry cultivates the most useful of all human capacities- the capacity to learn from others".
>
> (Patton, 1990, p.7)

Patton (1990) states that qualitative design is appropriate for following and documenting process-oriented approaches to facilitating change, such as community development.

While quantitive measures can tell you where you started and where you ended up, it takes qualitative methods to capture the developmental dynamics of the process between.

This study aims to build a picture from the experiences and perceptions of the subjects.

> "Such an approach is of immense value to the future of community action on drugs issues, since the knowledge gained will assist in future effectiveness".

> (McCann, 1I999, p.7)

1.3.2: Insider Research

This study takes the form of an 'insider research' study. 'Insider research' refers to research undertaken by a professional within his/her own agency and work setting. The insider researcher is typically already known to respondents prior to the study (Robson, 1993). This is the case with this study as the researcher works closely with all of the interviewees.

1.3.3: Limitations Of Insider Research

A)   Interviewer Influenced By Researcher:

A natural limitation of this approach is that the interviewees would respond according to how they felt the researcher expected them to respond. To overcome this, the researcher stated at the opening of each interview that this study is a reflection on their understanding of and perspective on certain areas of their work, and not the researchers. Also interviewees were assured that their comments and thoughts were for the purpose of this study alone and confidentiality was assured.

B)   Retaining Objectivity:

Patton (1990) comments that the human factor is both the great strength and the fundamental weakness of qualitative inquiry and analysis. In an effort to retain objectivity the researcher identifies her own stance and opinions as they arise and also she attempts to triangulate (use 3 or more methods) the findings of the interviews with written records and other sources of data. The objective and the responsibility is to be balanced, fair and conscientious in taking account of the perceptions, interests and realities which emerge (McCann, 1999). Rather than ignoring personal views and perceptions, an attempt has been made to include them with the multiple evidence, and present all of this as perspectives only, rather than any discovered truth about the subject (Patton, 1990).

> "Objective observations are impossible to achieve, but observers are still required to convince others that their accounts are credible and not mere subjective perception".

> (Bowling, 1997, p.333)

Bowling (1997) states that observational methods should be part of a triangulated research methodology so that observed events, behaviors and attitudes can be verified by independent sources (eg: records or interviews). This study includes a broad review of documents and publications on the subject matter.

C: Ethical Issues:

Every attempt was made to protect the identities of the respondents in the final text. However, as the number of interviews conducted was very small (3) this proved quite difficult. Each of the respondents were given the opportunity to read the data to be used, and to approve or withdraw it. Any information which was considered confidential was not quoted verbatim in the text.

To respect and protect the confidentiality of the groups that the DAP works with, their names have been omitted, as have any identifying terms/ phrases.

1.3.4: Unstructured Interviewing

Qualitative research involving observation can take a variety of forms, as shown in Figure 1, below:

Figure 1: Observational Methods In Qualitative Research:
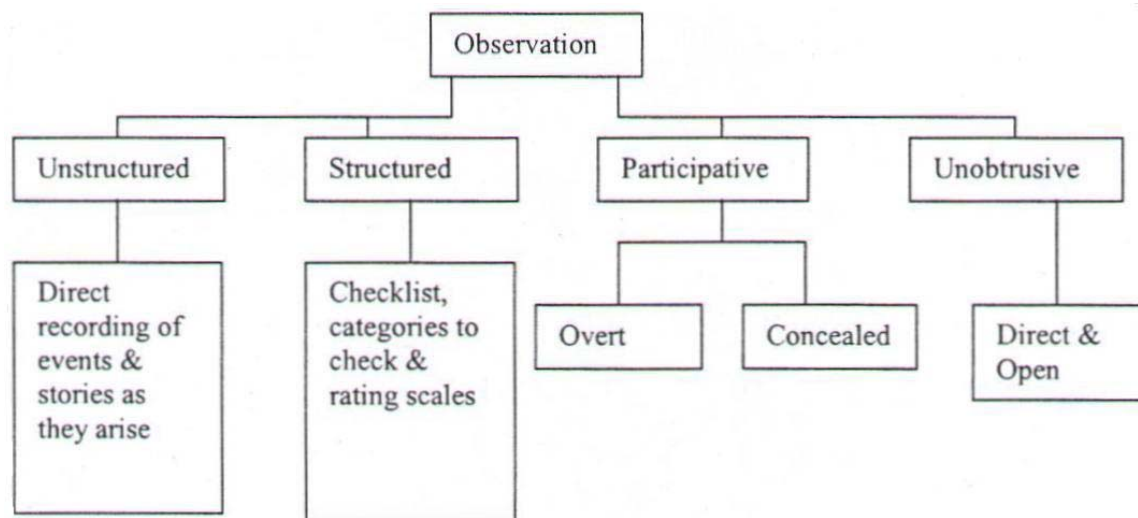
This study uses unstructured interviews, directly recording the participants stories as they arise, These interviews form the basis of the study from which a greater understanding of the processes involved in the work can be ascertained. This is an inductive approach.

"In contrast to the deductive method, an inductive approach will begin with the observations, and postpone definitions and structures until a pattern has been observed. Much qualitative research, particularly observational research adopts a grounded theory approach".

(Bowling, 1997, p333)

The procedure adopted in the unstructured in-depth interviews adheres to recommendations outlined by Bowling (1997, p.339) as follows:

(i)   Respondents were informed of the aims of the study, and confidentiality (See Appendix 1)

(ii)   A brief structured list of questions about the respondents' socio-demographic characteristics (eg: sex, date of birth, occupation, education, ethnic status, date and place of interview) was used.

(iii)   A post interview comment sheet was used by the interviewer to record any information about my feelings about the interview, rapport, insights, disruptions, and so on.

(iv)   A simple checklist of topics/questions (See Appendix 2) was used as a tool rather than fixed questions, and there were no pre-codes.

(v)   Interviews were audio tape-recorded (with respondents permission) in order that they could be analysed in detail later. This also enabled the researcher to attend to the informant, rather than manually record all the responses, and communicate that the respondent was being listened to.

(vi)   The interviewer still took some notes, for example, key words and phrases for back up and as a guide to topics covered.

1.3.5: Data Analysis Procedure:

"Qualitative research data should be collected rigorously and systematically... in order that checks on reliability can be made. Meticulous records need to be kept; and the categorisation of the data should be carried out systematically and impressionistic material avoided in the report".

(Bowling, 1997, p.332)

The procedure which I followed once the interviews were completed is detailed as follows:

♦   Full transcriptions verbatim of interviews, by myself, to familiarise myself with the content
♦   Common themes identified
♦   Themes categorised
♦   Categories reviewed
♦   Major ideas listed

♦ Attempted to understand and explain patterns and themes

It may prove useful here to identify the stages involved between transcription and identification of common themes and categories:

(i) 1st reading: Regularly mentioned words, phrases and experiences noted

(ii) 2nd reading: Developed these, noted other things often mentioned, retained seldom mentioned things as they could be relevant to later emerging themes.

(iii) Further reading: Coded transcripts according to emerging themes, and created headings for the clustering of topics

(iv) Written data (apart from interviews) gathered and also organised under these headings, to identify those themes emerging strongly, ie; triangulation, or verifying data from interviews and identified topics not prominent in the interviews

1.3.6: Key to Interview References

Quotations from interviews are referenced by interview number, and transcription page number. Thus, a quotation from page 10 of the transcription of interviewee number three would be referenced:

(Int. 3, 10)

2:   Background

In order to assess the efficacy of the community development approach as a means of drug prevention we will have to take a few steps backwards first. We need some clarity. We need to be sure that the concepts involved are understood in the same way by all interested parties.

This section aims to provide an overview and explanation of the basic concepts involved, and disperse some of the clouds which can blur our vision of the topics being discussed.

The following topics will provide the foundations for an analysis of a community development approach to drug prevention.

2.1:   What Is A Drug And How Is It Abused?

We can begin on a positive note, by stating that there is more or less unanimity in defining what a drug is. Dr. Des Corrigan, from the School of Pharmacy in Trinity College, Dublin describes a drug as:

> "A chemical which causes changes in the way the human body functions, either mentally, physically or emotionally."

> (Corrigan 1994, p.2)

Peter Laurie concurs with this view, but he highlights why we are concerned with drug use:

> "A drug is any chemical substance that alters mood, perception or consciousness and is misused, to the apparent detriment of society... in many people's minds the most important and dangerous quality of a drug is its addictiveness".
> (Laurie, 1971, p.9)

It is clear that a drug can have no effect until ingested by someone. Once ingested, however, disagreement erupts amongst those involved or concerned about drug prevention. There are huge discrepancies between the various descriptions of the person who has ingested a drug. Terms such as drug user/abuser/misuser/addict are amongst the 'polite' descriptions used. There is no definitive answer to the question what is drug abuse. Some will reply any use of any drug, for non-medicinal purposes; some will reply physical or psychological dependence; some will reply that there is no such thing. The topic of drugs and their effects on people who use them arouses highly volatile emotional reactions in many people, as huge numbers of people have experienced personal devastation, seeing their lives, their families and their communities ripped asunder. Many quick-fix answers to the enormous problems related to drug use have merely acted as a bandage, masking, but failing to heal the wound. Surveying these ineffective responses leads us to a deeper questioning, and requires us to step outside of our immediate

emotional reactions to try to understand the person who uses drugs, in a more open and objective manner.

> ".......there is no shortage of moral crusaders in the modem war against drugs. Drug taking continues to be surrounded by a miasma of confusion and fallacy. One of the principle causes of this has been the masquerade of moral values as biomedical facts" (p. 249)
>
> (Gossop, 1984, p.249)

One interpretation of the term is provided by Corrigan (1994)

> drug abuse can be taken to mean the use of any drug, legal or illegal, which damages some aspect of the user's life - whether it is their mental or physical health, their relationship with their family, friends or society in general or their vocational functioning as students or as workers both inside and outside the home. This definition includes not only the use of illegal drugs but also the dangerous use of legal drugs such as alcohol and tobacco, the harmful use of prescribed medicines exceeding the recommended prescribed dose and the illegal use of legal drugs, eg: drinking and driving or smoking cigarettes in a no-smoking area. The fact that a drug is legal and socially acceptable does not mean that it causes less harm or damage than an illegal drug. Indeed, it appears that as the use of a particular drug becomes more acceptable, more of it is used by more people, more often, with greater adverse consequences for the user's health and well being.

> (Corrigan, 1994, p.2)

This places the focus firmly on the harmful effects of the drug, the damage it causes, and moves us away from seeing the individual as inherently weak or wrong. Thomas Szasz (1972) highlights how our views on addiction are only beginning to evolve. He Claims that, abuse cannot be defined without specifying the proper and improper uses of certain pharmacologically active agents. The regular administration of morphine by a physician to a patient dying of cancer is the paradigm of the proper use of a narcotic: whereas even its occasional self-administration by a physically healthy person for the purpose of "pharmacological pleasure' is the paradigm of drug abuse. He submits that these judgements have nothing to do with medicine, pharmacology, or psychiatry. They are moral judgements. Indeed, our present views on addiction are astonishingly similar to some of our former views on sex".

A term which is used quite often in this sphere is "drug dependence".
The WHO outlines what this means:

> "Individuals may become dependent on a wide variety of chemical substances. Covering the whole range of pharmacodynamic effects from stimulation to depression. All these drugs have in common: they are capable of creating a state of mind in some individuals which is termed psychic dependence. This is a psychic drive which requires periodic or chronic administration of the substance for pleasure or to avoid discomfort".
>
> (WHO, 1964, p.5)

Some people may define dependence as harmful in itself, while others may see dependence as a natural response to a wide range of substances. Laurie (p. 12 1971) draws an analogy between the withdrawal of a drug and the withdrawal of a persons trousers. Though a whimsical analogy it is clear that one would experience quite severe mental and physical discomfort if ones trousers were removed. However, one cannot describe a dependence on wearing trousers in public as "harmful", or damaging, as one can operate more comfortably within this cultural sphere while wearing trousers.

People have many dependencies, some are enabling, some disabling, but we must be extremely careful in how we go about defining something as a harmful/damaging dependency, and examine our own attitudes carefully, to ensure as objective an approach as possible.

> "There are many in our society who need the satisfaction of fast driving as badly as many addicts need their drugs, and their "fix" causes a good deal more social damage."

> (Laurie: 1971, p.10)

Very often we can move without noticing from the often-cited war on drugs to a war on drug users.

2.2: Why Do People Become Addicted?

Uchtenhagen and Okulicz-Kozaryn (1998) comment that drug prevention as a professional task has emerged in pluralistic societies where traditional beliefs and lifestyles no longer guarantee generally accepted forms of substance use, limits of use, and use patterns. Transgressors traditionally were not regarded as suffering from a specific condition; they were morally judged, outcast or punished. Prevention was a part of the educational mainstream how to live a life which is compatible with societal norms. They claim that since norms and lifestyles have lost much of their educational value, and since contradicting norms and lifestyles coexist in pluralistic societies, everybody has to find his or her way between personal needs, given opportunities and their chances and risks. The opportunities for substance use are abundant, and apart from specific rituals in specific milieus, substance use is mainly geared by individual expectations.

'Addiction', like 'mental illness', does not refer to any unitary process or disorder. It is just as meaningless to ask which is the best treatment for people addicted to drugs or alcohol as it is to ask how best to treat people suffering from mental illness. The addiction therapist must match the treatment to the *specific* circumstances, needs and problems of the individual. It is futile to look for a single treatment intervention which can be used to treat all addicts or all alcoholics" (Gossop, 1984, p.244)

An IFT (1994) report on the theoretical foundations of substance abuse prevention, concluded that there was no definitive theory to explain drug addiction. It noted that on the one hand there is a proliferation of theories whose explanatory usefulness is quite limited in scope and which are not or cannot be empirically proven. On the other hand, there is an overabundance of mostly anecdotal case descriptions which are difficult to weave into a coherent theoretical pattern, not least because they occasionally contradict each other. These inconsistencies not withstanding, it is indispensable for preventive measures to be based on a scientifically sound and verifiable concept to avoid costly trials and errors.

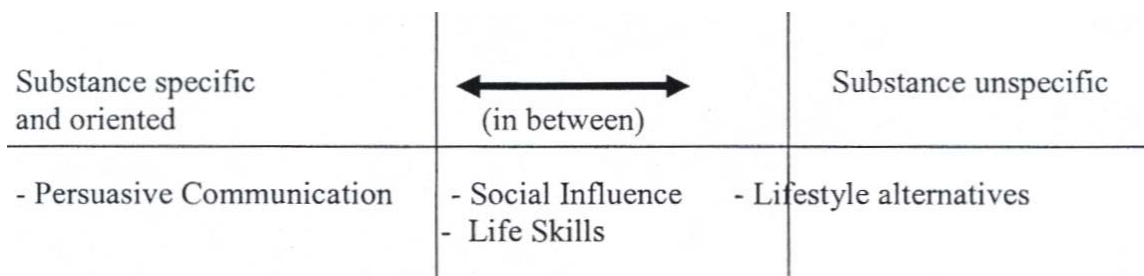Figure 2, below, gives an overview of theories relating to reasons for addiction.

Figure: 2: Overview Of Causative And Probability Indicator Theories Of Addiction
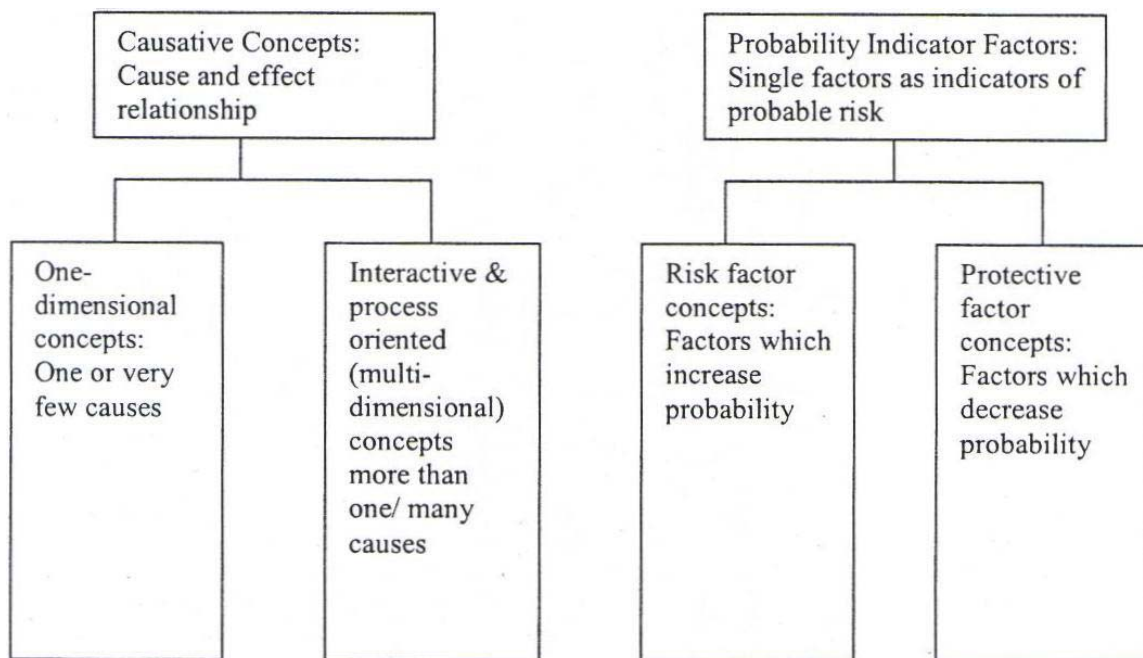
2.6: Can Addiction Be Prevented?

A huge variety of models of prevention have been postulated and tested. Many have failed to live up to expectations. This section will provide a review of a variety of approaches to prevention and their efficacy. Figure 3 below provides a sketch of substance-specific versus substance unspecific approaches

Figure3: Prevention Models: Substance specific versus Substance unspecific.

Substance specific and oriented	(in between)	Substance unspecific
- Persuasive Communication	- Social Influence - Life Skills	- Lifestyle alternatives

McGuire's (1989) communication/persuasion model (1989) is based primarily on preventive measures through dissemination of information (Rabes, 1987). According to McGuire, the process between the time the information is absorbed and the time a behavioural change takes place involves 7 steps:

1) The targeted individual is exposed to a convincing message
2) his interest in its contents is awakened
3) the message is understood
4) he learns new skills
5) he agrees with the conclusions and possibly changes his attitude
6) he retains the new idea, and finally
7) he acts in keeping with his new attitude.

Bandura's (1969) Social Influence Theory postulates that behaviour is a result of the positive or negative consequences that follow that behaviour. Some forms of behaviour are adopted when they are observed in persons who are accepted role models, or if the model is observed while being rewarded for the behaviour. Thus, the particular environment which generates these stimuli, rewards and penalties also plays a specific role. The concept emphasises a situation-oriented intervention strategy that is precisely tailored to the abuse behaviour and is primarily directed toward external influences such as social pressure (Lopez and Fuchs, 1990). To identify social influences and develop adequate strategies to counteract them is the fundamental concern of the preventive measures which espouse this concept. Primarily in the U.S. the social influence theory frequently forms the scientific underpinning of preventive programs."

The Social Bonding Theory of delinquency is a broader term for and is linked closely to Social Development model of delinquency is a integration of Hirschi's (1969) social control theory of delinquency and Bandura's (1977) social learning theory

The social bonding model views antisocial and delinquent behaviour as varying inversely with the strength of a person's bond to conventional society. This bond consists of affective attachments to other members of society, commitment to and involvement in accepted activities and social institutions and a belief in the legitimacy of the social order.

The model postulates that bonding to a social group or institution will occur to the extent that each person has (A) opportunities to be actively involved with others in the group or institution (B) the skills necessary to perform competently in the setting, and (C) receives consistent positive reinforcement for participation. Bonds to traditional socialising agents and institutions, such as family and school, will reduce the probability of attachment to deviant groups and thus inhibit delinquent behaviour, because the normative behaviours rewarded in the family and the school are not compatible with those likely to be rewarded in deviant groups. On the other hand, to the extent that traditional socialisation agents fail to provide opportunities for effective involvement or to reward participation the person is likely to seek these experiences among deviant groups and to develop attachments to delinquent peers. The Seattle Social Development Project attempts to prevent delinquency by promoting the formation of bonds to the family, school, and non-delinquent peers. (Hawkins and Weis, 1985)

There has been emphasis recently on social influence or peer preference rather than peer pressure models (e.g. peer education). This researcher would concur with this shift.

The life skills concept was originally developed by Botvin and colleagues in the U.S. (Botvin, 1988, Botvin et al 1990) and at first focused primarily on smoking prevention (Lopez and Fuchs 1990). This concept is theoretically rooted in the social influence and the problem behaviour theories (Jessor and Jessor, 1983), meaning that substance abuse is perceived as a result of social learning processes in combination with personal factors such as knowledge, attitudes and beliefs. The life skills training concept is contextually related to that of "affective child rearing", although it is considerably more complex and is intended primarily to achieve changes on the behavioural level, as exemplified by the predominance of methods from the behavioural theory complex. Despite its emphasis on a specific dependency the goal of this concept is very broadly conceived in that it is aimed at developing general coping strategies, and improving overall social skills. Specifically, the objectives of this approach are to:

1)   Provide information and focussed training for resisting social influences to prevent drug use of keep it from getting out of control,
2)   Impart fundamental social skills and
3)   Teach personal coping techniques.

With increasing frequency, scientific publications acknowledge the development of life skills as one of the foremost preventive goals.

"In combating both legal and illicit drug abuse, the focus should be placed on immunising each and every individual adolescent both socially and emotionally against drug abuse"

(Hurrelman, unpublished manuscript, 1991)

It envisions an individual conscious of having a number of effective life management skills and thus in no danger of becoming ensnared in a negative developmental process such as drug addiction.

Thus preventive programs seek to promote healthful behaviour while at the same time imparting the skills needed to resist social influences (Rabes, 1987).

Hurrelmann (1989) also turns the spotlight on life skills training. The development of life skills, he says, is an effective preventive measure with which individuals can overcome even complicated and stressful events and situations in life. He even goes a step further in advocating a change in social - structural and socio-ecological living conditions because drug abuse cannot be addressed on the individual level alone. This researcher would agree with this statement and would advocate focussing on both an individual and socio-ecological level in drug prevention.

The life skills training concept can be categorised as cause-specific abuse prevention since its methods are tied in with vital personality-specific and behavioural-psychological protection factors.

Concepts seeking to promote emotional health pursue a concern essentially similar to the life skills model. The approach is part of a general trend to de-emphasise drug-specific prevention in favour of a more broad-based objective that targets both personal and environmental conditions and continues to grow in significance. Health as the WHO defines it, is a combination of personal and environmental structures in which both have equal value.

> "Founded on this basic understanding of health is the premise that anyone can improve his health by developing his functional abilities (social skills, coping styles) and exploiting them to the fullest, even if current circumstances leave something to be desired. In this sense, health is an expression of comprehensive life skills"

> - International WHO Workshop Protocol (Dresden '89)

The scientific body of knowledge on "health protective factors" is increasingly gaining significance, as a result of which the heavy concentration on the risk factor model has lost some validity today (IFT, 1994)

The objective of current health education and promotion programs is to promote and support a healthy lifestyle and a wholesome way of life. Until quite recently health education primarily referred to physical health or changes in individual health practices/behaviour as a way of preventing illness.

Lifestyle concept proponents argue that the individual should be viewed as a whole. Behaviour, they say is not created in a vacuum, but develops and arises from specific economic, ecological, social and cultural conditions and relationships.

Health education must now also strive to effect changes in the social, political and natural environment.

Areas of research and intervention efforts in health education include variables such as emotional state, stress, critical life events, coping strategies personal strengths (protective factors) and social resources (support system, etc).

Recently, community-based programs achieve results if built on the family, school and peer group programs. This is especially true when all individual measures are successfully co-ordinated and instituted on a permanent basis. Of continued importance is that public initiatives, local groups, and individual citizens remain strongly committed, Prevention must be regarded as a task in which everyone has a stake. (IFT, 1994).

> "Heroin addiction in many European countries at present occurs primarily in the 18-40 year old age range, especially amongst males, and can be associated with various cultural, social and individual risk factors. It can also be highly concentrated in cities or in certain districts within major metropolitan areas, for example amongst more socially marginalised or disadvantaged communities with high unemployment rates and other social problems, and in some cases in areas linked to heroin trafficking and distribution. This means that prevalence can be many times higher than the national average, for example up to 5-10% among young people in the highest risk groups or communities"

> (Hartnoll, 1998, pi 02)

This highlights the urgency of a concerted community based approach in terms of enabling and empowering a community to address the issues it is affected by in a cohesive and integrated way.

2.7:   The Movable Feast: Prevention?

Difficulties arise when terminology taken to mean one thing is interpreted differently by different practitioners. Unfortunately, a lack of consistency in definitions is widespread. Thus, from the very outset we have hurdles to cross. Even the basic objective of prevention is open to a variety of interpretations.

Prevention is "the act of preventing; hindrance or obstruction" (Brown, 1997, p 1150).

> "Researchers politicians and practitioners all understand the word differently.... These different views of what prevention really means illustrate that the term is a 'movable feast', depending on who is using it".

> (Buhringer, 1998, p.16-17)

But what are we trying to hinder or obstruct? Here, we encounter a difference between the levels of prevention. Various approaches adopt different objectives, A list of these objectives would include:

- Preventing supply of drugs: including preventing production/manufacturing, distribution and trafficking, smuggling, etc.
- Preventing demand for drugs: including prevention of use, delay in onset of use, reduction in use, prevention of problem use/harm reduction, etc.

Prevention is evidently an enormous task.

Morgan (1998) endorses an awareness of possible bias in our objectives:

"Implicit in many prevention programmes is that the lesser use of drugs the better.......this suggests therefore that total abstinence is an ideal that should be sought. However, a recent study by Shedler and Block (1990) raises serious questions about his "idea!" state...... they did not simply assume a continuum of nonuser to abusers. Rather they identified and contrasted discrete groups of non users, experimenters and drug abusers...... The results indicated that adolescents who had engaged in some drug experimentation (primarily with marijuana) were the "best" adjusted of the sample. In contrast adolescents who used drugs frequently were maladjusted showing a distinct personality syndrome marked by alienation poor impulse control and manifest emotional distress. On the other hand adolescents who by age 18 had never experimented with any drug were relatively anxious, emotionally constricted an lacking in social skills". P126

(Morgan, 1998, p. 126)

The next section will provide an overview of the evolution of models of drug prevention.

2.8:   The Evolution of Prevention

This section provides a brief review of the evolution of drug prevention models and strategies. The review is adapted from Buhringer and Kunzel's (1998) study on evaluating drug prevention.

Greek Literature: described <u>alcohol's</u> positive and negative effects and suggests ways to regulate drinking eg: Hippocrates: gave detailed medical descriptions of the factual and assumed consequences of drunkenness; and Plato: drew up drinking regulations according to age: under 18 boys should not drink, 18-30 could drink in moderation, 30+ getting drunk was fine. He proposed regulations for prohibition during wars, for slaves, for drivers politicians and judges during working hours, for everyone during the day and for men and women trying to conceive.

Middle Ages: rituals that included excessive drinking were deemed very important and getting drunk at least twice per month was an essential part of good medical advice. No notion of preventive activities existed.

16th Century Europe: an increasing emphasis on <u>self-control</u> and self-determination was applied to drinking behaviour. Drunkenness interpreted as a sign of weak character.

1520's: first temperance organizations emerged in Germany and several German parliaments banned 'raising a glass". Previously uncritical use of <u>opium</u> as a cure all was challenged, Therapeutic use of opium was described for the first time as the ultima ratio ('the last resort'). Medical literature was full of detailed descriptions of its negative consequences.

19th Century: Industrial Revolution brought modem techniques to alcohol production. Alcoholism began to be seen as a <u>disease</u> rather than a weakness of character.

Mid 19 Century: Modem Temperance Movement spread through Germany, Scandinavia, UK, US and a few other European countries. Concept of the <u>substance,</u> not the drinker as causing alcohol - related problems. Thus <u>abstinence</u> was deemed the only possible option. Supported by doctors re: health and industrialists re: business effects.

1920's+ 1930's: Temperance movement peaked with partial/total <u>prohibition</u> in Scandinavia and US, <u>Supply-reduction</u> approach.

Latter half of 19th Century: Large scale <u>demand-reduction</u> activities emerged for the first time: mass-media campaigns, pamphlets, paintings, plays, social activities and meetings run by local and national 'temperance societies': privately run.

Turn of 20th Century: Scandinavian countries implemented the first <u>alcohol control policy,</u> with partial and total prohibitions, monopolies, high prices,

taxation, rationing and limits on the number of retail outlets and their opening hours.

1900-20: The volume of medical literature produced on the effects of cocaine and opiates led to the first proposals for concerted <u>supply reduction.</u>

Early 1950's: The need for <u>demand-reduction</u> activities was discussed formally at conferences in 1953 + 1959. No scientific knowledge base, but <u>recommendations</u> were made:

♦ <u>Attitudes</u> should be changed and accurate <u>information</u> disseminated.

♦ Prevention should not just be drug-specific, but related to the <u>whole person.</u>

♦ <u>Parents' behaviour</u> has major influence on children's use of alcohol: positive or negative.

♦ <u>Positive family environment</u> is important for avoiding alcohol-related problems.

(Deutsche Hauptstelle gegen die Suchtgefahren, 1954, 1961)

Early 1970's: Bejerot (1975) concluded that liberal laws increase and repressive laws decrease drug use and drug-related problems, (Note: it can be argued that this methodological analysis does not support the conclusions.)

1970's: Move from supply reduction focus to <u>demand reduction focus. Preventive concepts</u> became accepted in modem research. Three phases in the decades since then:

♦ <u>Information dissemination:</u> based on moral principles, factual knowledge and fear arousal.

♦ <u>Value clarification:</u> based on concepts of self-worth and developing positive alternatives to drug use.

♦ <u>Risk factors and protective factors:</u> based on increasingly strong empirical research.

1979: U.N. study on measures to reduce illicit demand for drugs, highlighted:

♦ need for <u>evaluation</u>

♦ need for a balance <u>of supply and demand reduction</u> activities in prevention initiatives

♦ need to <u>educate</u> the public about alternatives to drug use

♦ need for <u>programmes</u> to deal with adolescent problems

• need to incorporate drug abuse prevention into <u>health education.</u>

1983: U.N. Expert Group on Drug Abuse Reduction:

♦ called for a balance of <u>supply and demand reduction</u> and the promotion of 'positive <u>alternatives</u> to drug use'.

♦ Recommended that <u>licit substances</u> be included in prevention programmes

♦ Conducted <u>critical evaluation of fear based information</u> activities

   ♦ Conducted <u>positive evaluation of long-term school, parental and community programmes</u>

   ♦ Called for <u>training</u> educational staff in schools and workplaces

   ♦ Recommended simple, "off the shelf <u>evaluation</u> techniques based on an adaptive learning system so that prevention activities could be continually analysed and improved.

Early 1980's: High quality European epidemiological surveys, American prevention research and evaluation technology ensured the development of new techniques and programmes such as:

   ♦ Concept of <u>social 'inoculation'</u> to resist drug offers

   ♦ The <u>Life Skills</u> Training Programme

   ♦ The evaluation of national mass media campaigns in Germany, Sweden and the UK.

   ♦ The evaluation of modem school-based programmes in Greece, the Netherlands and Scandinavia.

Mid 1980's: <u>Epidemiological information</u> about the size and structure of the drug problem was widely available. The theoretical <u>concepts of risk and factors that could protect</u> against the onset and development of substance abuse were developed. Prevention programmes using this information and theory were instigated.

1986: The world Health Organisation (WHO) Regional Office for Europe launched the <u>'Healthy City Network'.</u> 20 European cities joined together in a common effort to reduce substance abuse. This was the first time a large-scale programme had evaluation as an integral part.

1990: The European Community launched a programme including the 1992 & 1994 <u>European Drug Prevention Weeks,</u> and 3 <u>European Action Plans</u> (which included evaluation) were launched; focussing on <u>drugs, alcohol, and tobacco.</u>

1996: The European Monitoring Centre for Drugs and Drug Addiction published a report (1996) which concluded:

   ♦ Prevention is currently generally understood as <u>primary prevention,</u> focussing on demand reduction rather than supply reduction.

   ♦ Prevention interventions exist all over Europe but are <u>predominantly school-based.</u>

   ♦ Prevention interventions are based more and more regularly on modem research-based knowledge.

   ♦ Prevention interventions are more regularly evaluated.

1998: EMCDDA's (monograph No. 2) makes these conclusions:

   ♦ A comprehensive prevention approach requires both <u>supply and demand reduction</u> measures, how much weight each should be given is unclear.

   ♦ Modem demand-reduction activities in primary prevention are based on a probabilistic theory of how harmful use

develops and explains it through 'protective' and 'risk' factors. The <u>'biopsychosocial' concept</u> states that genetic, psychological and environmental conditions all play a role in this process. Weighting of the risk and protective factors is still unclear.

♦ Major <u>risk factors include family education</u> and <u>parenting styles</u>, <u>peer pressure</u> and the general <u>availability of drugs</u>. Thus, there is a need for more family activities, especially in early childhood and <u>prevention should start among 6-10 year olds.</u>

♦ Major <u>protective factors include promoting certain life skills</u> (self-confidence, problem-solving, communication skills, stress management) and <u>drug-specific resistance training</u> (how to refuse)

♦ Most current prevention is either carried out in schools or via public-information campaigns but comprehensive <u>community-based approaches</u>, (making use of the family, youth centres, local businesses, the police and so on) have also been shown to improve the outcome.

♦ <u>'One-off time-limited prevention activities are of little value.</u>

♦ <u>Public information campaigns cannot change harmful use (they may even increase it).</u> Such campaigns can, however, promote public awareness and support for financing prevention activities.

♦ Regarding ecstasy and other synthetic drugs: a shift from primary prevention towards <u>harm reduction</u> was visible across the spectrum, from high level politics to on-the-spot measures.

To sum up, preventive measures should start early, take a long-term approach and avoid flashy spectacle. They should focus on family, community and developing life skills in the individual. There should be a shift from the school-only focus in drug prevention. Risk and protective factors should be taken into account.

Prevention is only effective with actual experimental research and continual evaluation. Without research prevention has no foundation, but without evaluation, it has no future. Continuing evaluation is essential for assessing the initial situation ('needs analysis') for planning and carrying out prevention activities adequately and to a high standard ('process evaluation'), and for adapting the approach depending on the results ('outcome evaluation').

3:   Community Development: Overview And Definition Of Concept

> "Drugs prevention can contribute to a wider process of community development and community development methods can be applied to community-based drug prevention work".
>
> (Henderson, 1995, p.3)

In the course of this study, I will examine a particular interpretation of 'community' as purported by the Drug Awareness Programme, Crosscare. I will further examine their interpretation of the term 'community development', however it may be useful to examine relevant literature in these areas as a grounding. This section will review these terms and some principles of good practice in the field of drug prevention.

Efforts to stem or reverse the ravaging effects of drug use on people and their communities have evolved in response to the problem.

Frustration has been experienced on many levels by many groups working in the field of drug prevention. Firstly, difficulties in evaluation methods; and secondly, the poor results of evaluations, deemed valid and reliable, have led to a broadening of horizons, in terms of an approach to effective and sustainable drug prevention. This broadening of horizons has led some groups to believe that the community development approach can be adopted and used to support rather than coerce people in responding to drug use in a productive way.

In order to comprehend the subtleties of the term 'Community Development*, it **is** helpful to begin by studying its components.

The word 'community' involves a sense of having something in common. This common factor could be social group, location, purpose, desire, or some other quality. A community can thus indicate a housing estate or a street or a town; while it can also indicate a number of individuals who are concerned about a particular issue. The term is dynamic, and organic, evoking a sense of having life and thus being capable of growth/ movement, e.g.: a life cycle. The term is thus a very flexible entity.

Williams (1983) describes community as the warmly persuasive word to describe an existing set of relationships, or the warmly persuasive word to describe an alternative set of relationships. What is most important, perhaps, is that unlike all other terms of social organisation (state, nation, society, etc) it seems never to be used unfavourably, and never to be given any positive opposing or distinguishing term.

This sense of warmth which the term community evokes seems to stem from the sense of strength and unity involved. Sometimes this can be difficult to enter into, from without, as new community members must adapt to the group's identity and vice versa. This is especially true in the case of drug prevention:

> "Working in the Community also means involving non-experts, something which may alarm the experts. The problems that arise in such situations relate above all to issues of participation, responsibility, and transparency".
>
> (Bertoletto, 1998, p. 117-8)

When a community aspires to political activity, it does so in a different sense to our understanding of formal politics. Williams (1983) comments that community politics is distinct not only from national politics but from formal local politics and normally involves various kinds of direct action and direct local organisation working directly with people', as which it is distinct from 'service to the community', which has an older sense of voluntary work supplementary to official provision or paid service.

Cox and Lawless (1998) maintain that the notion of 'community' has often been oversimplified by being used as a catch-all way of analysing social aspects of the lives of people within a locality. However, 'community' also refers to a complex network of social relationships (on both a real and abstract level) which takes place within a geographically defined area or neighbourhood (Jary and Jary, 1991). On another level, the term 'community' can be used to illustrate a positive sense of 'spirit and feeling'. In short, it is one of the most difficult and controversial concepts in modem society which has attracted many different interpretations (Lowe, 1986). Moreover, the label 'community' tends to receive little scrutiny or precise definition because of the evocative nature of the term (Cox and Lawless, 1998). The commonplace use of the term and myriad interpretations can lead to difficulties.

> "'Community', as an entity, is beginning to be viewed in a different way. We no longer define community in a strictly spatial manner, but rather attribute qualities of the collective to our definitions. Community may now represent a collective of women, older people, people with disabilities, travellers or of residents in a particular area. All of these 'communities' have a common goal or purpose, issues and strategies for change within a broader geographical context".
>
> (Aontas, 2000, p.l3)

McCann (1999) makes a distinction between interpreting the community as a setting or as a resource. Each of these interpretations has implications for the level of involvement of the community and the work methodology undertaken. When viewed as a setting, the originating agency is seen as having the resources and the power to make decisions, determine the timing, the extent and the terms of the service. Contact is only made with the target population when the service is about to be commenced, and location, staff and programmes have been decided upon. This model sees the State as delivering and the community as receiving; the worker is active, the community is passive.

The second model outlined by McCann (1999) is that of the community **as** a resource. She states that this involves equipping local people to implement projects which are largely determined by the outside sponsoring agency. She notes that there are limitations in this approach, in that it is more readily approved than the more challenging approach of collective change.

Southwell (1995) states that recruiting workers from affected populations can be used to help agencies avoid their responsibilities to transform themselves, and that in using this approach the range of activities conducted may be a substitute for real policy.

Development is also a dynamic and organic term. 'Development' has its roots in 'envelope' thus it originally meant to unwrap or unroll. The term 'developed' has notions of reaching a pinnacle **or** peak in development, while 'underdeveloped' defines in relation to the 'developed' as the ideal and not in positive terms the development of itself. It is therefore a relative concept, linked to something else: the ideal of a developed community. The question begs: can development ever be achieved or is it a continuous process?

The use of these terms can create difficulty in clarifying the approach 'Community development'. Williams(1983) comments that very difficult and contentious political and economic issues have been widely obscured by the apparent simplicity of these terms. Thus a particular land might be 'developed' for its own purposes, as in some kinds of subsistence economy, but seen as 'underdeveloped' in terms of a world market dominated by others.

The Community Development approach envisages the community itself defining what the ideal state would be, and what development is necessary in order to achieve that state. The historical mistake was to inform the community what they needed in order to be 'developed'.

> "What is community development? It is the process which enables members of a community to identify and analyse their needs, and collectively work towards change. This happens at 3 levels: personal, community and political."

(Clarke, 1993, p. 5)

Focussing on the process rather than the task leads to people becoming equipped with the resources necessary to prevent drug related problems, thereby tackling the issue at source rather than symptomatically. While keeping the task in mind, the community development approach focuses on and often lends more weight to the process.

Community development as a concept is strongly associated with notions of self-help and self-reliance, and has been defined in the following way by the community Action Network:

"Community development aims to encourage people to take control of their lives, to develop fully their human potential and to promote community empowerment. **It** involves people coming together in groups to identify their collective needs and to develop programmes to meet these needs. The process or the way the work is carried out is as important as the programme of development being undertaken. The process of community development stresses the need to develop community awareness, engender group cohesiveness, and promote self-reliance and collective action. This logically leads communities to seek change at policy and institutional levels, often highlighting the need for the redistribution of society's resource".

(Kelleher and Whelan.1992)

Aontas (2000) comments that CAN'S definition encompasses these elements:

♦ Human beings are capable of development to their full potential and this can be harnessed to bring about the development of the potential of the community.

♦ Agency: people can take control of their own lives, and overcome restrictions and constraints of social structures and institutions, changing them in the process.

♦ Need for people to own the process rather than have it imposed from the outside.

Aontas (2000) declares that community education is one of the principal mechanisms used in community development to achieve these outcomes. They maintain that the coincidence of community development and community education is such that they overlap like two intersecting stars. They have the same core values: they form a coherent whole, but they lead to outcomes beyond themselves. Whereas the overall outcome of community development is the transformation of society to include marginalised groups and individuals and encompass diversity and difference; the overall outcome of community education is the provision of skills to enable people to bring about the transformation of society, but also to link in with the provision of qualifications, further education and economic engagement.

"Those who are engaged in Community Education see it as a tool for the overall development of communities as well as individuals."
(Aontas, 2000, p.8)

Community education is seen as:

♦ Person-centred, not teacher-centred
♦ Located geographically in the community
♦ Responds to the needs of the community
♦ Decisions are made by and for the community
♦ Aimed to enable people to analyse and challenge their position in society
♦ Philosophy of active participation

Aontas (2000, p.8) also provides an outline of the process involved in community education:

(i)   Courses provided in response to local needs and use local skills wherever possible
(ii) Encourages move from individual needs to skills development for active engagement with family community and labour market
(iii) Learning is motivated by personal enrichment which may or may not lead to engagement with the labour market, depending on the participants wishes
(iv) Learning is a stepping stone to other forms of learning, and is aimed especially at those who have had previously negative educational experiences
(v)   Programmes take account of where the learner is at and values his/her experiences
(vi) Emphasis is placed on awareness raising and confidence building as a mechanism for development of individual progression pathways.

This researcher would agree that community education plays a central role in community development, but would broaden the focus from the individualist ethic evident in the above process outline. The process should include socio-political awareness raising. I would maintain that community education which merely focuses on family community and the labour market, is limiting the potential of that community to participate in the political sphere, and limiting its ability to determine its own needs and engage in developing and instigating responses to meet those needs.

According to Thomas, (1983) when most (not necessarily all) of the following group and worker aspects are in evidence then community work is being practiced:
Group Aspects:
   Felt needs of local people (finding out and acting on local needs).
- Personal responsibility (community doing things for themselves).
- Personal experience and need (community experiences and needs a particular thing).
- Voluntary involvement.
- Constituency (work will benefit wider constituency than those actively involved in the group).

Worker Aspects:
Formation and support of groups (worker interested in people working as a group).
- Participation (promotion of participative forms of membership and trying to counter elitism).
- Partnership (works with, not for group, encourages independence).
- Process (process of education through activities, increasing confidence, knowledge, etc).
- Task (setting objectives and achievement of tangible goals).

The Combat Poverty Agency (1993) defines community development as:

> "Community Development is a process where by those who are marginalised and excluded are enabled to gain in self-confidence, to join with others and to participate in actions to change their situation and to tackle the problems that face their community. It is a key means of challenging powerlessness and isolation and promoting participation and involvement".

(C.P.A., 1993, p.11)

The statutory agencies are also coming to find that a community development approach is one in which they should invest. The Dept. of Social Welfare and the Combat Poverty Agency stated in 1995 that community development is about promoting positive change in society in favour of those who benefit least. However, it is not just about making concrete changes in the quality of peoples lives, it is also about <u>how</u> this is done, i.e.: both the <u>task</u> and the <u>process</u> are important.

The 3 elements which the Drug Prevention Initiative (1995) states as forming the core of the community development concept are:

Felt Needs: "The aim is for a community to define its own needs and make provision for them". (DPI, 1995, P.5)

Consensus: "The processes involve fostering creative and co-operative networks of people and groups in communities". (DPI, 1995, p.5)

Role of Change Agent: "Usually there will be a community practitioner involved who has community development skills. He/She will tend to work in a non-directive way, enabling, encouraging, educating". (DPI, 1995, p. 5)

The Drug Prevention Initiative also outlines two alternative models of community development approaches: Community Action and Community Service. Community Action is defined as:

"A model of community development which involves communities in making demands of policy makers and resource holders". (DPI, 1995, p.5)

The focus in this instance is action based, with three elements involved:

► Issue-based action: "Goals involve organising for power around concrete issues. This can be reactive or defensive, or it can be to challenge negative images". (DPI, 1995, p. 5)

► Conflict-based action: "Employs conflict-oriented strategies and tactics and the tactics can be collaborative (e.g.: deputation) campaigning (e.g.: petitions/rallies), or coercive (e.g.: rent strike)". (DPI, 1995, p. 5)

► Activist-led Action: "Organisers are generally activists or paid professional organisers. The evidence is that it is very difficult for practitioners employed by public authorities to play this role." (DPI, 1995, p. 5)

The Community Service Approach involves:

"Those methods and strategies that are employed to develop and maintain community-oriented service delivery and planning organisations", e.g. councils for service, also private, voluntary and statutory sector partnerships, 3 elements are involved:

► Needs based: "Developing services and organisations that are responsive to community needs as assessed by local people and professionals". (DPI, 1995, p.6)

► Participative: "Maximising opportunities for community involvement, including the capacity of local authorities to consult with community organisations". (DPI, 1995, p. 6) (Note: Task Force and membership)

► Inter-organisational: "Promoting inter-agency collaboration to further community interests". (DPI, 1995, p. 6) (Note: Task Force & Membership)

The activities of Drug Prevention Teams, according to the DPI (1995) should include:

- Deployment of workers,
- using existing networks,
- creating new networks,
- training (also to enable training of trainers),
- action research,

The focus is on the community as the protagonist, and the agent of change as outlined by the DPI. The role of the DAP worker is as a support to that change or developmental process.

McCann (1999) found in her study of the Youth Action Project, Ballymun, that important elements in community development are:

♦ Community as the unit of action
♦ Community initiative and leadership as resources
♦ Use of both internal and external resources
♦ Concern about process as well as services.

She focusses on the basic principles of participation, equity and intersectoral collaboration.

This approach is one which appeals greatly to this researcher and appears to be the one which advocates the communities interests and capabilities most succinctly. I would concur with the community education outcomes as outlined by Aontas (2000), yet 1 feel that the 'process' they describe focusses heavily on the individual. My own preference would place more weight on the community and the collective approach, with strong links and participation externally, driving initiatives forward rather than merely holding the map for the external agencies to decipher direction and targets.

It is an approach which encompasses a commitment to a holistic approach to health, recognising the central importance of social support and social networks and attempting to facilitate individual and collective action around common needs and concerns which are identified by the community itself rather than being imposed from the outside (Smithies and Adams, 1990).

The W.H.O. emphasises massive public involvement:

"not just in the support and operation of health services, but more importantly in the determination of health priorities and the allocation of scarce health resources".
(W.H.O. 1991, p.3)

This envisages:

"community groups as moving beyond being merely service providers and to play a role in planning and decision making".
(Community Workers Coop, 1990, p.2)

Cox and Lawless (1998) propose the involvement of community groups in policy making at a local level, can ensure that the needs of the communities are addressed in a relevant manner. They found that the evaluation of the Drugs Awareness Training Programme of Merchants Quay indicated that the provision of such training to members of communities disproportionately affected by the 'drug proble' has benefits in terms of: increasing participant's knowledge, developing participant's skills and changing participant's attitudes. All of which can ensure a coordinated and sustained approach to community action.

A number of recommendations are put forward by **Cox** and Lawless (1998):

♦ A need for inclusive drug policy at a local level that embraces the notion of 'community' as a whole rather than creating an 'us' and 'them' situation
♦ A need to involve community groups in decision making at a local level in order to obtain sustained and coordinated action
♦ A need to provide training programmes at a local level, based on an experiential learning model, that will provide the basis for such sustained and coordinated action
♦ A need for research to establish the relationship between drug use and homelessness.

I would propose however that communities must look far beyond the local level, and must organise in such a way as to determine their own stance on policies and procedures that they would envisage as having relevance.

Henderson (1995) advocates that all drug prevention workers need to be aware that communities are a real and active context, and to engage with that reality. The report identifies 4 aspects of communities they need to relate to: the problems and crises of

certain communities; rapid economic and social change; networks such as women or ethnic groups and active individuals and groups who are struggling to improve their communities. He recommends that:

a) Local Drug Prevention Teams need to play an indirect, supportive role in community development.
b) Drug prevention workers must get to know and understand communities and to establish trust through involvement with them.
c) Multi-agency partnerships are essential in combining support for community development with the provision of information on drugs and drug misuse. Members of the community need the knowledge skills and crucially the resources for meaningful participation in projects and programmes.
d) Practising community development adds to the knowledge and understanding of communities attitudes towards drug misuse.
e) Drugs prevention strategies which support community development must be framed within the context of a community's agenda and developed as an integrated package.
f) External evaluations are vital.
g) Drugs prevention services can learn from the experiences of community development as well as contribute to it.

Henderson (1995) elaborates by highlighting a number of reasons why community development is an effective means of preventing the spread of drug misuse. Because;

− the problems resulting from drugs misuse affect the community,
− communities can inform the development of drugs prevention (local people have a lot of useful knowledge, for example, about how communities work).
− there are potential drugs prevention resources within communities; people who are interested and willing to help,
− the community is an effective arena in which to influence attitudes
− it offers an opportunity to influence the policies of local and regional agencies,
− communities are affected by a wide range of influences and it is important to work in partnership to maximise the potential for combined work.

Henderson (1995) lists principles of good practice:
1. Engaging Communities in Drug Prevention: specific communities
2. Role of Teams: indirect dev.: empathy but limited involvement
3. Development Work: trust-building, listening, integrating drugs into dev. Package for community action research
4. Being Accessible: flexibility and good communication
5. Delivering Drugs Prevention: information, awareness, training and funding opportunities
6. Working in Partnership: multi-agency partnership
7. Moving from Practice to Policy
8. Monitoring Progress

Regarding prevention in the community, it is advised that in order to avoid resistance to the programme and doubts about its outcome, all those who could be affected by an intervention should be involved in its implementation and evaluation. Programme planners should always be prepared to encounter problems when designing a community strategy, as issues of participation, responsibility, and transparency are never far from the surface. This means that drawing up a timetable is essential, as is recognising the often delicate balance of power that may exist between individual players. Compromise is therefore the key to successful community working (Bertoletto, 1995).

"The community development approach is thought to be an effective means of influencing health behaviours, since people are more likely to adopt ideas or practices that they played a part in forming. Moreover, the active involvement of local residents fosters a sense of collective ownership, which in turn strengthens the impact of community based programmes".
(Hyndman and Giesbrecht, 1993, p. 1614)

4:   Case Study: DAP Crosscare.

The Drug Awareness Programme of Crosscare was established in June 1984, and has over 15 years experience in the field of drug prevention in Ireland. It has evolved in accordance with the development of the field of drug prevention over the years, and has adopted a variety of methodologies.

Currently the DAP team consists of five members, who work in a variety of ways and areas and within a broad spectrum of groups and individuals.

This case study however will focus on the DAP's involvement in community based responses to drug issues, and provide an insight into a particular approach to drug prevention namely a community development approach.

This section will focus on responses given during interviews which will help to elucidate the principles and practices employed by the DAP in its community based responses and strategies.

DAP: A Brief Overview

Mission Statement

"The DAP aims to support, facilitate, train and empower communities to develop their own resources so that they can play a central role in preventing and repairing the damaging effects of drug misuse."
(DAP, 1999)

What is DAP Crosscare?

The Drug Awareness Programme provides training and support for those interested in preventing drug problems. It is part of Crosscare, a registered charity, and managed by the Teen Counselling Board of Management.

Who is it aimed at?

The Drugs Awareness Programme works with people of all ages and experience- young people, adults, parents, teachers, employers and health workers- helping groups and communities to develop a comprehensive approach to drug problem prevention.

By working in partnership with communities we can harness the expertise and resources which already exist. By training we improve these skills and heighten awareness of drug issues. By facilitation we empower people to put their skills into action.

The DAP receives funding from the Eastern Regional Health Authority (formerly the EHB), the Dublin Diocese/Crosscare, and other sources including the Health Promotion Unit, fundraising, donations and grants.

The DAP has worked with a range of groups and communities across Dublin, and has strong links with national and international groups and agencies.

How does it work?

Each programme is tailored to meet the needs of participants and the community. Training is usually carried out in weekly sessions in the community where the participants live or work and where meet.

Programmes can be divided into two distinct stages:
1.   Training and Needs Assessment-
This phase focuses on assessing the needs of the community or group, identifying and delivering the training required by the group.
2.   Development and Support-
This phase provides the practical support and assistance necessary for the group to develop and set up whatever service it has chosen as its objective.

What can the DAP do?

The DAP provides a wide range of services including:
- Needs assessment for local drug prevention
- Drug Awareness training for leaders
- Peer Learning training (adults, youths)
- Seminars and Drug-awareness courses
- One-to-one counselling and referral for drug users and their families
- Replies to telephone queries
- Materials for projects
- Resources for other trainers
- Networking for prevention
- Consultancy on prevention of drug problems in school, family and work place
- Adventure in the City (group activity)

The rest of this section will provide a detailed overview of the interviews conducted with the members of the DAP, Crosscare concerning their work, and focussing on aspects that may relate in particular to the concepts discussed in sections 2 and 3 previously.

4.1   Drug Prevention

The topic of drug prevention when raised with respondents generally met with a pause for reflection . The scope of what is meant by the phrase was acknowledged:

"Drug Prevention is very broad" (Int. 3, 3)

There were a range of perspectives on drug prevention identified.

"Drug Prevention, I think is either people reducing the amount of drugs that they use, people postponing their first use of drugs or people deciding not to use drugs. Prevention then is establishing the conditions in which those things happen, so that people make those choices. And, T think it's different from education. Education is about teaching people knowledge or skills and those things don't always lead to drug prevention." (Int. 1, 1)

While this perspective focuses on drug-specific action in drug prevention the area of harm minimisation/reduction was also highlighted.

"I hate to sound clichéd or to ramble off the mission statement[1] but I guess I would see it in the broad context of preventing the harm that drugs do. Not necessarily preventing people from using drugs, or making an assumption that you can do that, but more preventing the damage and the harm" (Int. 3, 1).

This focus on the damaging effects of drugs misuse plays a central role in the teams' understanding of drug prevention.

"My understanding of drug prevention is to prevent the abuse/misuse of drugs or the taking of drugs have an adverse effect on the person, the family or on the community as a whole". (Int. 2, 1).

This situates the drug prevention on a variety of levels: personal, family and community. On an individual level, DAP's work involving drug prevention was described as focussing on certain behaviours:

"I think we're trying to prevent drug problems. We're trying to prevent the harm that drugs can do. We're not necessarily against drugs per se, for instance alcohol, we're trying to help people avoid the harmful use of that drug. If people don't use drugs at all obviously that's going to prevent the harm. That's my understanding of it, and I would include harm reduction then as a part of what I think we're about, in the sense that if people are engaging in high risk behaviour it would be part of our remit to try to teach them less risky ways of using drugs". (Int. 1, 1-2)

A certain reluctance to adhere to the drug free ideal was evident in other participant responses.

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[1] The mission statement of the Drugs Awareness Programme states "The Drug Awareness Programme aims to support, facilitate, train and empower communities to develop their own resources so that they can play a central role in preventing and repairing the damaging effects of drug misuse" (DAP 1999)

"I don't advocate completely preventing drug taking, I can understand why people do it and especially with alcohol and in a way I'd advocate it in a lot of respects but only in moderation."(Int. 2, 1).

The harmful effects on the individual were identified as:

"A person becoming dependent on a substance which would alter their day to day living or in some way diminish their independent living or their capacity to live independently and self sufficiently. It's very subjective I think." (Int. 2, 1).

But the harmful effects were also identified as extending beyond the individual level causing:

"The destruction of families and communities and individuals lives. That would be the ideal, that we would be preventing individuals from harming themselves or wasting their opportunities or the potential as people, as communities as a family network and as humans with something to offer. Drugs and addiction can come in the way of that so preventing that lost potential" (Int. 3, 1).

The delineation between individual and community-focussed drug prevention was highlighted through exploring the various drug prevention methodologies which the DAP is involved in. A model of drug education as a means of examining a range of possible options and choices was described. The objective would be to encourage more healthy decision - making in the individual, which results in 'Drug Prevention'.

"I would say that my work involves drug education as well as drug prevention. I believe that drug use is about making choices and so by helping people to take control of their lives, teaching, helping, facilitating them in making healthy decisions. I think that's part of drug prevention" (Int. 1, 2).

Others on the team agreed that education is of central importance in drug prevention on an individual level.

"It's all predicated with education in my view. The fact that you would inform people about the dangers and the highs and the good points of drugs and tease through those and see if you can come up with happy medium for that individual with regards to their potential/prospective drug use or existing drug use." (Int. 3, 1-2).

Some of the elements of drug education were highlighted:

"Helping people explore their own attitudes, opinions, values, culture systems, all that stuff in relation to addiction and drug use and hopefully through that giving them a clearer understanding as to what's involved when somebody gets sucked into either alcohol or drugs, so in a very subtle way challenging peoples attitudes. Practically giving people knowledge, working with people to improve their level of knowledge around the areas of drugs or addiction so that they are able to make informed choices or that they

just even socially and politically have a clue of what's going on in relation to drugs and addiction." (Int. 3, 3)

The notion of health promotion was also evident in what is meant by drug prevention. Drug education and drug prevention were seen as 'subsets' of health promotion:

"By educating people I think we are giving them tools that they can use then to make decisions, they can use the information that they have gained in their drug education to make healthier decisions. If one is a subset of the other it would be they are subsets of health promotion." (Int. 1, 2-3)

Drug education therefore is identified as a methodology for drug prevention on an individual level. Counselling was another drug prevention methodology focussing on the individual.

"By counselling I would feel that I'm helping someone to take more control of their lives" (Int. 1, 2)

"The counselling end of things: it would be hopefully preventing them from further progressing in to their drug use or addiction. Again if they choose to do so you're challenging them or trying to open their eyes in some way to the road that they are going down" (Int 3, 2-3).

The Drug Awareness Programme's work in drug prevention on a broader level was also highlighted:

"We're looking at prevention in the broad context of preventing the harm. I think by doing the skills training and working with people to set up services or implement responses within their community networks would be one feature of the work that we would do and I would see it as preventing the harm. If you have people equipped with skills to go out there and provide a service, well then hopefully you're minimising some of the harm that people are experiencing. (Int. 3. 1-2).

This community based drug prevention work was seen as involving skills development to enable service establishment and a contextual awareness.

The DAP was seen as limited in it's scope. The team consists of 5 members, and focusses on demand reduction.

"It is really demand reduction that we are looking at. We're not focusing on the supply reduction or policing or vigilantying (sic)" (Int. 1, 9).

4.2   COMMUNITY DEVELOPMENT

The team members encapsulated their perspective on the notion of a "community" in very similar ways. There was a sense that the geographical location was of lesser importance than a sense of commonality in experience, understanding, task, (e.g. support or reducing drug problems), ideas and passion or commitment.

"A community is a group of people who live together but I would say that it's a group of people with a common experience and understanding so the common experience may be living together in the same vicinity, same town, same parish, same street. To make a group a community they have to have certain common experience, they have to have a way of looking at where they live that they share with each other or perhaps coming together for the task of trying to reduce drug problems in their own area." (Int. 1, 3).

"Definitely more than geography, so I wouldn't define it just as the place in which you live. e.g. The (-) have very much a sense of community and it would be made up of individuals from all different backgrounds and different geographical locations round Dublin. People come together with a common passion to work, you can get a sense of community when people come together to support and share ideas" (Int. 3, 3)

"A community is any group of people sharing a common geographical location, a common goal, a shared vision, or a group with similar social standing" (int. 2, 3)

"I think community can mean community in an agency community in a school, community in a staff room or any kind of training centre as much as it does a community in Tallaght" (Int. 2, 4)

Community development was envisaged as a process:

"Aiding, guiding, through co-operation and through concerted effort through a participating model rather than a partnership model. And the community in question becoming more self sufficient than it had been previously" (Int. 2, 8)

The process was seen as resulting in communities developing strategies to tackle relevant issues:

"Well my understanding is that it's a community moving from being sort of victim or passive to being creative and active. They may feel for instance that drug dealing, drug issues are something that happens to your community. Then they begin to realise that they are not passive it doesn't just happen to them, that there are ways that you can improve your community and reduce the risk of children in that community ending up with drug problems, or with other problems for that matter. It's about helping the whole community to develop more skills and even more practices of taking responsibility for what goes on in this community" (Int. I, 6-7)

A word of caution was noted in how this process should be supported. Community development is:

"Not doing stuff for the community which they could do for themselves". (Int. 2, 8)

The process should involve:

"Creating democratic independence, taking away from the marginalisation of a community to a more independent community and watching and keeping an eye on the external service providers creating a sense of dependency yet again." (Int 2, 8)

There was acknowledgement of the need to support and encourage a growth from within the community, without assuming the direction:

"Nourishing something helping something to grow but only assisting. The growth happens within the area so any development should be organised from the inside, should be fertilised by the inside and outside but not necessarily grown by a yardstick from outside agencies" (Int. 2, 9)

This sentiment was echoed by another team member, who also expressed the inherent role of reflection, in community development:

"Reflecting on whether it's working, if it's not why it's not. Asking the question why it's happening in the first place, as opposed to just responding to the problem, saying why are things the way they are, who's accountable, who's responsible instead of just treating the symptom, you're looking at root causes and challenging them. Reflection would be very significant before the action and when you're done reflecting again. Again it's a bit cliched but it's cliched because it makes sense. Action Reflection Action." (Int. 3, 5)

"Placing the problem in context, looking at historical backgrounds, or Just looking at the bigger picture and future planning, where is this going to lead us and how are we going to get there. So instead of just dealing with the situation in the here and now in the present, to look at where you can move people on to. Being open to being wrong. Asking all those questions, not assuming that you have the answer. If you assume that you have the answer then you're not doing community development, are you?" (Int. 3, 5-6)

It is seen as necessary to reflect on the current situation; the factors contributing to it from both within and outside the community, and possible strategies, methods and outcomes. Other principles were identified as being involved in community development.

"Communication, and a lot of information about what resources are available. Access to training and education which may mean money or it may mean courses. It means having places to meet like a community centre. Interagency co-operation, for instance, Health Board and the community collaborating to set up a treatment programme or any other service." (Int. 1, 8-9).

Community development was interpreted as adopting a humanistic approach to working with a community.

"I always see a very strong link between development and person centred approach, humanism. I think there's huge similarities in respecting the individual or the group as having the skills and resources to work through their own issues. So I'd see community development as encouraging and assisting people in groups to do that. Being a very practical tool in assessing what the problem is first, as you would do it in counselling and trying to come up with creative responses that tap into the person's resources to respond to whatever needs have been identified." (Int. 3, 4-5)

Community development was acknowledged as being more directive in certain instances.

One member made a distinction between partnership and participatory models of interagency collaboration, preferring participation as an objective:

"Participation is active, partnership is more passive. Partnership is representation, participation is active engagement." (Int. 2, 9)

4.3   Community development as a tool for drug development in DAP

Community development was seen as an effective tool for drug prevention:

"Because in that public health triangle of the user the drug and the environment, I think all three interact. Now the community development model gives people the power to act individually and to act on their environment, and to act on the drugs: whether to use them or not. So think that the community development model increases peoples ability to make choices about drugs and about other things." (Int. 1, 11)

"I do think it certainly has it's place in terms of working in communities that have been damaged or have a history of addiction over a long number of years. I think it is the most effective strategy, harnessing the skills and the passion and the anger, all the emotional stuff, that people have, harnessing some of that energy can be very, very effective and the only way to do that is by listening to what people have to say, reflecting, assessing what their needs are." (Int. 3, 9-10).

There was reference to the methodology of community development as defined by the DAP.

"It's taken us quite a while to decide our own definition of Community Development, coming up with 'the road'[2] and stuff like that. There was a lot of struggle and banter around that. It's murky, vague and sticky like chewing gum getting through it. It can be very difficult to define and it can be difficult to work in." (Int. 3, 13)

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[2] The Road' (See Appendix 3) is a pictorial representation of the procedure which evolved as the mechanism which DAP used in it's 'Community Leadership Programme'.

Another team member when asked 'Is Community Development a means of drug prevention, responded:

"Obviously, I do, I think it's very important, I think it's essential.' (Int. 2, 11)

Community development was seen as one of many tools that the DAP employs in it's work in the sphere of drug prevention.

"It can be a very powerful way of working but not the one and only and it won't work everywhere. It has it's slot." (Int. 3, 10)

"I think there are certain areas of drug prevention work that need to be maybe a little more focussed, " (Int. 3, 9)

"I don't think it's an exclusive modus operand for the DAP in certain communities" (Int. 2, 10)

There was reference to the evolving nature of the work of the DAP:

"I don't think that's the sum total of our work. We're an agency, by that I mean we're not static, and we don't stay in one community. So I think we're an agency which means moving forward. That's exactly what we do and we do it well. It would be disingenuous for us to believe that we're exclusively community development. (Int. 2, 10)

It was stated that the ethos of the DAP fits well with the ethos of community development.

"It certainly is working in an ethos that fits in with that package because there would be other models of working that would sort of, counteract that package. Like a very didactic sort of approach. So we're certainly working to a model that allows community development to happen." (Int. 1, 9).

This ethos parallels the principles mentioned earlier with reference to community development. The understanding is that the communities require certain supports and certain interventions, but the aim is self-sufficiency.

"We are helping people to prevent or avoid the problems that drugs can cause and if they're already involved in drugs or in drug problems to reduce or eliminate those problems. Teaching people the skills that are needed but always understanding that they themselves can use those skills, they have to make their own decisions about the way they use those skills." (Int. 1, 4-5)

Sustainable outcomes, however, do not require a consistent presence in the community on the part of the DAP team members.

"I think more and more we're learning by default and I think through that default is a learning process for everyone in the team. We can have a relationship and it can be sustainable and yet doesn't mean that we have to spend 50 sessions in a community. Sustainability can occur once you deliver a good programme and have support services in place if something goes wrong." (Int. 2, 5).

The work of DAP involves training communities to work within their area, schools, etc. to provide drug prevention programmes and interventions. An example is provided:

"In (-) where we are teaching and facilitating a group to do drug prevention in their own area. Now that means first of all that they have to learn the difference between drug education and drug prevention, because some of the groups would have started off with the idea that if we teach people the dangers of drugs they can pass that on to their children and the children won't use drugs, but research shows that it does not work. We teach them what may have a chance of working, which is helping people to look at their own attitudes, to understand that the relationships that you have with children is more important than the information you pass onto them, to take care of their own lives which is role modelling health promotion So we do these things for a group. We hope that group will then do the same for others and that they will do the same for their own families, in a snowball sort of way." (Int. 1, 5-6)

Another aspect of the ethos of the DAP was cited as not a top down approach but in response to needs:

"DAP is a multifaceted organisation. We're not single issue based. The drug element at times is secondary to the development of the group and the programmes we deliver. What we do is to try and move people from one situation to another, not top-down but in response to their needs. I think we're quite good at that, and also to educate them, whether it be upskilling, exploring attitudes, prejudices or giving them basic facts which would inform their own views on how they live, on drugs, personal use of drugs, drugs in their family, dependency in the community and the like." (Int. 2, 4)

The needs assessment and reflection-action-reflection response is echoed in other examples of the work of the DAP:

"I think we do a lot of reflecting. I think we think about what we do before we do it. We're open to changing based on the needs of the group or the community. I guess, prime example , because it's one of the most interesting things I'm working on now, and it's freshest would be the (-) in that a pretty thorough needs assessment was done both meeting the staff and meeting the participants to find out what they wanted and then at the first meeting presenting back to them what we had heard or what we had picked up in the needs assessment, breaking it into themes and throwing it back open to them to see did it meet their needs was there a mismatch or was there anything left out. Reflecting after every session with the participants and with staff. Planning week by week and reflecting week by week. And putting it into the bigger picture context culturally where they're coming from, they've been using maybe 15 years so being aware of all that

Being aware of the historical background of the centre, that they're not getting any other drug inputs. There isn't staff there trained to deal with drugs. Putting it into a context and operating out of that then." (Int. 3, 6-9).

There are different goals in the work of DAP depending on the group/community the team engages with. Goals are not easily identified at the beginning, but sometimes emerge through the work.

"I would measure effectiveness as when you round up a gang of people who have a passion and an interest and want to do something, do the training and go on to provide a service that's responding to the needs that they have identified maybe 15 years ago. So I'd say we're quite effective at that end of things.

Not necessarily seeing them as providing the service and getting loads of funding as the goals but it is one way of assessing the effectiveness and I think we've managed to do that with a large number of our groups who, before our inputs or training their only tool as they came into it was a bit of a passion for doing something in their area." (Int. 3, 11-12).

There was an indication that the DAP is limited in it's capabilities in the sphere of a community development approach.:

"I don't think DAP comprehensively works in that way. It tends to provide the training and the courses and to hope that some of the other elements are in place. It's only providing one or two of those elements and it's not proactively providing the whole package and even it's not proactively ensuring that the whole package is there. It's sort of hoping." (Int. 1, 9)

"We work with groups from communities but we're not doing much in a direct way to change the structures or the understandings of those communities. We are doing a lot indirectly because when you help a group like HOPE to skill themselves to empower themselves obviously that feeds back into the community. I think a little agency like ourselves is too small to really take on that environment or context change of a community, but in collaboration with others we could do it." (Int. 1, 4-5).

In some areas, the work of the DAP was seen as supporting the existing growth, empowerment and development of the communities/groups. Examples of this were given:

"With the (-) group again training would be hopeless if that group weren't linked into the school and the residents association and a few other groups. The (-) group is working on a community sort of a model, because again that group is trying to link it with the schools and the residents. (Int. 1, 9-10).

However, the DAP was seen as effective in enabling communities to be self-sufficient.

"What it is effective in is in enabling communities to do things for themselves and the groups that we have trained are able to function after training and to do the things that they set out to do". (Int. 1, 12)

The development of links with internal and external groups and agencies is thus identified as an important element in community development. An awareness of, and engagement with the context and the bigger picture and potentially political action. DAP is seen as having a role in supporting this. One respondent comments that DAP provides:

"Educational training and support to individuals and groups to work around the drug issue. Training and Education being the priority. I think the way in which we do that is quite supportive. I think the counselling is a support too. The other thing would be and I'm getting a little more political is helping individuals on groups to challenge, to have a voice, to challenge to say what's needed in their area and to challenge what's ineffective. We're getting a little bit more political. We've a role in that too, moving things politically on." (Int. 3. 3-4)

The awareness of politics and opportunities which can be availed of, is affirmed as vital for the empowerment of the community:

"For instance, I think in (-) communication helped the community to develop more power The community's power that has grown by having all the different groups there. The communities own power has grown by having people in the community who know how to access funding, how to access jobs, how to educate parents. The community is growing in power all of the time....it reduces their feelings of helplessness and enables them to do something about an unwanted thing, say people making noise, people stealing cars. If a community finds ways to deal wit the undesirable thing in the community then that's empowering." (Int. 1, 7)

The DAP was perceived as having a unique position, which created opportunities for employing community development methodologies.

"I think we are successful in using that methodology amongst others, why?. Because I think we have the insight, a unique overview of the situation in Dublin in different communities. We're not tunnel-visioned by geographical location that often works as a disadvantage when it comes to funding, but I think it's a good vantage point from which to view development work around Dublin communities" (Int. 2, 12)

It was acknowledged that the DAP has encountered difficulties at times. Certain initiatives were seen as falling short of the goal post and the reason for this was stated to be a lack of adherence to the needs, an ineffective needs assessment, or an overenthusiastic response- acting before the action was required:

"It was our first outing in doing community development stuff. There would have been a certain thing that they said, they wanted us to do and we didn't do enough teasing out and getting them to prioritise. They just said that they wanted a parents course and we did it,

it fizzled so sometimes you can get caught up in that. In community development it's not enough for people to identify it. You have to look at the logistics of the practical issues. Are there resources available? Is there stuff there to tap into and make it happen. Instead of thinking that everything's do-able". (Int. 3, 12-13)

Another example was provided:

"I mean (-) wasn't true to community development and we weren't successful. We went into an area where we weren't asked and we set up courses that hadn't been identified as one that needed to be done. (-) is a good case in hand. We went in and we decided to do adult education courses when the passion and the energy was tied up with getting a treatment clinic, so we were way off the mark. We didn't do a needs assessment. We did but just with the people working in the area as opposed to the people themselves" (Int. 3, 12).

There was an acceptance that the term community development is not static and is interpreted in a variety of ways:

"I think there is a vagueness that exists in different community development style approaches which is both it's strength but also at times can be its downfall because it's too vague. There is a need in the field for people to be able to get quite specific services like 6 week programmes or things that are a little bit more structured and more formal. My idea of community development is a little more informal and unstructured." (Int. 3, 9)

Another limitation of the community development approach is linked to this vagueness in the concept. One respondent stated that the lack of clarity on boundaries can lead to a sense of being overwhelmed on the part of the community person or group.

"One of the things about community development is that it can be overwhelming for the people who choose to take it on because they are surviving on passion and commitment and sometimes that's based on seeing problems so huge that you have to do something about it. So it can be quite overwhelming. You have to have objective perspectives what resources do we have what's practical to do. Prioritise the need and being realistic in what's achievable." (Int. 3, 13).

This led to identifying another stumbling block in the process namely practical elements such as funding, resources and time.

"There just isn't the time or resources to do that: do community development type work and all around the place." (Int. 3, 10).

The team was aware of the principles involved in community development and agreed that the ethos of DAP 'tallys' with the ethos of community development.

"We adhere to the principles we believe are good practice and these tally when we do look at academic research on the principle of good practice. I think it's based on our

ideology and philosophy of community development. We've a healthy respect, a healthy relationship, by that I mean we don't have a typical salvation crusading mentality to our work which a lot of community organisations often are guilty of. I think we know when to stop and when to go forward and when to help." (Int. 2, 12)

However there appeared to be a lack of awareness of research findings in the area of community development approaches to drug prevention:

"So I can not speak from a statistical point of view to say whether communities which have had more community development are less likely to use drugs in a harmful, problem way, I don't really know but I imagine they are, I hope they are." (Int. 1, 11).

5:   Critique:

The DAP's understanding of prevention covers a broad range of areas in demand reduction, focussing on the individual and the wider community.

Howard (1994) states that there is now a much wider perspective about what constitutes prevention and harm minimisation. This embraces concerns about drug users and those at risk of using but also goes beyond these to a wider concerns about the well being of the local community:

> "Prevention must be about more than simply information for individuals.….today's local drug misuse forums do not embrace the wider concerns of the local community. They have not achieved a balance between developing specialist services, prevention through education, promoting community safety and ensuring that mainstream services become more responsive to drug misuse issues"

> (Howard, 1994 p. 15)

He argues that tackling drug misuse at a community level relies on shifts in the policies and practices of public bodies. A new framework needs to be established within which a broad based response to tackling drug misuse can flourish based on a partnership between different agencies and acknowledgement of shared responsibility between the shareholders whether public bodies, specialist services or community organisations. The Combat Poverty Agency supports this view.

> "Strategies which consult and actively encourage the involvement of local people are most likely to lead to a reduction in the demand for drugs.., . Local groups and individuals have very valuable contribution to make to the development of national policy and can bring to the table a depth of local experience.. some of those local groups have been involved in tackling the drugs problem in their respective areas over a number of years and, during that time, have built up a considerable valuable experience which should be tapped as a resource."

> (Combat Poverty Agency, 1996).

The DAP, Crosscare, operates within this framework, consulting and actively encouraging the involvement of local people. There are however a range of ways in which the community can be involved in strategies for drug prevention.

Rhodes and Stimson (1994) provide a diagrammatical interpretation in Figure 4, below, of various levels of community involvement.

Figure 4: **Levels of community involvement:**

(Adapted from Rhodes and Stimson 1994 P.10)

This provides a differentiation between strategies occurring within the community and those involving an external advocacy or participation in the more political sphere. A differentiation between education and advocacy.

Rhodes and Stimson (1994) define community development as involving collaboration between agents of change from outside the community and the affected communities themselves. It encourages self organisation and mutual assistance within groups of like minded people. (Beattie 1991).

Brown (1991) defines community action as the deliberate organisation of community to accomplish some objective or goal. There are particular goals e.g. less needle sharing and a broader goal i.e. "communities having their own power and control of their own initiatives and activities " (Ashton 1988).

'Community Organisation' attempts to form temporary or permanent organisational structures involving members of a community. The aim is collective ownership and control over health related choices and activities. Community organising may also engage with forces outside the community to seek socio-political changes in health policy and material conditions (Rhodes and Stimson 1994).

Advocacy involves health action of communities and governments which have some control over the resources which influence health" (Nutbeam, 1986).

The DAP provides comprehensive training and education with a view to both community change and community empowerment. We support advocacy, yet it would not be our primary focus. The outcome of community change and community empowerment. We support advocacy yet it would not be our primary focus. The outcome of community change in terms of health promoting norms and behaviours is a goal, as is the goal of community empowerment in terms of the community having control over their health issues and drug issues.

DAP is aware however of it's limitations in terms of staff numbers, resources, funding and time. The focus of the work is in education training and support. This remit is flexible enough to meet the need of the groups an communities it engages with, yet is constricting also. There was not a sense that the DAP had a definitive role in what Rhodes and Stimson define as advocacy yet we do have a role in supporting it's inception, i.e. encouraging a community to challenge and to have a voice in the political domain.

Stimson and Rhodes (1994) examine the limitations of focussing purely on the individual or purely on the community. This is exemplified in Figure 5. Below:

Figure 5: Individual and Community Interventions:
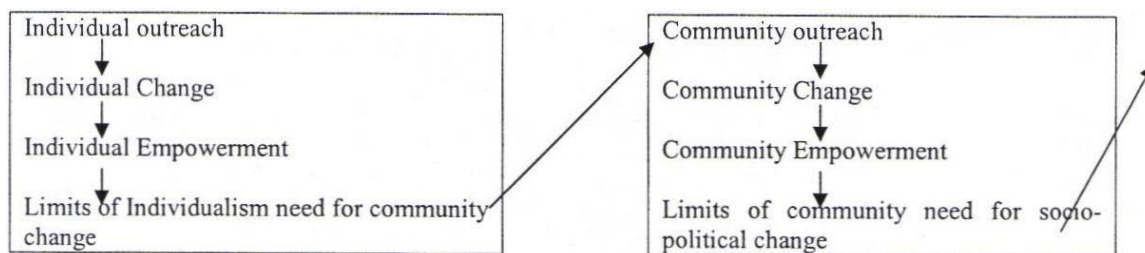
(Adapted from: Rhodes + Stimson G., 1994, P.9)

Although each has it's place there must be clarity in positioning the focus in a broader context. An agency such as DAP provides both individual and community level support initiatives and programmes and movements in the area of socio-political focus, yet would be over stretching our limited resources by entering into that arena in a concerted fashion.

Difficulties arise when projects and initiatives isolate themselves from the broader picture. McCann (1999) notes:

> "The community workers Co-op has been to the fore in campaigning for effective local government in Ireland. However very few drug workers are members of this organisation, certainly no counsellors' are. They have built their own organisation (IAAAC) Irish association of Alcohol and Addiction Counsellors, and neither seem to have made attempts to interact with the other around working effectively to promote change."
>
> (McCann 1999).

Cullen's (1990) case study of drug problems in the St. Theresa's Gardens area of south inner city Dublin trace the emergence of concerned parents against Drugs (CPAD), a social .movement which grew from local residents sense of threat from drug use in their neighbourhood but which had the potential to demand and perhaps achieve change on a much wider social and economic scale. Ultimately Cullen concludes that CPAD failed to

realise it's own potential through it's own failure to develop an explicit political analysis which could keep it in track, and avoid the internal conflicts and external pressures to which it eventually succumbed.

Burke (1994) notes that the community response movement in the south inner city did not evolve as a spontaneous grassroots reaction to the problem a did CPAD, yet it may prove more effective she states, if it sustains the theoretical base to it's activities which it has worked to set in place. The constitution of this group includes as an objective: to promote a partnership of statutory, voluntary and community interests concerned with the issues of problem drug use, drug related HIV and AIDs, drug-related crime, environmental educational and other social conditions that perpetuate problem drug use in the target area.

Howard (1994) advocates establishing Drug Misuse Community Partnerships at local level to:

−   Monitor and provide info. or drug misuse.
−   Assess the needs of drug misusers and the wider communities.
−   Develop strategies to prevent drug misuse and to reduce the availability of illicit drugs.
−   Enable and empower individuals and communities too address risks and problems associated with drug use.
−   Develop programmes for commissioning specialist services and prevention initiatives involving the wider community.

However he notes a fundamental problem in attempts to co-ordinate nationally and locally:

> "The problem that national and local co-ordinating efforts shape is that tackling drug misuse does not fit easily into the institutions created for the administration of nineteenth and twentieth century social policy. Not only do enhanced efforts have to be made to bring about good collaborations but we have to set new agendas for collaboration to address"
>
> (Howard, 1994, p. 15).

The DAP, Crosscare is aware of the difficulties in this arena, and has seen the drugs issue carved up into task force areas in an effort to improve co-ordination and collaboration. Unfortunately this creates problems as well as solving other ones. The prioritising of areas according to numbers in a geographical area presenting for treatment has segregated those areas from each other to a large extent. Drug workers engaging in prevention work, for example, in one task force area may be quite unaware of initiatives being developed in another area in their field, yet they would have a good insight into the treatment an support initiatives in their own task force potentially.

Intersectoral collaboration is evident in some areas, some of the time. Quite often the presence of certain statutory bodies is no longer expected in these task force structures.

These local drug task forces are intended to work in consultation with representatives of local community group, thereby permitting members of the communities to have an impact on policy at a local level. However, Cullen (1997) argues that the task forces are being set up in an overall co-ordinating structure that is addressed up as containing community sector representation and a sharing executive functions, however the reality is much different. He further argues that, in the absence of a coherent policy and planning, the new focus on community could become "an attempt to shift all the responsibility onto the same communities, with professionals and administrators remaining aloof but retaining overall power control"

Although it is debatable whether the local drugs task forces established by the government gives any real power to the local communities - community involvement in decision making is vital. Such involvement has the ability to promote substantial long-' term changes in policy making (Cox and Lawless, 1998).

The DAP, Crosscare supports community participation in inter-sectoral structures but differentiates between an active participation and a passive partnership approach.

Participation as defined by Rifkin, Muller and Bicchmann (1988) has essential elements.
−   Participation must be active, mere receiving o services dos not constitute participation.
−   Participation involves choice.
−   Choice must have the possibility of being effective.

The World Health Organisation confirmed the rights of individuals and groups in this sphere.

"The people have the right and duty to participate individually and collectively on the planning and implementation of their health care".

(WHO, 1978, Article IV.)

McCann (1999) describes the role of the community in planning and implementing their health care regarding drug related issues:

"A central, fundamental role is outlined for communities through the identification of need and decisions taken to meet those needs and the planning and implementation of responses"
(McCann, 1999, p.53).

This encapsulates the approach which DAP Crosscare advocates and employs.

"It is a useful framework for considering the issues involved in moving drug services from a centralised medical model to one based on comprehensive community care"
(McCann, 1999.p.53)

Within current Irish Structures though a community development approach to Drug privation is impeded at the outset. However, through identifying such impediments,

strategies can be developed to minimise their effects or to support the emergence of new methodologies and truly participating structures.

Cox and Lawless (1998) state that it is clear that the 'drug problem' is highly localised and disproportionately effects certain communities. These communities tend to demonstrate the presence of indices of social depravation. Their low levels of participation in the political process of decision making, can result in such communities expressing their concerns through 'community action' rather than through formal political structures.

They maintain that in order to assist these communities in contributing to social change and to prevent further marginalisation, community groups need to be presented with an analysis of the causes of social problems, and based on their detailed local knowledge of their communities, the skill and resources needed to implement changes. The provision of such training, at it's most basic level enables the inclusion of all community members on influencing policy at local level.

The Merchants Quay training programme which forms the basis of Cox's study (1998) study focusses on:
−   knowledge of drug use and related issues within their community;
−   skills necessary for them to be a resource within their own community;
−   attitudes towards drug users, in terms of increased tolerance and acceptance.

This approach recognises the willingness of communities to address the drug issue and their vested interest in doing so. Providing educational and training of this type (as does DAP) encourages accepting responsibility and authority in determining the future for a certain community in terms of drugs and related issues.

Education of this sort must be made relevant to the lives of the people who live within the community (Ashcroft, and Jackson, 1974). As adult residents of communities are the most able and vocal contributors to community action, adult education of particular relevance.

DAP provides both youth and adult programmes, however community development methodologies are predominantly best mediated through adult groups.

Cox and Lawless (1998) delineated a difference between adult education and forma education in that adult education has the flexibility which allows the individualisation of the educational intervention. It offers a practical rather than abstract approach to learning. Characteristics include, being learner centred, using local resources, having community orientated content, horizontal relationships between facilitator and learner, immediate time focus and age inclusiveness (Hamilton, 1992).

The DAP reflects these characteristics, as identified earlier: person/group centred, inclusive and contextually appropriate, etc. This educational approach is not blinkered off from the context.

Although self reliance is the hallmark of non formal or adult education it nonetheless encourages assistance from sources external to those which exist within the community (Cox and Lawless, 1998).

This approach is identified as community education:

This is a planned and organised attempt to help people develop the attitudes, skills and knowledge they need to help develop the attitudes, skills and knowledge they need in order to solve the problems of their community. Community education is also concerned with the process of empowering people to take control of their own lives and to participate fully in the local community in which they live (Kelleher and Whelan, 1992).

It acknowledges the educational validity of learning by doing and the relevance of lived experiences in developing awareness and raising consciousness. It is learner centred and aims to promote participation of community members in programme design and implementation. As such it differs from structural taught courses which characterise other forms of adult education (Hamilton, 1992). In the true community based adult education model, control is in the hand of community residents.

The DAP could be said to employ a community service approach to community development, and use community education as a methodology.

A number of limitations of the training were explored by Cox and Lawless (1998).

"However the merchants quay project recognises that training per se in universal panacea for social problems, such as the rug issue. Firstly governments need to be willing to identify and address the root causes of such problems. Secondly, as regards training, its effectiveness depends on the willingness of community members to engage in the learning process, to challenge their perceptions, views and attitudes, and ultimately to change their behaviour accordingly. Furthermore, informing an individual is not the same as informing a community. Ideally, training programmes should be taken into each community. Such an approach would permit a training programme to be designed specifically for the needs for the specific community in question" (Cox and Lawless, 1998, p.6)

DAP would concur with these views, and has encouraged difficulties in providing training at times that has not fully engaged a community. The DAP has found that the team's willingness and flexibility in siting training in the community overcomes many barriers and makes the training far more accessible for the target group/community.

"If community-based projects are serious about facilitating the process of 'empowerment', then it is imperative that local residents possess the knowledge, skills, opportunities, resources and authority necessary for meaningful participation".

(Hyndman and Giesbrecht, 1993, p. 1616)

6:   Conclusion:

In conclusion, the efficacy of community development as a means of drug prevention is evident. There is however a dearth of conclusive evaluative research in this area. Furthermore agencies and groups working in this area and through this methodology are limited in terms of resources and capabilities. A lack of true collaboration between organisations and between sectors has led to difficulties, and will require enormous work in terms of structural and attitudinal change in order to rectify this situation.

The work of the DAP in particular has been shown to have sustained positive outcomes in areas where principles of community development have adhered to, and readily accepts that problems can arise when comers are cut due financial, or time limitations.

Community education is an essential component in community development, but must focus on the individual and the wider community and socio-political context to prove effective.

The area of drug prevention through community development is literally erupting at this time. New community based groups and initiatives are emerging with astonishing rapidity. This growth must be harnessed, however, and grounded in current theoretical and practical understandings of best practice. Innovation must not be stifled, merely guided away from reinventing wheels which don't turn, and which are known not to turn.

We must all take responsibility for evaluating our work, and for disseminating information or models of best practice (and highlighting the ineffectiveness of 'models of worst practice'). Misinformation about drugs and risk practices is a dangerous thing. But we must also realise the danger of perpetuating (and finding) models of drug prevention which have no effect, or worse still, can reinforce or promote interest in drugs and drug use.

It must acknowledged that there have been huge advances in drug prevention methodologies and that effective community based drug prevention quite often relies on the voluntary community worker, unpaid and under appreciated. I hope that statutory support in terms of funding and resources (such as the Task Force funding and the youth development Fund) will endure and increase, enabling the establishment of and security of employment for those with the passion and commitment to engage in prevention work and training, and also a sense of stability in service, project and programme provision.

Finally, I would concur with McCann(1999) in her definition of community development, which sees the community as the unit of action; identifies community initiative and leadership as resources; recommends the use of both internal and external resources and is concerned with both process and outcomes(services). I would agree that while we allow communities to be defined as merely a resource or a setting, we are limiting their potential, and the potential of our society as a whole.

APPENDIX 1: Instructions given during unstructured interview

♦ Thank you for agreeing to participate in this study.

♦ This thesis is about community development and drug prevention. It is a reflection on these concepts and the methodologies involved.

♦ I have my own perspective and thoughts on this area, but I would not like this to colour your perspective. I hope and I know that you won't be influenced by what you think that I want to hear.

♦ Be honest in your responses.

♦ The responses you give will be treated in confidence. The final draft will not make specific reference to who said what. I will give you a draft copy of any quotes I will be taking from your input and if you are not satisfied with anything we can amend it at that stage.

♦ I will be recording the interview and taking notes during it to help me to remember your responses.

♦ Finally, if something comes up at a later stage which you would like to add to your responses, you could write it down and I could include it in your interview responses.

APPENDIX 2: Guide questions for unstructured interview

1.   What is your understanding of drug prevention?

2.   What is to be prevented?

3.   How does your work/ DAP, Crosscare's work involve drug prevention?

4.   How would you define:
                the work of DAP
                community
                DAP's relationship and role with any particular community

5.   What is your understanding of community development?

6.   What principles are involved in con-immunity development?

7.   Do you think that DAP adheres to the principles that you have listed? If so, can you give examples?

8.   Do you see community development as a means of drug prevention? If so, why/ If not, why not?

9.   How effective is DAP's work in the community development sphere? Why?

10.   Any other comments/ thoughts?

<u>Appendix 3: The Road</u>

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