

COMMUNITY AND DRUGS:

*A DISCUSSION OF THE CONTEXTS AND
CONSEQUENCES OF COMMUNITY DRUG PROBLEMS
IN IRELAND, 1976-2001*

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ADDICTION RESEARCH CENTRE, TRINITY COLLEGE

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CONTENTS

INTRODUCTION.....	5
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SECTION 1

THE CHANGING PATTERNS AND EFFECTS OF DRUG PROBLEMS IN IRELAND.....	7
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<i>Community context of drug problems</i>	8
<i>Health and social effects</i>	10
<i>Impact of drug problems on families</i>	14
<i>The local impact of drugs and crime</i>	17
<i>Conclusion</i>	20

SECTION 2

EXPLAINING COMMUNITY DRUG PROBLEMS.....	21
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<i>Underclass communities</i>	21
<i>Structural issues</i>	22
<i>Social disorganisation</i>	23
<i>Conclusion</i>	25

SECTION 3

RESPONDING TO COMMUNITY DRUG PROBLEMS	26
---	----

<i>Community mobilisation and anti-drug movements</i>	27
<i>Community and voluntary bodies and emergence of cross community networks</i>	28
<i>Public health demands for community-based treatment</i>	30
<i>Developing a community partnership approach</i>	32
<i>Conclusion</i>	35

SECTION 4

DISCUSSION AND ISSUES FOR RESEARCH AND FURTHER CONSIDERATION.....	45
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ADDICTION RESEARCH CENTRE, TRINITY COLLEGE DUBLIN

The aim of the Addiction Research Centre, which was established in 2000, is to provide a source for independent debate and critical research into the prevention and treatment of drug and alcohol related problems in Ireland. The Centre is sponsored by the Department of Social Studies, which has been centrally involved in drug and alcohol issues through the Diploma in Addiction Studies, a one-year multi-disciplinary course that has run annually since 1984 and the M.Sc. in Drug and Alcohol Policy, a post-graduate course specifically aimed at policy makers and administrators that was established in 1998. The Centre has three specific objectives as follows:

1. *Academic research*: To undertake and support academic research aimed at contributing to society's knowledge of drug, alcohol and addiction problems.
2. *Policy and practice evaluation*: To undertake commissioned evaluation of drug and alcohol prevention, treatment, and rehabilitation services and policies.
3. *Research and policy interface*: To organise an annual conference, bringing together practice, research and policy personnel from universities and other bodies to engage in public debate on drug, alcohol and addiction issues.

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INTRODUCTION

To most observers and commentators drug-taking is primarily a psychological act: based upon individual motivation and with individual effects and consequences. In particular, drug-taking is associated with specific individual health and legal risks. However, drug-taking is also a public act that is inextricably linked to multiple social contexts: it has variable patterns across time and places as indeed does drug policy¹. Indeed, the psychology of individual drug use might, in many respects, be considered a function of its social contexts. In the US for example, which has experienced successive, separate waves of cannabis, heroin and cocaine misuse, contemporary drug policy – reflecting current social values and priorities – unconditionally emphasises law enforcement, punishment and zero tolerance. But, historically it has also experienced alternate periods that have focused on treatment and prevention and differentiating drugs on the basis of evident dangers². Variable drug policies have helped to shape different and often contrasting patterns of use. In the wider international field such variations in social context and policy are even more evident.

This paper is primarily concerned, not only with individual effects but with social context and consequences. It is particularly concerned with community context: with exploring both proximal and distal neighbourhood influences and effects. The paper reviews the consequences of *community drug problems* in Ireland during the last twenty-five years and considers issues of current concern. The reason for this particular focus is that irrefutable evidence suggests that serious drug problems over this period have been spatially concentrated in certain *urban* neighbourhoods in the capital, Dublin. Furthermore, through the designation of 14 urban neighbourhoods for local drugs task forces current policy on drugs in Ireland has a decidedly area-based orientation³, reflecting the importance of community development, public health and social exclusion perspectives⁴, thus emphasising that in certain social circumstances the drug problem is perceived, fundamentally as a community problem. The ways in which these perspectives have emerged to influence policy over the last two decades, provide an important framework for understanding drug problems and their neighbourhood effects.

The research and other literature available on this experience of community drug problems are assessed in this paper. Apart from a small number of local studies, there is, unfortunately, a serious dearth of Irish-based research of the type that allows for a

¹ Zinberg, N. (1984) *Drug, Set, and Setting: the basis for controlled intoxicant use*, London: Yale University Press.

² Harrell, A. (1996) “Drug Abuser” in G. Galster (Ed.) *Reality and Research: Social Science and US Urban Policy Since 1960*, Aldershot: Avebury in association with Urban Institute Press.

³ Department of Tourism, Sport and Recreation (2001) *Building on Experience: National Drugs Strategy 2001-2008*, Dublin: Stationery Office.

⁴ Loughran, H. (1999) “Drug policy in the 1990s”, in S. Quin, P. Kennedy, A. O’Donnell, G. Kiely, *Contemporary Irish Social Policy*, Dublin: University College Dublin Press

comprehensive examination of community context⁵. There is a treatment-based literature, which provides estimates of prevalence, distribution and health and social effects. Also a few studies have examined figures and profiles of drug users who are drawn into the criminal justice system. Overall, however, there is an absence of published studies that would allow an extensive critique of community contexts comparable, for example, to the review, *Drug Misuse and the Environment*, undertaken in the UK in 1998, by the Advisory Council on the Misuse of Drugs⁶.

Although there is a limited pool of published Irish research, there is a fairly extensive “grey literature” incorporating community profiles, conference reports, consultation documents, case studies and policy discussions. There are also a variety of reports on relevant issues with direct impact on communities who are worst-affected by drug problems. Together this literature provides insights into the socio-economic contexts and consequences of drug problems, the development of local community models of response and the increasing role of community-state partnerships in supporting inter-sectoral, collaborative interventions at local levels. However, the overall weight of this grey literature needs qualification, given both the general absence of methodological rigour and the fact that much of this literature originates from stakeholders with committed views as to the origins, effects and consequences of drug problems.

The starting point of this paper is to assess the changing patterns of drug problems in Ireland over the last 25 years and in this regard it reviews the prevalence of drug use and drug problems at both national and local levels and examines the available literature on health and social effects, family effects and drug-crime links in local communities. The paper then explores explanations for community problems, focusing especially on the processes whereby concentrated drug use has become associated with concentrated poverty. This is followed by a discussion of responses to drug problems with particular reference to linking past and current policy positions, the emergence of community anti-drug groups and the development of networks for linking local responses and linking these together with government policy on social exclusion. Key tension points in relation to an emerging community policy are discussed, including the development of community-based forms of treatment, the experience of community drug teams and the emergence of new partnership structures. Finally, the paper concludes with a discussion of the changing contexts of communities and the implications of this for drug policy and responses to drug problems.

⁵ Mayock, P., Moran, R. (2001) “Social issues and public attitudes associated with drug misuse” in Moran, R., O’Brien, M., Dillon, L., Farrell, E., Mayock, P. (2001) *Overview of Drug Issues in Ireland, 2000*, Dublin: Health Research Board.

⁶ Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*, London: The Stationery Office.

SECTION 1 -

THE CHANGING PATTERNS AND EFFECTS OF DRUG PROBLEMS IN IRELAND

Prior to the late 1970s there was little indication of an emerging opiate problem in Ireland, although a significant increase in recreational drug use was evident⁷. As is clear from the work of the National Drug Advisory and Treatment Centre, a relatively small number of persons did, during the early to mid 1970s, attend for the treatment of drug problems, usually resulting from their use of cannabis, hallucinogens, amphetamines and barbiturates with little use of opiates reported⁸. At the time these problems were perceived within the context of middle-class, student and youth disaffection associated with the era, and the few new services founded as a response were located within the overall framework of individually-oriented psychiatric services⁹. At a policy level the problem generated little other than occasional concern¹⁰.

The situation has changed considerably since. Recreational drug misuse is now more commonplace throughout Irish society, although as with problem drug-use, the research literature on this topic is sparse. Two national surveys conducted in 1998 (one on lifestyles¹¹ and the other on drug related knowledge, attitudes and beliefs¹²) and a 1995 regional survey on tobacco, alcohol and drug use¹³ report lifetime cannabis prevalence rates of between 14-17%. Also a national school-based survey highlights that the use of cannabis by 16 year old school children is twice as common as the average of 30 participating European countries, while the use of illicit drugs other than cannabis is slightly above average¹⁴. Currently Ireland is among three EU countries (the others are France and UK) where recent use of cannabis is reported as higher than 15 % among young adults (recent use is defined as use within the last 12 months)¹⁵.

The position in relation to serious drug problems has perhaps showed greatest transformation. It is generally accepted that the period 1977-9 showed significant

⁷ *Report of the Working Party on Drug Abuse, (1971)* Dublin: Stationery Office.

⁸ Law, B. (1972) *Developments in the Irish Drug Scene*, National Drug Advisory and Treatment centre (unpublished).

⁹ Harty, T. (1975) "Services for Drug Users" in *Contacts, Journal of the Eastern Health Board*, vol. 1, no. 2

¹⁰ Butler, S. (1991) "Drug problems and drug policies in Ireland: A quarter of a century reviewed." *Administration*, 39 (3), 210-233.

¹¹ Friel, S., Kelleher, C. (1999) *Report of Irish Adult Use of Illegal Substances*, Unpublished report, Health Promotion Unit, Department of Health and Children, Dublin and Centre for Health Promotion Studies, National University of Ireland, Galway.

¹² Bryan, A., Moran, R., Farrell, E., O'Brien, M. (2000) *Drug-Related Knowledge, Attitudes and Beliefs in Ireland, Report of a nation-wide survey*, Dublin: The Health Research Board.

¹³ Jackson, T. (1997) *Smoking, Alcohol and Drug Use in Cork and Kerry*, Cork: Southern Health Board.

¹⁴ Hibell, B., Andersson, B., Ahlstrom, S., Balakereva, O., Bjarnasson, T., Kokkevi, A., Morgan, M. (2000) *The 1999 ESPAD Report: The European School Survey Report on Alcohol and Other Drugs in 30 European Countries*, Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN)

¹⁵ EMCDDA (2002) *Annual Report on the State of the Drug Problem in the European Union*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

increases in the availability of heroin in Dublin¹⁶, increases that reflected changes in international market supplies and, were also quite unique in an international context¹⁷. These changes also arose from the involvement of criminal elements in its distribution in Dublin¹⁸, as well as increased demand and changing social and environmental conditions that both fuelled and surrounded such demand¹⁹. Estimates of opiate-users in Dublin vary from between 6,000-13,500²⁰. Since 1996 the Irish government has recognised that heroin-use is the most pressing of the country's drug problems²¹. Although this policy position continues, there are indications that levels of heroin-use have stabilised in recent years and there is no research evidence of any significant escalation. Since 1996 national increases in problem drug-use are reported across seven EU States: no national increase is reported for Ireland, although regional and local levels show some variation and increase²².

Community context of drug problems

There is a distinct community context to the emergence and development of these drug problems, as is evident from reviewing various Irish community studies of local drug-use. Two sets or types of community studies are evident. The first includes three studies of Dublin communities conducted in the early 1980s²³ during the *opiate epidemic*²⁴ and a further round of similar studies conducted in a variety of Dublin communities since the late 1990s, following the setting up of local drug task forces²⁵. This first group of studies

¹⁶ Eastern Health Board (1982) *Task Force Report on Drug Problems*, limited circulation

¹⁷ Hartnoll, R. (1989) "The International Context" in S. MacGregor (Ed.) *Drugs and British Society*, London: Routledge.

¹⁸ See the following:

Flynn, S. Yeates, P. (1985): *Smack - The Criminal Drugs Racket in Ireland*. Dublin: Gill and Macmillan.

Anonymous, (1981) "Harvest of Misery" in *Strumpet - Dublin City News Magazine*, Vol. 1., No. 1. January.

¹⁹ Dean, G., Bradshaw, J., Lavelle, P. (1983) *Drug Misuse in Ireland 1982-83: Investigation in a north central Dublin area and in Galway, Sligo and Cork*, Dublin: Medico-Social Research Board.

²⁰ Prevalence estimates are based on a capture-recapture study (Comiskey, C. [1998] *Estimating the Prevalence of Opiate Use in Dublin*, Unpublished report, Department of Health and Children.) The figure of 6,000 is obtained from using two original medical sources, while the figure of 13,500 is obtained from using police arrest sources alongside the two medical sources.

²¹ *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, (1996)*, Dublin: Stationery Office.

²² EMCDDA (2002) *Annual Report on the State of the Drug Problem in the European Union*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

²³ For example, see the following:

Dean, G., Bradshaw, J., Lavelle, P. (1983) *Drug Misuse in Ireland 1982-83: Investigation in a north central Dublin area and in Galway, Sligo and Cork*, Dublin: Medico-Social Research Board.

Dean, G., Smith, R., Power, B. (1984) *Heroin Use in a Dun Laoghaire Borough Area 1983-1984*, Dublin: Medico-Social Research Board

O'Kelly, Bury, G., Cullen, B., Dean, G. (1988) "The rise and fall of heroin use in an inner city area of Dublin", *Irish Journal of Medical Science*, 157 (2), 35-37.

²⁴ Dean, G., O'Hare, A., O'Connor, A., Kelly, M., Kelly, G. (1985) "The opiate epidemic in Dublin 1979-1983", *Irish Medical Journal*, 78 (4), 107-110

²⁵ For example, see the following:

Coveney, E., Murphy-Lawless, J., Redmond, D., Sheridan, S. (1999) *Prevalence, Profiles and Policy - A Case Study of Drug Use in North Inner Dublin*, Dublin: Isis Research Group, Centre for Women's Studies, TCD.

D'Arcy, J. (2000) *Drugs and Community - An exploration of the Nature and Extent of Drug Use in the Greater Blanchardstown Area*, Dublin: Greater Blanchardstown Response to Drugs

was undertaken primarily to quantify and help explain *suspected* patterns of local opiate use. The studies underline important community contexts and, specifically, highlight an association between poor urban neighbourhoods and persistently high levels of drug misuse.

The second set of community studies was conducted at county, town and sub-city levels during the 1990s. The objectives of such studies include:

- mobilising local concerns in order to design appropriate preventive responses²⁶;
- developing comprehensive youth services²⁷;
- providing a focus for developing inter-agency responses to local social problems²⁸; and
- ensuring the voice of young people is heard in discussions about drug problems²⁹.

In a broader, public health sense, focus groups have also been used in such studies to consult young people as part of a process of getting their input into shaping health promotion³⁰, while at the same time, ascertaining individual knowledge, and use, of drugs³¹.

Overall, both sets of community studies confirm the value of conceptualising drug problems in local terms, but also reveal two broad patterns of local drug use. On the one hand both sets provide insight into localised patterns of recreational drug use (cannabis and ecstasy), confirming the relatively abundant opportunities for recreational drug use by young people generally, and the differentiated nature of drug-use, even in deprived communities³². As such they reflect a national trend with respect to an increase in the use of such drugs, and variable patterns of use, and many of their conclusions are focused on *primary* preventive strategies. Such interventions would therefore be directed at the whole youth population within any particular community or neighbourhood and focused on diverting young people from the possibility of problem experiences with drug-use and into social, educational and recreational alternatives.

Nexus Europe (Irl) (1997) *Profile of Problem Drug Use in Finglas: Implications for Treatment and Prevention Strategies*, Dublin: Author.

²⁶ Brennan, F. (2000) *Substance Abuse in South Kerry: A project to investigate its extent and propose and strategies for its prevention*, Cahersiveen: South Kerry Development Partnership

²⁷ Sheerin, E. (1999) *Youth Needs in Portlaoise and Portarlington*, Laois Youth Forum and Midland Health Board.

²⁸ The Forum For Longford (1998) *First Report Action for Youth: An Action Plan to Combat Substance Abuse in Longford*, Longford: Author.

²⁹ Community Outreach Drugs Awareness Project (1999) *Drugs Unplugged: Facing the Reality of Drug Abuse in Cork City*, Cork: Author

³⁰ Keenaghan, C., Denyer, S. (1996) *Young People and Drug Misuse in the North West – Report of the Multi-Agency Committee on Drug Misuse Prevention*, Letterkenny: North Western Health Board.

³¹ Sheerin, E. (2000) *Life as It Is: Values, Attitudes and Norms from the Perspective of Midlands Youth*, Midland Health Board and National Youth Federation.

³² For example, see the following:

Murphy-Lawless, Brady, C., Coveney, E., Davis, A., Murray, K. (2000) *Problem Drug Use in Cabra*, Dublin: Centre for Gender and Women's Studies, Trinity College Dublin.

Mayock, P. (2000) *Choosers or Losers? Influences on Young People's Choices about Drugs in Inner City Dublin*, Dublin: Children's Research Centre.

The former set of studies on the other hand, highlights a particular experience of serious opiate problems associated only with a small number of urban neighbourhoods in the Dublin area. It is clear from these studies that the communities concerned are dealing with endemic drug problems alongside endemic poverty. The application of primary prevention in such conditions would need to take place side by side with secondary preventive strategies. In this latter approach young people with high-risk indicators (e.g., parental or sibling drug problems, prior experimentation with recreational drugs or alcohol, school attendance difficulties or problems with juvenile justice system) would be specifically targeted for counselling or other psycho-social supports in order to directly prevent an escalation of drug-use behaviour.

These two broadly different experiences of drug problems are also reflected in research of treated drug misuse³³. This research, based on annual returns provided by drug treatment centres and clinics, confirms an association between community drug problems and poverty indicators. It highlights that, since treatment data began to be systematically collected, firstly in Dublin only (1990), and then later (1995) throughout the whole country, treated drug misuse has been concentrated in urban, particularly Dublin, public housing estates, that are characterised by poverty, high unemployment and generalised deprivation. The research provides a geographic breakdown of areas in Greater Dublin with low (< 50) treatment contacts with drug services and high (≥ 50) treatment contacts. In 1996 treatment contacts were as high as 642 for one of the latter areas and this area accounts for 11% of all first-time treatment contacts in Greater Dublin during 1998 (14.6% of all contacts), with high percentages for other similar areas. The respective percentages for areas with low levels of treatment contact in 1998 were as low as 1.4 (lowest city percentage) and 0.2 (lowest county area). Although these figures need to be treated with caution because of area variations in overall population figures and in the location of treatment facilities, they nonetheless highlight sharp differences in the experience of drug problems across Dublin's communities and neighbourhoods. According to the research, drug users in treatment are predominantly young (58% aged 15-24) and predominantly male (70%) have an unemployment rate of 72%, while 55% left school by age 15 and less than 3% attended a third level college. The seriousness of their drug misuse is highlighted by their use of heroin (71%) as their main drug of misuse, followed by cannabis (11%).

Health and social effects³⁴

Alongside changes in the pattern and prevalence of drug problems – at both national and community levels - medical, social and other problems associated with drug-use have also changed, especially with the emergence of new health risks as a result of human

³³ Moran, R., O'Brien, M., Duff, P. (1997) *Treated Drug Misuse in Ireland, National Report – 1996*, Dublin: Health Research Board. and O'Brien, M., Moran, R., Kelleher, T., Cahill, P. (2000) *National Drug Treatment Reporting System: Statistical Bulletin 1997 and 1998*, Dublin: Health Research Board.

³⁴ A detailed summary of health issues and consequences of drug misuse was prepared by the Health Research Board (in Moran, R., O'Brien, M., Dillon, L., Farrell, E., Mayock, P. (2001) *Overview of Drug Issues in Ireland, 2000*, Dublin: Health Research Board). Coverage of health issues therefore, in this paper, is confined to issues that have particular relevance in a community context.

immunodeficiency virus (HIV) and hepatitis C virus (HCV). A longitudinal study of a cohort of drug-users from within a single electoral area in the inner city, first interviewed in 1985, found that by 1994, 80% of the group had an HIV test, of which 65% were positive. Twenty-six per cent of the cohort had died and in 1994, 44% of the cohort continued to inject heroin³⁵. A 1993 study of drug users attending a voluntary drug treatment project found that 80% of 120 interviewed had previously been hospitalised about five times mainly as a result of overdosing³⁶. A study of HCV, published in 1995, found a prevalence rate of 84% among injecting drug users³⁷ and four years later the authors of the report continued to express concern about drug users' lack of knowledge or understanding of the infection³⁸.

A study of HIV risk, published in 1997, found high rates of equipment-sharing and sexual risk behaviour among a sample of injecting drug users³⁹. Similarly, a study of injecting risk behaviour found that young injectors were significantly more likely to report having recently borrowed and lent injecting equipment, to have been sexually active and have multiple sexual partners or have regular partners who were intravenous drug-users⁴⁰. While this research also reported younger drug injectors more likely to use condoms, as a protective measure, a pattern that was also confirmed by a study published in 1999⁴¹, a more recent study reports that needle sharing continues to persist, especially among those drug users "with a background of social deprivation"⁴². Overall, these studies highlight the susceptibility of drug-users to ill-health and infection and the associated risks for partners and other family and community members.

In addition to HIV, HCV and other infections, drug users also are at risk of accumulating years of poor health, poor nutrition, and unhealthy lifestyle and have a particular risk of becoming homeless and unemployable. A health board study of 94 drug users in treatment found that 80% of females and 26% of males did not eat a hot meal regularly, 50% experienced serious bouts of depression in previous month with 31% having considered suicide⁴³. Forty-four per cent are on prescribed sleeping tablets and of these 55% also buy extra tablets on the streets. One fifth of the sample complained of poor accommodation, of "properties not being well maintained, being damp or cold and being

³⁵ O'Kelly, F., Bury, G. (1996) "An analysis of the effects of HIV infection in a cohort of intravenous drug users, *Irish Medical Journal*, 89, (3), 112-114.

³⁶ McKeown, K., Fitzgerald, G. (1993) *Religious Community and Social justice: A Franciscan Initiative in the Inner City*, Dublin: Franciscan Friars, Merchant Quay

³⁷ Smyth, R., Keenan, E., Dorman, A., O'Connor, J. (1995) "Hepatitis C Infection among injecting drug users attending the National Drug Treatment Centre", *Irish Journal of Medical Science*, 164, (6), 267-268.

³⁸ Smyth, B., McMahon, J., O'Connor, J., Ryan, J. (1999), "Knowledge regarding Hepatitis C among injecting drug users", *Drugs: Education, Prevention and Policy*, 6 (2), 257-264.

³⁹ Dorman, A., Keenan, E., Schuttler, C., Merry, J., O'Connor, J. (1997) "HIV risk behaviour in Irish intravenous drug users", *Irish Journal of Medical Science*, 166 (4), 235-238.

⁴⁰ Cassin, S., Geoghegan, T., Cox, G. (1998) "Young injectors: A comparative analysis of risk behaviour", *Irish Journal of Medical Science*, 167 (4), 234-237.

⁴¹ Mullen, L., Barry, J. (1999) *Needle Exchange in the Eastern Health Board Region: An Analysis of First Attendees, 1990-1997*, Dublin: Eastern Health Board.

⁴² Smyth, B., Barry, J., Keenan, E. (2001) "Syringe borrowing persists in Dublin despite harm reduction interventions", *Addiction*, 717-727.

⁴³ Dorman, P., Jones, L. (1999) *Rehabilitation Research Project: Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board area*, Dublin: Eastern Health Board.

too small for their needs”. Fourteen per cent (13) of the sample have been threatened with eviction by family and five were actually put out by a family member.

A 1999 study of 120 drug users identified as homeless, reported exceptionally high levels of social and medical vulnerability, particularly with respect to rough sleeping, injecting behaviour and non-attendance with GPs⁴⁴. Ten per cent of the group reported that they had at some point been forced out of their accommodation by vigilantism and a further 12% stated they were forced to leave as a result of pressure from tenants’ or residents’ associations⁴⁵. The prospect of being unfairly denied long term accommodation in public housing estates, as a result of previous drug-use, through the implementation of the Housing (Miscellaneous Provisions) Act, 1997, is highlighted in a 1999 study on families, communities and HIV⁴⁶ and also criticised in a report completed by a city housing advice agency⁴⁷.

Alongside these serious health and social effects, heroin users also face a risk of premature death. During year 2000 the apparent unexplained deaths of eight intravenous drug users within a very short time period was subsequently attributed to their exposure to contaminated heroin supplies⁴⁸. Indeed, the reported number of drug-related deaths increased faster for Ireland during the 1990s than any other country in the EU⁴⁹, although this trend was halted in 1999⁵⁰. A 1999 study highlights that five areas that experienced three or more opiate-related deaths were all designated drug task force areas⁵¹. A further study confirms this association: it identifies 77, 86 and 91 opiate-related deaths for the years 1998, 1999, 2000 respectively, and highlights that 89% are from areas designated for local drug task forces⁵². The implications of drug-related deaths in task force areas go quite deeper than that reported in the figures. Numerous deaths in specific localised areas over relative short periods (5-10 years) can reinforce a picture of continuous trauma and suffering, which in a number of communities is symbolised through periodic memorial services and other events⁵³ and illustrated by the following comments from the chairperson of one local drugs task force:

During my time working and living in the community..... I can safely say that the loss to families and to the community as a result of drug-

⁴⁴ Cox, G., Lawless, M. (1999) *Wherever I Lay My Hat: A Study of Out Of Home Drug Users*, Dublin: The Merchant’s Quay Project.

⁴⁵ Eastern Regional Health Authority (ERHA) has commissioned a study on what has happened to tenants forced out of public estates through operation of Housing Act and is waiting completion of this report.

⁴⁶ O’Gorman, A. (1999) *No Room For Complacency: Families, Communities and HIV*, Dublin: Cáirde

⁴⁷ Memery, C., Kerrins, L. (2000) *Estate management and Anti-Social Behaviour in Dublin. A Study of the impact of the Housing (Miscellaneous Provisions) Act 1997*, Dublin: Threshold.

⁴⁸ Center for Disease Control (2000), “Unexplained illness and death among Injecting-drug users – Glasgow, Scotland; Dublin, Ireland; and England, April-June 2000” *MMWR Weekly*, Vol. 49(22); 489-492, June 9.

⁴⁹ EMCDDA (2000) *Annual Report on the State of the Drug Problem in the European Union*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

⁵⁰ EMCDDA (2001) *Annual Report on the State of the Drug Problem in the European Union*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

⁵¹ Ward, M., Barry, J. (2001) “Opiate-related deaths in Dublin”, *Irish Journal of Medical Science*, vol. 170, No. 1

⁵² Byrne, R. (work in progress) *Opiate-Related Deaths Investigated by the Dublin City and County Coroners in 1998, 1999 and 2000*, Dublin: Addiction Research Centre.

⁵³ Family Support Groups Network (2000) *Leaflet on Service of Commemoration and Hope held in Our Lady of Lourdes Church, Sean McDermott Street, Dublin 1*

related tragedies and illness is overwhelming. Over the past eight years alone, the death of almost 100 young people from this and adjacent communities can be attributed, at least in part, to the ravages of drug use. This has a massive negative impact, firstly, on individual families, who are coping with loss and coming to terms with the tragic circumstances surrounding the death of loved-ones. The practical and day-to-day ramifications, including those related to child-care, are real and ever-present. The impact on friends can also be profound. For the wider community – individuals not directly involved with the core families experiencing greatest grief – there is the stark reality of living in an area where drug-use is commonplace. The negative consequences of drug problems are palpable and they constantly impinge on daily social and economic activities⁵⁴.

The general health status of drug users, alongside their exposure to further risk, not to mention their need for addiction and methadone treatment services, provides strong indication of their likelihood to absorb a significant share of public health and medical resources for their care and treatment. In the current operation of the Irish methadone treatment scheme the annual *per capita* additional fee payment of EURO 1,300 to participating general practitioners is a multiple by 8 of the next highest *per capita* payment for normal services⁵⁵. Moreover, with AIDS and drug services undergoing substantial reorganisation since 1996 in line with the formation of a new National Drugs Strategy, considerable local management and technical expertise of health officials, not to mention that of community agencies, has been devoted to tackling these problems⁵⁶. Drug users who are hospitalised or who spend long periods being ill or homeless have indirect costs for the community as a result of not being productive. Failure to find employment compounds the desire for further drug consumption, thus creating a vicious cycle of long-term unemployment.

These challenges are recognised in health board service plans in relation to vocational rehabilitation and other services⁵⁷. It is also emerging that local employment services are modifying their vocational support programmes in order to provide intensive counselling and assistance to drug users who have stabilised through treatment and who are seeking labour market training⁵⁸. Finally, proposals in relation to drug users accommodation, and other social needs feature regularly in the proposals and reports of voluntary homeless

⁵⁴ MacCarthaigh, T. (2001) "The Social Environment of Young People's Choices" in P. Mayock (ed.) *Drugs and Drug Problems: Reporting on the Perspectives of Young People*, proceedings of a half-day conference held in Robert Smith Lecture Theatre, Trinity Medical Centre, St. James's Hospital, Dublin 8 September 20th, 2000, Dublin: Children's Research Centre.

⁵⁵ General Medical Services (Payments) Board, (2000) *Report for the Year Ended 31st December 2000*, Dublin: Author. Also a major national report on drug problems in Australia estimated the health costs of drug users to be 80% higher than average citizens {*Report of Premier's Drug Advisory Council – Drugs and our Community (1996)* Melbourne: Victorian Government.}

⁵⁶ Farrell, M., Gerada, C., Marsden, J. (2000) *External Review of Drug Services for the Eastern Health Board*, London: National Addiction Centre.

⁵⁷ Dorman, P., Jones, L. (1999) *Rehabilitation Research Project: Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board area*, Dublin: Eastern Health Board.

⁵⁸ Ballyfermot Local Employment Service (LES) (2000) *2001-2003 Action Plan*, Dublin: Author.

agencies⁵⁹. A particular challenge with respect to this issue is reconciling the desire of some community groups to support local drug users through treatment and other services, with the demands of other community groups to prevent persons with a history of drug misuse or drug dealing from being housed in public estates.

Impact of drug problems on families

Although many drug misusers, particularly in recent years, experience periods of prolonged homelessness, most continue to live in, or be otherwise associated with, their neighbourhoods and families of origin. In research on drug misusers in treatment, 66% were living in the parental home while 17% were living with a partner, 6% were living alone, 4% were homeless and 3% were living alone with children⁶⁰. This picture is reflected in an evaluation of a community drug project where most attendees continued to live in their parents' homes and while the majority report positive relationships with their parents, significant numbers experienced problems associated with conflict, violence and physical abuse⁶¹. Fifty per cent of attendees of the project had siblings who were also drug users and 20% of members of this group had a brother or sister who died as a consequence of their drug problems. Similarly, a health board report on drug-users in treatment also highlights large numbers (60% of 94) who continued to live in the family home, with the majority of these reporting family problems⁶².

The impact of drug use in extended families, within the same community, is further highlighted by two other community studies. The first reports that of 18 non-drug-using respondents, two-thirds had two or more drug-using immediate family members and 16 (89%) had nieces or nephews who were also using⁶³. One mother had nine children, six of whom were using drugs, while another had five children, as well as their father, using drugs. In three families, grandparents were raising children of drug-users as a result of the deaths of parents through AIDS or other drug-related illnesses. The study reported one mother who had four children who died of AIDS. A second study, undertaken by a counselling practitioner, resulted in a social network map that was based on oral histories of individuals and families within a single community. The map drew attention to a concentration of social problems around a number of families and extended families in one estate, illustrated in particular by two findings:

- 40% of the housing units in the estate were closely connected through extended families reporting problems related to drug-use and related problems;

⁵⁹ Costello, L., Howley, D. (2001) *Working Towards Inclusion: A feasibility study on the provision of accommodation for people sleeping rough and using drugs in Dublin city*, Dublin: Dublin Simon and Merchants Quay Ireland.

⁶⁰ O'Brien, M., Moran, R., Kelleher, T., Cahill, P. (2000) *National Drug Treatment Reporting System: Statistical Bulletin 1997 and 1998*, Dublin: The Health Research Board.

⁶¹ McKeown, K., Fitzgerald, G. (1999) *Treating Drug Addiction: An Evaluation of Addiction Response Crumlin*, Dublin: Addiction Response Crumlin.

⁶² Dorman, P., Jones, L. (1999) *Rehabilitation research project: Towards a blueprint for opiate addicts in the Eastern Health Board area*, Dublin: Eastern Health Board.

⁶³ McCarthy, D., McCarthy, P. (1997) *Dealing with the Nightmare: Drug-use and Prevention Strategies in South Inner City*, Dublin: Community Response.

- 10% of housing units had an experience of HIV and/or death from AIDS-related illness⁶⁴.

The overall impact of opiate problems within the context of multiple family problems provides the context for other studies on motherhood, parenting and family support. One study emphasises the necessity for women to adapt to new complex roles in the midst of overwhelming community drug problems⁶⁵. Already over-burdened with social and economic stress such women must take on even further roles and responsibilities.

....they may have to confront the drug economy as mothers, sisters, carers, partners of users, users themselves. They can be dealing with the problems thrown up by a partner or older sibling attending a treatment programme while a child/younger sibling is experimenting with drug use.

A health worker interviewed in the same study expressed deep frustrations with regard the particular effects of drug problems on the more vulnerable families:

Some of them are functionally illiterate. In some streets and blocks of flats, there is 50% unemployment, usually intergenerational, families which are termed dysfunctional; there are big alcohol problems as well. Parents are often very young themselves and not very mature....there are quite a lot of teenage pregnancies, and they are getting younger. The sense of achievement and pride in their beautiful children is an important aspect. However, as they get older and get into mischief, frustration grows, and the parents are missing out on their own adolescence.

The particular theme of drug users as parents is explored further by another study⁶⁶:

The everyday strains experienced by parents with low incomes living in areas of pronounced social disadvantage can be greatly exacerbated by problem drug use. Parents who are dependent on opiates, and especially those who use heroin, face conflicting pressures between the time and lifestyle demands of their drug problem and their children's needs for care and attention, all in the context of wider social and economic disadvantage.....Opiate use, and especially active heroin use, can take parents away from their children, both physically and emotionally, and parents may thus be forced to rely heavily on relatives to support care-giving to children.

⁶⁴ MacCarthaigh, T. (2001) "The Social Environment of Young People's Choices" in P. Mayock (ed.) *Drugs and Drug Problems: Reporting on the Perspectives of Young People*, proceedings of a half-day conference held in Robert Smith Lecture Theatre, Trinity Medical Centre, St. James's Hospital, Dublin 8 September 20th, 2000, Dublin: Children's Research Centre.

⁶⁵ Murphy-Lawless, J. (2001) *Motherhood and Drugs: Women, Family Life and the Impact of Heroin in North Inner City Dublin* (limited circulation).

⁶⁶ Hogan, D., Higgins, L. (2001) *When Parents Use Drugs: Key findings from a study of children in the care of drug-using parents*, Dublin: Children's Research Centre, Trinity College.

This latter study identifies four separate areas in which parents' drug use can have impact on children's daily lives: disruption to parenting and care (including separation arising from prison, hospitalisation and death); exposure to parents' lifestyles (including contact with drug market activities, police and prisons); emotional well-being; and academic progress.

The highly gendered nature of both research and professional practices relating to drug-using women who are also parents is questioned in yet another study (currently ongoing). A paper on this study emphasises the negative effects of increased clinical and child-care monitoring of this particular group, in the absence of adequate consideration of their other needs, for example their need for educational and vocational opportunities⁶⁷.

Finally, an evaluation of a community project identifies the need to look more deeply at micro-level conditions associated with "family and upbringing experiences" that increase the likelihood of drug-use⁶⁸. While attendees at the community rehabilitation project shared the same general social class characteristics of the community in which they resided, many seemed to have experienced significant problems associated with parental violence, alcoholism, separation, imprisonment or loss.

The above quoted studies provide some insight into the family context of drug problems within particular communities where high levels of drug problems are apparent, indicating that alongside distal influences on drug-using opportunities, choices and consequences, other, and in the circumstances, equally critical proximal influences and effects are also operating. The data suggests that just as community drug problems are clustered *around* particular urban neighbourhoods, so too family drug problems are clustered *within* particular families. In the broader literature, proximal influences on drug-use risk may be summarised as:

- early incidence and frequency of problem social and / or emotional behaviours;
- parental drug and/or alcohol problems;
- parental and/or sibling criminality;
- family conflict and / or breakdown
- family poverty and lack of employment / income;
- lack of family human capital – poor participation in education;
- lack of community social capital and of opportunities for social bonding with conventional social, cultural and employment institutions;
- community transience and lack of community cohesion or organisation;
- poor community infrastructure and lack of play, recreational and sporting facilities⁶⁹

⁶⁷ Woods, M. (2000) "Women, drug use and parenting in Dublin: The views of professional workers in the drug treatment and social work fields", in A. Springer, A. Uhl (Eds.) *Illicit Drugs: Patterns of Use – Patterns of Response: Proceedings on the 10th Annual ESSD Conference on Drug use and Drug Policy in Europe*, Innsbruck: Studien/Verlag.

⁶⁸ McKeown, K., Fitzgerald, G. (1999) *Treating Drug Addiction: An Evaluation of Addiction Response Crumlin*, Dublin: Addiction Response Crumlin

⁶⁹ Hawkins, J., Lishner, D., Catalano, R., (1986): *Delinquents and Drugs: What the Evidence Suggests About Prevention and Treatment Programming*, Washington, DC: Office of Juvenile and Delinquency Prevention, US Department of Justice

The potentially accumulative and mutually reinforcing impact of these influences heighten the social isolation of certain families within already socially excluded neighbourhoods, limiting the opportunities of developing connections with mainstream society and heightening the possibilities for sustaining, an alternate, “substitute universe filled with drug consumption and criminal activities.”⁷⁰

The local impact of drugs and crime

Much of the pressure on drug users giving rise to social, health and other risks emanates from their involvement in crime. Studies of the links between drugs and crime show that just under 20% of cases receiving custodial sentences in Dublin district courts were for drugs-related offences⁷¹. Sixty-six per cent of 19,000 detected crimes in Dublin were committed by drug users, who made up 43% of the total number of persons committing these crimes, with 31% of drug users committing more than 3 crimes, as against 8% of non-drug users⁷². In the latter study, 41% (254) committed their crimes in their own neighbourhoods and 66% sourced their drugs from within their neighbourhoods and usually from a known local dealer⁷³. The numbers that are known by Garda authorities to have convictions for other non-drug-related offences may explain the higher percentages of drug users in the latter study. Studies of prison populations confirm these tendencies, highlighting that 52% of a national sample⁷⁴ and 66% of a male sample in Dublin⁷⁵, had histories of opiate use and also highlighting that the numbers of prisoners reporting a history of drug-use are consistently higher than the numbers convicted on drug-related crime⁷⁶.

Local studies also highlight the link between drugs and crime. Seventy-seven per cent of a local cohort of 82 in a longitudinal study served a prison sentence⁷⁷, while in another local study 85% of 26 drug users had contact with the criminal justice system: 54% served time in prison, four had been in more than three prisons and a total of nine had been in two or more⁷⁸. Similarly, a 1993 study of persons attending a voluntary drug agency found that more than 80% of 120 had been arrested and appeared in court for

⁷⁰ Dunlap, E. (1992) “Impact of drugs on family life and kin networks in the inner city African-American single-parent, in A. Harrell and G. Peterson (Eds.) *Drugs, Crime and Social Isolation*, Washington, Urban Institute Press

⁷¹ Bacik, I., Kelly, A., O’Connell, M., Sinclair, H. (1998) “Crime and Poverty in Dublin: an analysis of the association between community deprivation, District court appearance and sentence severity” in I. Bacik and M. O’Connell (eds.) *Crime and Poverty in Ireland*, Dublin: Round Hall.

⁷² Keogh, E. (1997) *Illicit Drug Use and related Criminal Activity in the Dublin Metropolitan Area*, Dublin: An Garda Síochána.

⁷³ A follow up to this study is currently underway and should provide further insights into this topic.

⁷⁴ Allwright, S., Barry, J., Bradley, F., Long, J., Thornton, L. (1999) *Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk*, Dublin: Government Publications.

⁷⁵ O’Mahoney, P. (1997) *Mountjoy Prisoners: A Criminological and Sociological Profile*, Dublin: Government Publications.

⁷⁶ Dillon, L. (2001) *Drug Use Among Prisoners: An Exploratory Study*, Dublin: Health Research Board.

⁷⁷ O’Kelly, Bury, G., Cullen, B., Dean, G. (1988) “The rise and fall of heroin use in an inner city area of Dublin”, *Irish Journal of Medical Science*, 157 (2), 35-37.

⁷⁸ McCarthy, D., McCarthy, P. (1997) *Dealing with the Nightmare: Drug-use and Prevention Strategies in South Inner City*, Dublin: Community Response.

drug-related activities, for on average more than 25 times and that just under 60% had been held in prison either on remand or on conviction for a total average of 4 years⁷⁹.

The wider literature emphasises this inter-connection between drugs and crime: highlighting that measures of drug misuse and delinquency are positively related⁸⁰ and an involvement with drug misuse either leads to an involvement with crime or has a multiple impact on the criminal activities of drug users already involved with crime⁸¹.

Furthermore, young people who frequently use drugs are more likely to engage in criminal activities than their non-drug-using peers⁸² and there is also a relationship between a person's frequency of anti-social and / or criminal behaviours during adolescent years and the likelihood that they will take illicit drugs in the following years⁸³. Their deep connections into the world of criminality impede their prospects of employment. Through early juvenile delinquency, they stockpile illegal contacts and networks and they become socially embedded in criminality and increasingly isolated from legal job referral and other job-seeking networks even as these generally improve⁸⁴. Just as continued success in accessing employment is linked to socially embedded networks of contacts, which generate work opportunities, so too an absence of these networks or initial difficulty or failure in entering employment, as a result of an involvement in crime or drugs can also dampen future job prospects⁸⁵.

While an increased use of drugs by young people in any particular setting or neighbourhood accelerates the level of crime within the same setting, the reverse argument also holds. Much drug misuse is caused by crime and furthermore, both drug-use and crime need to be more clearly understood within the context of other social and economic processes⁸⁶. Drug-users are often blamed for bringing increased levels of crime into poor neighbourhoods, but the crimes themselves, particularly the acquisition and local distribution of stolen consumer goods, are sometimes seen as having functional

⁷⁹ McKeown, K., Fitzgerald, G. (1993) *Religious Community and Social Justice: A Franciscan Initiative in the Inner City*, Dublin: Franciscan Friars, Merchant Quay

⁸⁰ Johnston, V., O'Malley, P., Evelopad, L. (1978): "Drugs and Delinquency: A Search for Causal Connections." Paper presented at the Conference on Longitudinal research on Drug Uses, San Juan, Puerto Rico, April. In D. Kandel (ed.), *Longitudinal Research on Drug Use*, 137-56, New York: Wiley.

⁸¹ For example, see the following studies:

Ball, J., Rosen, L., Flueck, J., Nurco, D. (1982): "Lifetime criminality of heroin addicted in the United States, *Journal of Drug Issues*, 12, 225-239.

Farrington, D., West, D., (1990): "The Cambridge Study in Delinquent Development: a long term follow up of 411 London Males", in H. Kerner and G Kaiser (eds.), *Criminality, Personality, Behaviour, Life History*, Heidelberg: Springer: Veerlag.

Huizinga, D., Loeber, R., Thornberry, T. (1994): *Urban Delinquency and Substance Abuse*, Washington, DC: Office of Juvenile and Delinquency Prevention, US Department of Justice.

⁸² Elliott, D., Huizinga, D., Menard, S. (1989): *Multiple Problem Youth: Delinquency, Substance Use and Mental Health Problems*, New York: Springer-Verlag.

⁸³ Hawkins, J., Catalano, R., Miller, J. (1992): "Risk and Protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention", *Psychological Bulletin*, 112, 64-105.0

Robins, L., McEvoy, L., (1990): "Conduct problems as predictors of substance abuse" in L. Robins & M. Rutter (Eds.), *Straight and Devious Pathways from Childhood to Adulthood*, 182-204, Cambridge: Cambridge University Press.

⁸⁴ Sullivan, M. (1989) *Getting Paid: Youth Crime and Work in the Inner City*, London: Cornell University Press.

⁸⁵ Hagan, J. (1994) *Crime and Disrepute*, London: Pine Forge Press

⁸⁶ Seddon, T. (2000), "Explaining the Drug-Crime Link: Theoretical, Policy and Research Issues", *Journal of Social Policy*, vol. 29, 1, 95-107.

value in these same neighbourhoods⁸⁷. For example a 1994 estimate of the annual value of the drug economy in one poor Dublin postal district was £9m⁸⁸. In reality, young drug users can help provide a “real economic system”⁸⁹ in situations where normal market failure is evident⁹⁰ as illustrated by the following quote from a 2001 study:

When a (drug) user robs or shop lifts in order to get money for his or her fix, the stolen goods must then be converted into cash, by selling them, often at local level. This off-loading of stolen goods, usually at cheaper prices than shop prices, can indirectly create economic benefit in a community which has had very little opportunity to convert its entrepreneurial skills into legitimate work⁹¹.

A social worker interviewed for the above study commented that “sympathy and family loyalties” often provide a context whereby extended family members become involved in selling goods for drug-using members. However, the underlying causes of this embeddedness in crime and drugs goes deeper. Concentrated drug misuse offers young people who are unemployed and socially excluded “an alternative means by which to demonstrate status and achievement” thereby sustaining illegal, informal economies⁹². In particular drug misuse helps relieve the monotony and purposelessness among unemployed young people and in overcoming fears that they might have about adverse consequences⁹³,

...they don't know how to occupy their minds. It gives them something to do, to go scoring and thieving. It's like a job⁹⁴.

Young people with few qualifications and few prospects of employment in a shrinking economy are relatively easily attracted into an involvement with street drug dealing, where initial returns in terms of finance or in-kind drug supplies, may exceed the profits from other crimes and have lower probabilities of arrest⁹⁵. Basically, an involvement with drugs in poor neighbourhoods is itself a kind of job and under the circumstances the most

⁸⁷ Johnson, B. Goldstein, P., Preble, E., Schmeidler, J., Lipton, D., Spunt, B., Miller, T. (1985) *Taking care of Business: The Economics of Crime by Heroin Abusers*, Lexington, Mass: Lexington.

⁸⁸ ICON (1994) *Grasping the Future: Inner City Organisations' Network Area Action Plan for Dublin's North East Inner City*, Dublin: Author.

⁸⁹ Kierans, C., McCormack, P. (2001) *Ballyfermot Consultation Feedback Report*, Dublin: Ballyfermot Local Drugs Task Force (limited circulation).

⁹⁰ Rafferty, M. (1996) “Between Scylla and Charybdis” in *Partnership in Action: The Role of Community Development and Partnership in Ireland*, Galway: Community Workers' Cooperative

⁹¹ Murphy-Lawless, J. (2001) *Motherhood and Drugs: Women, Family Life and the Impact of Heroin in North Inner City Dublin* (limited circulation).

⁹² Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*, London: The Stationery Office.

⁹³ Parker, H., Bakx, K., Newcombe, R. (1988) *Living with Heroin: The Impact of a Drugs 'Epidemic' on an English Community*, Manchester: Open University Press.

⁹⁴ Burr, A. (1989) “An Inner-City Community response to Heroin-Use” in S. MacGregor (ed.) *Drugs and British Society*, London: Routledge.

⁹⁵ Johnson, B. Goldstein, P., Preble, E., Schmeidler, J., Lipton, D., Spunt, B., Miller, T. (1985) *Taking care of Business: The Economics of Crime by Heroin Abusers*, Lexington, Mass: Lexington.

challenging and exciting job available to youth⁹⁶. This involvement in drugs therefore is an economic option in circumstances where economic alternatives are few⁹⁷ and whose persistent absence has a crippling effect on the prospects of young drug users managing to break the habit, once addicted. As explained by one UK report:

...local efforts to curb drug misuse are likely to be severely handicapped unless supported by wider schemes of urban regeneration, access to jobs and training, and other initiatives to combat social exclusion⁹⁸.

Conclusion

It is evident from the above discussion that significant and even dramatic changes have taken place in the nature and pattern of drug misuse in Ireland over the period 1976-2001. From a situation where drug misuse was quite negligible recreational drug misuse became commonplace and serious opiate problems became endemic in communities already badly affected by other social problems arising from economic and social change. In the midst of these changes and developments a distinction between individual drug problems and community drug problems is clearly evident. Community drug problems have consequences that go far beyond the aggregated sum of individual drug-using experiences as represented in official facts and figures. Health and social effects have wider impact on local community and family members, particularly in relation to the risk of infection, the cost of providing health care, the loss of employability and related formal income. It is also often necessary for community members to raise children who have been bereaved or who other reasons cannot be raised by their drug-using parents. There are also crime effects: increased levels of criminality and an increased risk of community members of being a victim of crime. Open dealing and increased levels of petty theft serve as visual reminders to community residents of the serious nature of the drug problems in their midst. However, there are also deeper and even more perverse effects especially as drug economies increasingly replace formal economy. In many respects drug problems symbolise community decline and the processes giving rise to this decline are explored in the next section.

⁹⁶ Preble, E., Casey, J. (1969) "Taking Care of Business: The Heroin User's Life on the Street", *International Journal of the Addictions*, Vol. 4 (1).

⁹⁷ Pearson, G. (1987) *The New Heroin Users*, Oxford: Basil Blackwell.

⁹⁸ Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*, London: The Stationery Office

SECTION 2

EXPLAINING COMMUNITY DRUG PROBLEMS

The previous section explored how increased levels of heroin-use have impacted on health and social risks and are also interconnected with higher levels of crime. It is clear from this discussion that the effects of drug problems extend to wider community domains and this suggests the need to explore more deeply the interrelationship between drug problems and community contexts. Three particular explanations are explored below: underclass communities, structural issues and social disorganisation.

Underclass communities

In the last two decades researchers have developed a special interest in focusing on urban neighbourhoods as a particular location for studying social problems and in drawing theoretical and policy conclusions⁹⁹. Debates about the family, lone parenthood, crime, unemployment and welfare reform, as well as drug problems, have all emerged within this context reflecting a distinct urban analysis. Much of this debate during the 1980s in the US and UK was dominated by underclass theory, reflecting a monetarist discourse in economic and social policy. Drawing from literature that emphasises a culture of poverty, underclass theory tends towards a “process of social contagion” as an explanation for neighbourhood effects¹⁰⁰. This model assumes that

..once a critical mass of a certain behaviour has been reached (*such as violent crime, welfare dependency or drug use*) the neighbourhood is likely to ‘tip,’ so that such behaviour becomes the local norm¹⁰¹.

In this model the resultant sub-cultures mitigate the capacities of neighbourhood residents to make the behavioural changes appropriate for a re-adaptation to mainstream society.

At a policy level the thrust of much underclass discourse is towards supporting a re-direction of public expenditure away from the residents of poor communities on the basis that social welfare and other programmes help reinforce rather than overcome poverty conditions¹⁰². In the case of Ireland, there is no substantial evidence to support the existence of an underclass¹⁰³ and, in general, official policy throughout the 1980s recession had the effect of redistributing, through high tax and welfare spending, more

⁹⁹ Kearns, A., Parkinson, M. (2001) “The Significance of Neighbourhood”, *Urban Studies*, Vol. 38, No. 12, 2103-2110.

¹⁰⁰ Crane, J. (1991) “Effects of neighbourhoods on dropping-out of school and teenage childbearing” in C. Jencks and P. Peterson, *The Urban Underclass*, Washington: Brookings Institution.

¹⁰¹ Peterson, Harrell, A. (1991) “Inner-city isolation and opportunity” in A. Harrell and G. Peterson (Eds.) *Drugs, Crime and Social Isolation*, Washington, Urban Institute Press

¹⁰² Murray, C. (1984) *Losing Ground: American Social Policy, 1950-1980*, New York: Basic Books

¹⁰³ Nolan, B., Whelan, C. (1999) *Loading the Dice: A Study of Cumulative Disadvantage*, Dublin: Oak Tress Press in association with Combat Poverty Agency.

income from the better-off to the poor¹⁰⁴. Nonetheless, some underclass rhetoric is evident in institutional efforts to face up to the serious problems in urban neighbourhoods. The 1992 report of the interdepartmental group established by government following public order incidents in a Dublin suburban estate identified “criminogenic” areas with typical characteristics, for example: newly-built, public housing estates; single class; young families with high levels of lone parents; few local extended family connections; long-term and second generation unemployment; poor levels of income; poor levels of educational attainment and a high tendency towards criminal and anti-social behaviour¹⁰⁵. This use of the term ‘criminogenic’ is clearly associated with underclass discourse and may help explain why in the face of an evident association between poverty and community drug problems, there was no substantial public investment into worst-affected communities until the mid 1990s, almost seventeen years after drug problems first escalated.

Structural issues

An alternative model for viewing neighbourhood effects focuses on structural issues emphasising the wider economic dimension to this concentration of social problems. In this approach, the emergence of drug problems and increases in crime problems are directly linked with social and structural change¹⁰⁶. During periods of both industrial expansion (1960s/1970s) and industrial contraction (1970s/1980s) there was a lack of coherent official strategies for attracting and replacing industry in Dublin communities that had previously relied on traditional industry¹⁰⁷. Particularly badly affected were local, unskilled manufacturing workers and, newly arrived rural dwellers seeking such work. As a result large-scale unemployment became concentrated among low-income groups, whose unskilled or semi-skilled jobs, were never replaced following subsequent economic reconstruction. Whole communities that previously relied on unskilled jobs experienced the greatest level of redundancy and in these same areas, usually public housing estates; high concentrations of unemployment and poverty persisted¹⁰⁸.

The international restructuring of education that followed industrial contraction in the 1980s failed to have impact on the educational and employment prospects of residents of low-income communities¹⁰⁹. Although, since the early 1990s the steady improvements in the Irish economy led to greater jobs availability, there are indications of new jobs being inaccessible to many residents of particular neighbourhoods mainly as a result of poor levels of educational attainment¹¹⁰.

¹⁰⁴ Fitzgerald, E. (2001) “Redistribution through Ireland’s Welfare and Tax Systems” in *Rich and Poor: Perspectives on tackling inequality in Ireland*, Dublin: Oak Tree Press in association with Combat Poverty Agency.

¹⁰⁵ Inter-Departmental Group (1992) *Urban Crime and Disorder*, Dublin: Stationery Office.

¹⁰⁶ Rottman, D. (1980) *Crime in the Republic of Ireland: Statistical Trends and Their Interpretation*, Dublin: Economic and Social Research Institute.

¹⁰⁷ Bannon, M., Eustace, J., O’Neill, M. (1981) *Urbanisation: Problems of Growth and Decay*, Dublin: National Social and Economic Council (NESCC).

¹⁰⁸ Drudy, P., Punch, M. (1999) *The ‘Regional problem’, Urban Disadvantage and Development*, Trinity Economic Paper No. 1, Dublin: Trinity College.

¹⁰⁹ Government of Ireland (1997) *National Anti-Poverty Strategy*, Dublin: Author.

¹¹⁰ Fitzgerald, E., Ingoldsby, B. (1999) *Evaluation of the Employment Network and the Whole-time Job Initiative*, Dublin: Dublin Inner City Partnership.

An overall effect of these structural changes is to create new forms of social exclusion as a result of which in certain communities “crime becomes a mode of economic and social survival”¹¹¹. Furthermore, in these communities concentrated unemployment reinforces social and economic decline: businesses move out and in some instances consumer services, particularly shopping markets and banks are downgraded. With reduced local resources and economy a cycle of poverty prevails and this is particularly evident in terms of poor levels of educational attainment, the development of a local welfare economy and the emergence of social problems such as family violence, drug use and crime. This confluence of job-decline, the rise of illicit activities and welfare dependency, and associated social problems in Dublin neighbourhoods, reflects developments in a number of US cities during the 1970s and 1980s¹¹², although as already mentioned, not on the same scale or magnitude, and with different, if comparable causes. In communities where this process intensifies the problems multiply and have continuous knock-on effect, thus limiting employment and other normal vocational opportunities, especially for young people, who begin the process of exploring other meaningful identities¹¹³. As discussed in the previous section, in the absence of a formal local economy, an alternative underground economy thrives, contributing to concentrated drug problems and in turn this leads to further problems and difficulties for the neighbourhood¹¹⁴.

Social disorganisation

The structural explanation of drug problems links to the idea of *social disorganisation*, a concept that draws from research on the spatial clustering of social problems¹¹⁵. In the wider literature *social disorganisation* is evident in many studies of local drug problems conducted over the last forty years¹¹⁶. The approach underlines the association between transient neighbourhoods and social problems, highlighting that drug problems cluster in urban areas. However, unlike the underclass approach, which attributes drug problems to neighbourhood residents, social disorganisation suggests that drug problems tend to be more representative of the neighbourhoods than of their populations. Under similar *community* conditions diverse groups show similar rates of crime, delinquency and drug misuse, mutually reinforcing each other. One review of various US and European studies undertaken in local communities, describes the social disorganisation process as follows:

¹¹¹ McCullagh, C. (1996) *Crime: A Sociological Introduction*, Cork: Cork University Press.

¹¹² Kasarda, J. (1992) “The severely distressed in economically transforming cities” in A. Harrell and G. Peterson (Eds.) *Drugs, Crime and Social Isolation*, Washington, Urban Institute Press.

¹¹³ McCullagh, C. (1996)

¹¹⁴ Fagan, J. (1992) “Drug selling and licit income in distressed neighbourhoods: the economic lives of street-level drug users and dealers”, in A. Harrell and G. Peterson (Eds.) *Drugs, Crime and Social Isolation*, Washington, Urban Institute Press

¹¹⁵ Shaw, C., McKay, H. (1942) *Juvenile Delinquency and Urban Areas*, Chicago: University of Chicago.

¹¹⁶ See the following:

Chen, I., Lee, R., Rosenfeld, E. (1964) *The Road to H: Narcotics, Delinquency and Social Policy*, New York: Basic Books.

Hagedorn, J. (1998) (2nd ed.) *People and Folks: Gangs, crime and the underclass in a rustbelt city*, Chicago: Lake View Press.

Sullivan, M. (1989) *Getting Paid: Youth Crime and Work in the Inner City*, London: Cornell University Press

Pearson, G. (1987) *The New Heroin Users*, Oxford: Basil Blackwell.

Burr, A. (1989) “An Inner-City Community response to Heroin-Use” in S. MacGregor (ed.) *Drugs and British Society*, London: Routledge.

In a vicious cycle, the downward slide of ...marginal communities is accelerated by the impact of drugs themselves – especially their impact on the stability and competence of adults in the community.....What makes this process so insidious is that it is self-reinforcing.(T)he spread of drug abuse weakens the economic viability of families and simultaneously weakens their authority over the young: both of those in turn increase the appeal of drug dealing and further reduce the community's capacity to control it¹¹⁷.

Similarly, a UK report¹¹⁸ by the Advisory Council on the Misuse of Drugs, uses the term “urban clustering” in exploring the concentration of drug problems in certain communities and suggests

...that they are a consequence of the housing market which brings together people who are experiencing a variety of otherwise unrelated problems in ‘hard-to-let’ housing estates.

The report further posits that an important consequence of such urban clustering is that the effects of dense and visible drug misuse can become a problem for entire neighbourhoods, including those community residents who are not drug misusers. This explanation of urban clustering is mirrored in the Irish experience. Local authority housing policy in Dublin during the 1960s and 1970s, focused on de-tenanting and demolishing public estates in the inner city, promoting commercial and private residential development in their place, and re-locating large numbers of families out to new estates in the suburbs, which were built to accommodate population growth¹¹⁹.

Although the building of new suburban estates represents a remarkable public housing achievement¹²⁰, some developments have reinforced spatial and social segregation, with the result that “the poorest groups have the least choice and end up in the least desirable locations” in inner city ghettos and “peripheral deprived urban neighbourhoods”¹²¹. While many housing estates were successful others were not¹²². In particular, in some estates there is widespread unhappiness with the perceived ineffectiveness of the police and local authorities in managing social disorder problems¹²³. Also, for a long period (almost two decades) many estates lacked (and continue to lack in some cases) community infrastructure (services, amenities, central focal areas) thus contributing to and

¹¹⁷ Currie, E. (1993) *Reckoning: Drugs, the Cities, and the American Future*, New York: Hill and Wang.

¹¹⁸ A review of many of such studies conducted in both US and UK is available in Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*, London: The Stationery Office.

¹¹⁹ Wright, M. (1967) *The Dublin Region Advisory Plan and Report*, Dublin: Stationery Office

¹²⁰ NESCC (1988) “Council’s Comments on a Review of Housing Policy”, in J. Blackwell, *A Review of Housing Policy*, Dublin: National Economic and Social Council, Report No. 87.

¹²¹ Drudy, P.J., Punch, M. (2001) “Housing and Inequality in Ireland” in S. Cantillon, C. Corrigan, P. Kirby, J. O’Flynn (Eds.) *Rich and Poor: Perspectives on Tackling Inequality in Ireland*, Dublin: Oak Tree Press in association with Combat Poverty Agency.

¹²² Fahey, T. (ed) (1999) *Social Housing in Ireland: a Study of Success, Failure and Lessons Learned*, Dublin: Oak Tree Press.

¹²³ Corcoran, M. (1998) *Making Fatima a Better Place to Live*, Dublin: Fatima Groups United.

exacerbating the experience of poverty and disadvantage and reinforcing a sense of residents being unable to escape the forces that exclude them from participating in society¹²⁴. Furthermore, statutory authorities are perceived as having failed to develop coherent responses to multiple problems in such neighbourhoods¹²⁵, thus leaving it to community groups, often with very little resources, to pioneer new approaches and interventions¹²⁶.

The marginal position of public housing estates (inner city and suburban) was further exacerbated in 1984 by the introduction of a grant scheme to encourage tenants to vacate their tenancy to purchase new houses in the private market. The main effect of this scheme was to deplete local estates of residents with highest competitive skills and income thus exacerbating even further the concentration of lower income groups in these estates and contributing to disaffection and a desire by many remaining residents to transfer out by other means¹²⁷ leaving behind a community that lacked unity and a sense of identity. While overall housing policy during the 1990s has changed, reflecting a desire to build smaller, more integrated estates, it will take some time for these and other policies designed to revitalise larger marginalised estates to have a sustainable impact on the way in which older estates have concentrated needs and problems¹²⁸.

Conclusion

The discussion above reviews three explanations of community drug problems: underclass communities, structural issues and social disorganisation. The underclass thesis is generally blaming of drug users, their families and their communities. While popular as an explanation for a range of urban problems during the late 1980s, particularly in the US and UK, it provides little insight into the social context of drug problems, and furthermore, there is, in Ireland, little evidence of an underclass as defined by the proponents of this thesis elsewhere. The discussion above pays more attention to the interplay of social and economic developments. Drug problems and related crime reflect deeper structural problems in society and community. They also reflect declining trends in the physical structure and organisation of communities that lack economic activity. Tackling crime and drug problems clearly requires measures that address community conditions and at the same time succeed in overcoming the processes whereby drug and crime involvement become socially embedded. In this sense appropriate responses need to be community in focus and predicated on an analysis that understands and works out from these explanations. They also need to have some basis in the experiences of the communities affected. The development of community responses are explored in the next section.

¹²⁴ Donnison, D., Bell, D., Benington, J., Blackwell, J., Elphick, C., McArthur, A., McKeown, K., O'Shea, E. (1991) *Urban Poverty, the Economy and Public Policy*, Dublin: Combat Poverty Agency.

¹²⁵ Kelleher, P. Whelan, M. (1990) *Dublin Communities in Action: A Study of Six Community Projects*, Dublin: Community Action Network / Combat Poverty Agency.

¹²⁶ Cullen, B. (1994) *A Programme in the Making: A Review of the Community Development Programme*, Dublin: Combat Poverty Agency.

¹²⁷ Threshold (1987) *A Study of the £5,000 Surrender Grant in the Dublin Housing Area*, Dublin: Author.

¹²⁸ Brennan, C., McCashin, A., O'Shea, J. (2001) *Partnership for Housing Renewal*, Dublin: Canal Communities Partnership and Department of Social Studies, Trinity College Dublin.

SECTION 3

RESPONDING TO COMMUNITY DRUG PROBLEMS

For most of the period 1976-2001, despite the evident connections between spatial deprivation and the prevalence of drug problems, public policies have been concerned primarily with the provision of clinical services to individual drug users and usually outside the context of their communities or environments¹²⁹. As an example of this policy pre-occupation with “individual responsibility”, in 1986 the then National Coordinating Committee on Drug Abuse – which met on only a small number of occasions between 1983-1986¹³⁰ - emphasised that the overall aim of drug education was:

.....to help young people to take responsibility for their own well-being and that of others and *to take positive control of the environment*. Even the most disadvantaged should be made feel that they can help others and that they should not necessarily be the recipient of help on all occasions¹³¹ (*italics added*).

The persistence of this individualist approach is all the more remarkable considering that in 1983 a government report recommended an area-based response to drug problems¹³². The report was never published however, and a government statement on the report did not make any reference to this particular recommendation¹³³. The unpublished recommendation was, perhaps, quite radical: it constituted, according to one reviewer, an acknowledgement that “drug problems in Dublin were largely explicable in terms of the poverty and powerlessness of a small number of working-class neighbourhoods”¹³⁴. The inclusion of the recommendation in the unpublished report, and its omission from the government statement, indicates that the need for a concentrated response to concentrated problems was at least being officially considered, but that institutionally, the relevant authorities were not, at the time, ready to engage in such developments.

It is against a background of perceived failure of state agencies to move beyond an individualised perspective (a perspective that reflects underclass discourse as discussed in previous section) that a momentum in support of local demands for a community response to drug problems gradually developed. These demands evolved through a number of connected developments. First, the seriousness of drug problems in worst-

¹²⁹ O’Gorman, A. (1998) “Illicit drug use in Ireland: An overview of the problem”, *Journal of Drug issues*, 28 (1), 155-166

¹³⁰ This committee was later re-convened in 1989 to assist in compiling the 1990 report, Government Strategy on Drug Misuse.

¹³¹ National Coordinating Committee on Drug Abuse (1986) *First Annual Report*, Dublin: Author.

¹³² Butler, S. (1991) “Drug problems and drug policies in Ireland: A quarter of a century reviewed.” *Administration*, 39 (3), 210-233.

¹³³ Department of Health. (1983) *Government Statement on the report of the Special Governmental Task Force on Drug Abuse*, September 20th.

¹³⁴ Butler, (1991)

affected areas provided the impetus for the mobilisation of two waves of community-based anti-drug movements that involved direct actions against drug dealing and other local developments. Second, a number of community and voluntary organisations formed as a response to specific drug problems developed cross-community alliances, eventually leading to the formation of a cross-city campaign that had both networking and policy functions. Third, following the spread of AIDS / HIV associated with intravenous drug use during the late 1980s demands for new public health measures alongside community-based services were advocated by some health practitioners and policy-makers. Fourth, during the early 1990s, a number of new area-based programmes and measures were initiated by government as a response to long-term unemployment and the need for urban regeneration, and eventually these were extended to a community-based drug policy.

Community mobilisation and anti-drug movements

The two waves of locally-organised cross-community responses broadly coincided with sharp escalations in community drug problems in the early 1980s and in the mid 1990s. Both waves of response constituted mass mobilisations of disaffected communities that previously were only ever achieved through organised labour. These cross-community actions developed in the context of heightened community fears and the demands of neighbourhood residents to self-organise to deal directly with both drug dealing and drug-users. However, despite the cross-community nature of this mobilisation, it varied hugely in its character and scale within Dublin communities.

In the first wave of cross-community actions during the 1980s local communities mobilised to take direct actions against drug dealers through mass public meetings, street marches, the picketing of homes and forced evictions. A case study conducted in one neighbourhood, linked the emergence of these actions with the failure of the main health, justice and political institutions to acknowledge the particular impact of community drug problems on urban neighbourhoods and to design local responses, as appropriate¹³⁵. The study highlighted the inability of state bodies to establish working relationships with locally-based groups consisting of residents and professional interests. Of particular significance was the inability of health authorities to support the provision of drug treatments in any manner other than through a single centralised, specialist clinic, which, at the time, operated a policy of requiring participants to give a prior commitment to abstinence, as a precondition for treatment¹³⁶. This severe limiting of treatment choices helped reinforce a community-wide expectation of interventions based on abstinence *only*

¹³⁵ Cullen, B. (1991) *Community and Drugs: A Case Study in Community Conflict in the Inner City of Dublin*, Unpublished M.Litt thesis, Trinity College Dublin.

¹³⁶ A 1983 Government Ministerial Task Force on Drug Abuse recommended setting up a second, separate drug treatment facility on the grounds of St. James's Hospital that would be accessible to south side communities (Government Statement on the Ministerial Task Force Report, 1983). This second treatment centre, which potentially might have introduced a badly-needed choice of drug treatment options at a critical period prior to the onset of HIV / AIDS, was to be in addition to National Drugs Advisory and Treatment Centre at Jervis Street Hospital (Later Drug Treatment Centre Board, Trinity Court). The recommendation however, was not implemented at the time, although, when treatment services eventually expanded during the mid to late 1990s, this included the provision of services on the grounds of St. James's Hospital (services that are now re-located to Dr. Steeven's Hospital).

and at the same time sustain the everyday picture of large numbers of young, heroin addicts constantly engaged in a drug market, thus forcing community activists to remain focused almost exclusively on issues of drug supply. Later initiatives with respect to community-based treatment highlight that through supporting the everyday operations of community treatment facilities, many community activists were able to overcome their fixation on both abstinence and supply and developed a more comprehensive understanding of drug problems¹³⁷.

The above wave of community actions was initially quite successful in suppressing local drug markets, particularly in smaller, inner city neighbourhoods, and the intensity of its mobilisation both focused public and media attention on the drugs issue and also stimulated a number of other important community developments. However, its continued focus on supply issues inhibited its potential transformation into a more comprehensive campaign in support of community reconstruction. Consequently, it descended into an aggressive, vigilante movement with loose paramilitary associations, and some confusion with respect to its punitive attitude towards drugs, as distinct to its seemingly, more benign attitude towards crime. It also reinforced a sense of further community disintegration¹³⁸.

Community disintegration was also apparent during a second wave of mass community actions that commenced during the early 1990s and continued right up until and following the setting up of local drug task forces in 1996. At their worst, these actions, which at one stage resulted in the fatal assault on a drug user, created widespread abhorrence – at community and other levels - and some resistance towards community responses, at an official level¹³⁹. However, these marches continued to focus public and media attention on this issue. Unlike the first, this second wave of community action was set against the background of a more comprehensive community and voluntary agency-led debate on community drug problems, which is now discussed under a separate heading.

Community and voluntary bodies and emergence of cross-community networks

Despite the absence of State initiative in the area of community drug problems, some voluntary and community agencies had successfully developed new innovative responses to drug problems and through these, public discussion and policy proposals in favour of community-based responses were promoted. In due course these developments had wider application and impact including the effect of encouraging those engaged in street protests and marches to invest energies into organising local prevention and treatment services¹⁴⁰.

¹³⁷ Bowden M. (1997) *Community Addiction Response Programme CARP – Killinarden: Review and Interim Evaluation*, Dublin: CARP – Killinarden.

¹³⁸ Cullen B. (1990) “Community Action in the 80’s – A Case Study” in *Community Work in Ireland: Trends in the 80’s Options for the 90’s – A report of a conference*, Dublin: Combat Poverty Agency.

¹³⁹ Dublin Corporation (2000) *Submission to Review of National Drugs Strategy*, Department of Tourism Sport and Recreation.

¹⁴⁰ Lambe, S. (1997) “The experience of the Inner City Renewal Group” in *Drugs Poverty and Community Development: A report of the Conference for Community Development Programme Projects on Community responses to Drugs Issues, held in February, 1997*, Dublin: Combat Poverty Agency.

A community drug project, based in a northside suburb, and set up in 1981, pioneered local services, laying great emphasis on prevention and education through the development of communications and relationship-building. It emphasised the training of local people in addiction issues, “seeing the passing on of skills as of major importance”¹⁴¹. The project subsequently made its model of addiction training available to other community groups through establishing a community addiction studies training centre, which focused on developing the “ability of communities and generic agents to participate” in addiction issues¹⁴².

A second voluntary agency, which provided outreach and low-threshold counselling services in the city centre, initiated a public debate on the need for policy changes. It advocated that resources for tackling the demand for drugs be targeted at a small number of designated community priority areas in Dublin and that community-based treatment services (including the provision of drug substitution therapies which at the time were available only in a limited manner mainly to HIV infected persons) be provided. It also recommended that GPs and generic health workers become involved in drug treatment through community drug teams¹⁴³.

The development of area-wide and cross community networks through the early 1990s generated further momentum for supporting community and voluntary groups to focus on the need for policy changes rather than solely focusing on street-level supply issues. For example a conference in November 1990 hosted by an inner city network of individual community members, tenants organisations, community groups, Gardaí, social workers, public health nurses, community workers, voluntary workers and others, highlights an emergent sophistication among those supporting community demands. Not alone did this network group succeed in bringing together a wide variety of interest groups, it also published its conference proceedings¹⁴⁴, and in 1990 it made a detailed submission to the National Coordinating Committee on Drug Abuse. Its proposals were later presented to a special meeting of Dublin City Council and subsequently, the network set up a voluntary agency that engaged in community education¹⁴⁵ and preventive actions¹⁴⁶ and also conducted research into the local experience of drug problems¹⁴⁷. This new agency’s separation from previous, street-protest oriented actions, is highlighted by the following quote from its then coordinator in 1994:

Gone are the days, it appears, of mass action, large public meetings and vigils by communities struggling against the heroin problem in their

¹⁴¹ McCann, M. (1998) “Drug Services in Dublin: selective or comprehensive strategies?”, *Journal of Substance Misuse*, vol. 3, 150-55.

¹⁴² *Ibid.*

¹⁴³ Ana Liffey Drug Project. (1990): *Drug Treatment Policies - A discussion document*. Dublin: Author.

¹⁴⁴ Community Response (1991) A report of a seminar on drug problems in the south inner city held in Kevin Street College of Technology on November 3rd, 1990, Dublin: Author.

¹⁴⁵ Rourke, S. (1999) *Summary Evaluation of Community Drug Workers Training Course*, Dublin: Community Response.

¹⁴⁶ Community Response (2000) *Family Project Annual Report, 1998-1999*, Dublin: Author.

¹⁴⁷ McCarthy, D., McCarthy, P. (1997) *Dealing with the Nightmare: Drug-use and Prevention Strategies in South Inner City*, Dublin: Community Response.

areas. Such activities, synonymous with the eighties, have been replaced with different responses....a multifaceted approach...to get the communities active in determining their own responses....and backed up and supported by the State¹⁴⁸.

The demands of cross-community networks for a new community-oriented policy gathered greatest momentum during 1995. Arising from one very public meeting on the drugs problem in the inner city in 1995, a series of focused discussions for family groups provided the impetus for organising a march to government buildings in September 1995 to commemorate those who had died as a result of drug problems and to demand more and better treatment facilities. The march had widespread support from communities throughout Dublin and through this support a basis for developing a broad, cross-community campaign on drug issues emerged. The campaign emphasised the need for comprehensive, community-based treatment and rehabilitation alongside community prevention, family support and a more direct involvement by community organisations in policy and service development. The campaign was publicly launched in March 1996 with the essential aim of linking up organisations and providing a forum, for discussion, policy formulation, sharing information and campaigning for resources and policy changes¹⁴⁹.

In due course the campaign established a community development support project, with full-time staff and funding from Department of Social Welfare Community Development Programme, and with a focus on providing ongoing support, facilitation and networking opportunities to local community groups working on drugs issues¹⁵⁰. This has included providing support to community representatives on local drugs task forces, building networks amongst local communities, making submissions to public bodies, representing community groups on a small number of national bodies and also through hosting seminars on issues of relevance. The main importance of the campaign was that it established the possibility of an alternative representation of the seriousness of drug problems than that of street protest alone, thus providing a mechanism whereby the State could deal effectively with a community-drug sector, that was perceived as broadly representative and as non-aligned to vigilante-type activities. At the same time, through creating alternative mechanisms for representing community interests, the campaign helped reduce the necessity for street actions and marches.

Public health demands for community-based treatment

During the late 1980s and early 1990s community demands for new policies were reflected in the efforts of some health practitioners who argued the merits of moving away from the traditional, abstinence approach to drug treatment and to support the adaptation of more flexible models of community-based treatment, potentially with the

¹⁴⁸ Connolly, F. (1994) "Heroin – A Community Response", *Community Workers' Co-Op Newsletter*, Nov./Dec.

¹⁴⁹ Dublin City-Wide Campaign on Drug Abuse (1996) *Fighting Back Together, A Trade Union and Community Response*, Conference Leaflet, Dublin: Author.

¹⁵⁰ City-wide (1999) *Triennial Report, 1997/8/9*, Dublin: Author.

involvement of general practitioners¹⁵¹. With the onset of AIDS / HIV in the mid 1980s, there was an increasing momentum towards looking at drug problems as a public health issue, emphasising the social and environmental causes of drug problems and their effects on groups as well as on individuals. In practical terms this new approach placed greater emphasis on managing drug problems in the context of community-based, primary care, with the back-up of specialist services, as appropriate. Through the emergence of this more focused public health approach, changes in relation to the provision of alternative drug treatments had already commenced by the late 1980s, although it seemed that these changes lacked clear policy sanction¹⁵².

In 1987, arising from concerns over the spread of HIV through intravenous drug use, the first alternative non-abstinent drug treatment service was set up by the Eastern Health Board at a central city location. Although this centre was established initially as a public health service, ostensibly to provide information, testing, and counselling for persons with HIV / AIDS (including drugs misusers, gay men and other categories perceived at high risk), in practice it quickly established low-dose substitution treatments for HIV infected drug users. This involvement of public health authorities in drug treatment signalled a move to a more pragmatic approach as part of which indefinite substitute prescribing eventually became accepted. Furthermore, these developments also encouraged a coming together of individuals and professionals working on relevant health issues with both gay men and drug users to support the formation of self-advocacy groups among drug users, thereby adding further pressure for policy changes¹⁵³.

The ascending importance of the public health perspective was evident in the Department of Health & Children's *Government Strategy to Prevent Drugs Misuse (1991)*¹⁵⁴, which clearly advocated the need for harm-reduction. Arising from the new strategy the health authorities appointed a public health specialist to a new position as Drugs and AIDS Coordinator for Dublin. While this appointment brought a new urgency to the need to focus on the uniqueness of drug problems in the Dublin area, the initial absence of significant resource investment meant that there appeared to be very little actual services to coordinate. In September 1992 however, the first community based drug treatment centre opened in west Dublin providing an intensive outpatient detoxification service as well as offering structured methadone maintenance to chronic intravenous drug users aged 18 years or older. Patients who are HIV positive and pregnant women were prioritised. Methadone prescribing and dispensing took place on-site and regular urinalysis was carried out on patients. Similar centres were subsequently established in various other locations.

In addition, community drug treatment services were established in the course of the following years and these services were located in areas where significant numbers of opiate misusers required treatment. These were initially developed by a number of community groups who had previously actively engaged in anti-drug community

¹⁵¹ Irish College of General Practitioners (1990) *Policy Statement on Illicit Drug Use and the Problems of Drug Addiction*, Dublin: ICGP

¹⁵² Butler (1991)

¹⁵³ Ana Liffey Drug Project (1991) *Annual Report 1990*, Dublin: Author.

¹⁵⁴ Department of Health. (1991): *Government Strategy to Prevent Drugs Misuse*. Dublin: Author.

actions, along with a small number of private GPs¹⁵⁵. In a sense these groups bypassed medical and institutional obstacles to such treatments by setting up their own facilities and engaging doctors in a private capacity to provide clinical services. At the time, the Misuse of Drugs Acts 1977 & 1984 presented no legal obstacles to methadone prescribing, although in practice very few GPs actually prescribed. The few who did played an important role in building a momentum towards community drug treatment and eventually through the direct involvement of health authorities this form of treatment provision has increased to over fifty separate sites throughout Dublin by 1999, leading to an evaluation comment that “this expansion...is probably one of the more innovative community drug service programmes in Europe”¹⁵⁶.

Meanwhile arrangements were made to facilitate the involvement of GPs in the direct provision of treatment through normal primary care services. Although the 1991 government policy emphasised an increased role for GPs and an expert group agreed a Protocol for the Prescribing of Methadone in 1993¹⁵⁷, their effective involvement in drug treatment did not happen until 1996¹⁵⁸. Initially this took the form of a pilot project, which in 1996 included 55 GPs and 21 community pharmacies. Three years later this was mainstreamed and by 2001 the Eastern Regional Health Authority reported there were 138 participating GPs and 167 participating pharmacies providing a service to 1,749 patients, i.e. almost 35% of those in treatment¹⁵⁹. Although the Methadone Protocol took most of a decade to become fully developed and implemented, its introduction is considered an impressive policy achievement, particularly given the general unpopularity of drug-users from a policy perspective, and the fact that as a harm-reduction measure this added further to its unpopularity and also because it involved some curtailment of the previously-existing prescribing rights of doctors¹⁶⁰.

Developing a community partnership approach

The development of the community treatment centres and the methadone protocol signalled a policy shift towards a community and primary care policy. However, being community-based does not necessarily mean having sustainable community support and involvement. While the establishment of community treatment centres necessitated negotiations between health and community authorities, the nature of these relationships often lacked harmony. They also lacked an overall partnership framework and structure. The need to develop such structures was hampered because, at the time, while communities throughout Dublin were protesting against government and its inaction on drug problems many were also protesting against public health authorities in opposition

¹⁵⁵ O'Brien, L. (2000) *A Case Study of Heroin Users in Methadone Treatment in their own Community*, Thesis submitted for MSc in Drugs and Alcohol Policy, University of Dublin, Trinity College.

¹⁵⁶ Farrell, M., Gerada, C., Marsden, J. (2000) *External Review of Drug Services for the Eastern Health Board*, London: National Addiction Centre.

¹⁵⁷ *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone, (1993)*, Dublin: Department of Health.

¹⁵⁸ *Report of the Methadone Treatment Services Review Group, (1996)*, Dublin: Department of Health and Children.

¹⁵⁹ Cited in

Butler, S. (2001) “The Making of the Methadone Protocol: the Irish System?” paper presented at the 12th Annual Conference of the European Society for Social Drug Research (ESSD), Venice.

¹⁶⁰ *Ibid.*

to *their* plans to set up local services. On the surface, community resistance to plans for new services reflected a fairly typical not-in-my-backyard syndrome. Community resistance however, was also fuelled by the frustrations of community personnel working with health authorities that continued to reflect conventional medical models of treatment, which did not offer flexibility to incorporate community perspectives that advocated the employment of non-medical key workers and community assistants within the overall context of locally-based rehabilitation¹⁶¹.

Behind these difficulties was the complexity of partnership development. Multi-agency, partnership work is never easy: partnership arrangements do not simply evolve out of decisions to set them up. Agencies have contrasting aims, objectives and priorities as well as different management systems and styles, and procedures for dealing with confidentiality and sharing of information¹⁶². A partnership approach was slow to come about in the area of drugs. Since 1990 many community groups had already developed roles in other partnership bodies which were established by government as a response to long-term unemployment and the need for urban regeneration, roles that have since been strengthened in government policy on tackling social exclusion¹⁶³. However, slow progress in developing community partnerships with health authorities exacerbated tensions and these are particularly evident in the experiences of two community drug teams set up under the 1991 Government Strategy.

A report from one of these drug teams highlights that the conditions for creating a partnership between a community project and health authority did not exist and that failure to address issues of inequality and accountability meant the community drug team lacked a “strong foundation”¹⁶⁴ with the result that three years after this team was set up it disbanded. A second pilot community drug team managed to stay together but here again tensions between a community group (local youth project) and health authority were evident. The community group feared an imminent expansion of local treatment facilities would lack comprehensiveness and take place without adequate back-up or specialist assistance and would also lack the involvement of GPs and pharmacies in the provision of methadone¹⁶⁵. The situation became particularly frustrating for the drug team’s extended network when health board management “went ahead with plans for a drug treatment centre while delicate negotiations were going on at a local level involving all the interested parties”¹⁶⁶. As already discussed, the delay in developing a national support structure to facilitate the participation of GPs in treatment contributed to these difficulties. Many drug users continued to rely on non-official clinical treatments, arranged through GPs, acting in a private capacity and in conjunction with drug team members.

¹⁶¹ McCann, M. (1999) *The role of the community in responding to drug-related problems*, PhD thesis, Dublin City University.

¹⁶² Cullen, B. (1998), *Integrated Services and Children At-Risk: The Integration of Services for Tackling Early School-Leaving and Educational Disadvantage at Local Community Levels*, Dublin: Combat Poverty Agency.

¹⁶³ Ireland (2000) *National Development Plan, 2000-2006*, Dublin: Stationery Office.

¹⁶⁴ Forrestal, C. (1996) *Evaluation Report on Ballymun Community Drug Team*, Dublin: Community Action Network.

¹⁶⁵ Bowden, M. (1996) *Rialto Community Drug team – Policy Discussion Paper*, Dublin: Rialto Community Drug Team.

¹⁶⁶ Fergal Connolly, Coordinator of Community Response, quoted in McCann (1999).

A policy discussion document commissioned and published by the above community drug team criticised the health board approach to community partnership, which it perceived as being focused solely on liaison and consultation and not concerned with management, planning and policy¹⁶⁷. However, even as this report was being published, a new commitment to supporting effective community input into policy emerged at the level of national government. As mentioned above, throughout the 1990s, government was already engaged in developing partnerships with community bodies and it seemed inevitable that this approach would also include the area of community and public health¹⁶⁸.

The extension of this approach to drug policy came in the aftermath of the dramatic shooting dead by drug dealers of a nationally prominent crime journalist in 1996. Following this shooting, a publicly-supported political commitment, alongside new legal and supply control measures promised a more comprehensive crackdown on illicit drug dealing. Alongside these developments a government commitment to demand-side measures signalled a more radical approach than had ever previously been witnessed, in conjunction with a major new investment in resources, which for so long previously, had been missing. A National Drug Strategy emerged from the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* in October 1996. The Report drew greatly from the language of urban community organisations concerned with drugs when it emphasised that whereas the drug problem had *consequences for individual* users and addicts, in urban areas in which the drug problem was clustered, it had other, discernible *community consequences*. According to the report, these included: deterioration in the quality of life, in the local economy and in community safety, triggering a “vicious circle in which all the factors mutually reinforce each other to create a downward spiral” that neighbourhoods “face in the most stark and horrific terms¹⁶⁹”.

The Report’s new strategy was framed in the context of government policy on social exclusion and alongside other initiatives on social exclusion it was also framed within the context of new partnership arrangements and structures. Clearly, the demands of network groups, as outlined above, were also beginning to have impact at a policy level, particularly as many of these were articulated within the context of area partnership companies that were working in the area of unemployment and urban regeneration. In the course of community consultations, some of these companies discovered further evidence of the impact of drug problems on urban neighbourhoods¹⁷⁰.

Also, in 1995 an inter-agency drugs project, which had statutory funding and an independent coordinating structure, was established in an inner city community¹⁷¹. The project operated through sub-committees dealing with treatment and rehabilitation, prevention and education, supply control and in each of these committees were

¹⁶⁷ Bowden (1996)

¹⁶⁸ *A Health Promotion Strategy – Making the Healthier Choice the Easier Choice (1995)* Dublin: Department of Health.

¹⁶⁹ *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996), Dublin: Stationery Office.

¹⁷⁰ Canal Communities Partnership (1996) *Area Action Plan*, Dublin: Author.

¹⁷¹ Inter-Agency Drugs Project (1996) *Interim Report*, Dublin: Author.

represented members from community, voluntary and statutory sectors. In the following October 1996, when the First Ministerial Report was published, the government decided to set up local drug task forces in thirteen designated areas with local structures based on the area partnerships model and influenced by the structure and work of the inter-agency drugs project¹⁷².

Alongside new structures at local levels, a National Drugs Strategy Team was established and together these provided a focus for interagency collaboration around the drug issue. Since this new policy was formulated, drug services provision through community agencies has escalated. These include locally-based treatment and rehabilitation programmes, drug education programmes in schools and youth clubs and other community-based prevention activities, which are provided through community centres, after-school clubs and youth outreach programmes. The new policy also signalled the passing of new legislation that made it easier for local authorities to evict tenants who were considered “anti-social” as a result of their homes being used for drug-dealing and other related activities. These policy developments have since been consolidated under the National Development Plan, 2000-2008 and is detailed in the document, *Building on Experience*¹⁷³, which was launched in June, 2001. The latter document, officially described as “the most comprehensive analysis and assessment of the drugs problem in Ireland ever undertaken”¹⁷⁴ outlines four key pillars relating to supply reduction, prevention, treatment and research, alongside mechanisms for more effective coordination, which include the continuation of local drugs task forces in designated areas.

Conclusion

In the discussion in previous sections community drug problems are directly associated with spatial deprivation: they are attributed primarily to structural effects and community conditions and to the resultant diminished capacity of local institutions and organisations to deflect community members from criminal and drugs involvement. The accumulation of community drug problems generates a picture of community distress, potentially inhibiting local efforts that would have been developed as a counter to the escalation of drug use. The inability of those at an official level to acknowledge, let alone respond to, the problem’s community and spatial dimensions, could only have exacerbated this negative community predicament. This picture of disorganised community is regularly represented and, for some, is a compelling symbol across Dublin’s most economically marginalised neighbourhoods, deepening even further their sense of isolation, their sense of being outside the orbit of policy concerns or influence.

¹⁷² Twelve of these local drug task forces were located in Greater Dublin Area and the thirteenth in Cork. A fourteenth area, Bray, was also designated at a later stage.

¹⁷³ Department of Tourism, Sport and Recreation (2001) *Building on Experience – National Drugs Strategy, 2001-2008*, Dublin: Stationery Office.

¹⁷⁴ The Minister of State at the Department of Tourism, Sport & Recreation Eoin Ryan (Dail Eireann, *Debates*, 31st May 2001, 943-4)

However, alongside the picture of drug problems as reinforcing community disintegration, there is the reality of drug problems bringing about a mobilisation of community actions and effort, reflecting a broader movement of community involvement in tackling local problems, and in turn influencing the motivation of government and institutions to respond. Indeed, over the last two decades, neighbourhoods in Dublin with the most severe community drug problems have demonstrated an exceptional capacity to organise and to generate bottom-up, community-based responses, and to do so often in the absence of coherent, official, community-supporting policies. In this context, the reorganisation of local community structures and community development, alongside the involvement of public health workers with community health issues, has led to the emergence and development of a new drug policy. Importantly, the policy is underlined by partnership structures that operate at both local and national levels and have become embedded in a system that twenty years previously refused to accept or acknowledge the centrality of the community dimension.

SECTION 4

DISCUSSION AND ISSUES FOR RESEARCH AND FURTHER CONSIDERATION

The discussion in this paper above sets out to examine the consequences of drug problems from within a local, community context, in order that this understanding might help identify issues of current concern and in due course contribute to further study, analysis and policy development. At the outset of this discussion the dearth of appropriate research literature for such examination is highlighted and inevitably much of the discussion is drawn from “grey literature”. Most published Irish research is concerned with analysing drug misuse prevalence and profiles of drug users, at both national and local levels. This literature is drawn mainly from research of treated drug misuse and drug-crime links and it underlines the cumulative effect of these problems on individuals, families and their neighbourhoods. The overall literature however, is quite limited and there clearly is a need to expand the base of both health and crime-related studies. There is a need for research that draws in non-clinical samples of drug misusers – perhaps utilising a number of ethnographic field sites - in order to establish more precise information on drug-using trends and patterns, and changes in these across time and places. Such research should also examine the levels of the social environment that directly shape individual, family and community experiences of drug problems. This could add greatly to our understanding of the clustering of drug problems within particular neighbourhoods and among certain resident families, as well as providing explanations for inter- and intra-community variations. There is a need for more data on family backgrounds, family experiences and engagement of families with local environment and services. The use of oral histories and enquiring into the background to drug problems and other relevant issues (medical, social, and psychological) and linking these to accounts of the effects of wider social and economic changes would also be useful. Ethnographic research is also needed to examine the impact of drug misuse, drug dealing and related crime on local economies, and the social embeddedness of drugs and crime within urban neighbourhoods and among specific groups and families. Such research should contribute to an empirical basis for exploring the extent to which drugs lead to crime or *vice versa*.

The limitations of current Irish literature on drug problems notwithstanding, it is evident from earlier sections in this paper that there is a dynamic interaction between individual drug-use, its social and community contexts and drug policy. For individuals, their drug use increases their risk of addiction, of infection, of overdosing, of serious illness and of premature death. Long-term they also face the prospect of becoming isolated from families, marginalised by society and rejected by their communities (evicted), and homeless. They also risk an involvement in crime and of getting caught and being imprisoned. The longer they are embedded in a drug-using, criminal lifestyle, the more difficult for them to rehabilitate and reintegrate into normal society. It is clear however

that alongside these individual consequences that there are other important family and community effects. Family relationships can break down, the needs of children and other vulnerable members get neglected, bringing even further external intervention into the home. Moreover, family members experience the pain, trauma and grief of drug-related illness and death, of providing long-term care for children who are being raised amidst drug-use, police raids and external intervention systems, and of continuing to care for adult drug-using members following years of addiction and illness. There is a neighbourhood dimension to these family effects, especially as many extended families continue to live in close proximity. The community also feels the effect of drug-related crime. Persons living in a community with a drug problem are at high risk of being a victim of crime. Drug problems and related crime bring fear to communities, a fear of disorder and of being a victim of crime. Also according as drug misuse escalates within a declining community a drug economy inevitably thrives contributing to even further fear and a loss of community as previously known.

For the families and communities of drug users it would seem clear that these particular experiences of drug problems require an appropriate community response. For a long time following the escalation of community drug problems there was institutional resistance to a community approach. However, there is now a community drug policy and this has been strengthened through the publication of *Building on Experience*. Surprisingly, despite the centrality of community involvement in drug policy, the document *Building on Experience* provides little explanation as to how or why it took so long for this focus to be introduced. There is no official analysis of the limitations of previous statutory responses. There is no specific reference to the 1983 *Government Ministerial Task Force on Drug Abuse*. Indeed there is no mention of the recommendation of this Task Force that community drug problems should be tackled through designating community priority areas (not unlike local drug task force areas that were designated thirteen years later).

The absence of official explanation for a delayed coherent, community policy response reinforces *inter alia* a view outlined in 1996 by the then Minister for Social Welfare, following the setting up of local drugs task forces, when he commented:

Political action and statutory agencies are largely reactive. They act as a result of identified needs and the most *vociferous* interest groups get heard. There is no doubt that the most marginalised and disadvantaged parts of Dublin – the areas where the heroin and drug problems are worst – are the areas with least *political clout*. Thus the situation had to come to a crisis before a response came about. This is not to excuse it, but rather to explain how this has happened¹⁷⁵(*italics added*)

This is an important point for developing a discussion in the Final Section of this paper. If anything over the last seven years it has become clear that many of the communities who

¹⁷⁵ De Rossa, P. (1997) "Community Development and Tackling Drug Misuse" in *Drugs, Poverty and Community development: A report of the conference for community development programme projects on community responses to drugs issues held in February 1997*, Dublin: Combat Poverty Agency.

during the previous decade lacked political clout with respect to drug problems have been become more vociferous in articulating their particular interests. Following the setting up of local drug task forces and a new national drug policy in 1996, there was, a year later, a change of government. Among the policies of the main political party in the new coalition government was a clearly underlined reservation in relation to the provision of methadone maintenance as a drug substitution treatment¹⁷⁶. Also at an early stage of the government's tenure it seemed that the previous government's commitment to target a Youth Service's and Facilities Fund at local drug task force areas, would not be upheld. However, with little debate or argument reservations in relation to methadone maintenance were dropped and a major expansion of treatment places ensued. Furthermore, the central position of community in drug policy prevailed and youth service funding commitments from the previous government were improved upon¹⁷⁷. With these developments, followed shortly by the publication of *Building on Experience*, it is clear that the policy initiated in 1996 has now attracted all-party support. Evidently, there has been a sea-change with how community has been viewed in relation to drug policy. Unfortunately, there continues to be gap in society's understanding of these changes. In particular there is an absence of relevant information on the process of drug policy-making. According to one commentator on drug policy on the UK the "real hidden populations" with respect to drug problems are "the policy-makers, the civil servants, and the members of organisations, and interest groups" who influence the interplay between choice of research and policy application"¹⁷⁸. There is a need for research that critiques the aims and performance of drug policy, with particular reference to examining the rationale and motivations for community-oriented policies and the ways in which these adapt to changing social and economic realities, changing patterns of drug use and changing neighbourhood effects.

Despite the achievements of community drug policy in recent years it is not all plain sailing. The building of social solidarity within the context of pervasive community problems is not without trials and difficulty. Clearly community experiments have led to the introduction of policies that otherwise encountered major institutional obstacle. Clinical treatments are now regularly provided in community settings as an alternative to more medicalised provision in hospitals. Because of the uniqueness (and newness) of this approach there is a need for more information on its operation and efficacy in drug treatment. Furthermore, this new approach has drawn public health officials into a direct relationship with community agencies. There is the potential for quite a lot of conflict within these relationships especially as drug treatment professionals inevitably draw lines of confidentiality and other separations with local community personnel upon whom they continually rely to sustain community support for drug treatment. Also, the expansion of local services inexorably leads to a dramatic increase in the numbers of locally-based drug workers and an increase in community demands that their members have opportunities to qualify and compete for these positions.

¹⁷⁶ Fianna Fail (1997) *A Radical Approach to Drugs and Drug Related Crime*, Dublin: Author.

¹⁷⁷ "Ahern announces £30m for anti-drug services", *Irish Times*, January 22, 1998.

¹⁷⁸ Berridge, V. (2000) "The impact of qualitative research on policy-making: setting the scene" in EMCDDA *Scientific Monograph Series, No. 4, Understanding and responding to drug use: the role of qualitative research*, Lisbon: EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

There are also other, contrasting community demands. On the one hand the engagement of community groups with the processes of change and development arising from drug problems increases their awareness of underlying issues and problems, while on the other some groups remain more narrowly focused on excluding drug users and drug treatment services from their areas. In terms of structural issues it seems clear that community drug problems are linked with economic and social changes that brought about a contraction in unskilled, manufacturing jobs and the effect of these on urban neighbourhoods and local labour markets. In reality however, whatever the initial causes of these problems, the idea of local labour markets has virtually disappeared and these now tend to be structured on a regional, city or sub-city basis. The local supply of jobs is now not nearly as important as the capacity of local people in disadvantaged urban neighbourhoods to access such jobs and here education plays a key role.

Some groups who are involved in responding to community drug problems have reflected concerns about the lack of engagement by many young people in education. Concerns are raised about early school drop-out, the non-attainment of qualifications and the way in which young people become attracted to an alternative, street-oriented lifestyle, with little future prospects of work. It is clear that in recent years a restructuring of education - through expanding the number of places at third level and a convergence of academic and vocational learning - has been a key factor in improving national economic competitiveness, thus contributing to economic growth. To be fully included in the now, restructured, economy, and to avoid further marginalisation, young people from disadvantaged urban neighbourhoods need to be part of this educational change and to remain in education until post-leaving certificate or third level. Yet, their local culture lacks third level experience and is also seriously lacking in second level achievement. Moreover, many students initially intending to complete school at leaving certificate, are often tempted to do so at junior level (official school-leaving age), for the reason that differences in jobs attained at these levels do not greatly reflect differences in qualification.

In attempting to facilitate educational achievement at higher levels local drugs task forces and other community projects focus much of their energies on supporting homework clubs, after-school projects, educational support initiatives, and so forth. All of these are geared towards keeping young people in education at least until they complete leaving certificate, as well as affording some protection against an involvement with drugs. These are important objectives and clearly if they succeed in establishing second level graduation as a norm in the communities concerned, then this will be a significant achievement. However, if the community's overall educational standard is to succeed in establishing levels of competitiveness such that members are able to access good jobs and become more fully included in society, thereby improving the community's overall participation, then even higher levels of overall educational achievement are required. This is an enormous challenge. It is very difficult to see how the desired inter-generation changes in educational experience and outcome, can be achieved in the absence of extensive financial investment, alongside a transformation in the mindsets of both local people and education providers, and a mustering of community and cultural resources. The latter aspects are particularly important. Clearly, local parents and their children in

disadvantaged urban communities need to become more convinced of the critical role of educational achievement in shaping future life outcome. Mainstream education – in terms of its curriculum, structures and leadership – needs to more adequately value differential cultural experiences as a way of improving both basic retention rates and improving the overall engagement of their pupils’ parents and communities with the education system.

Another particularly difficult issue for many communities is their ambivalence towards the development of new services. Community ambivalence is underlined in the following quote from a community consultation study:

Communities are very divided around the issue of drugs. Communities no longer care if their neighbour’s families are falling apart and, at the same time, communities don’t work if the families are falling apart. Herein lies the paradox for the ‘community’¹⁷⁹

Community ambivalence is particularly acute with respect to the housing of drug users. When drug misuse first escalated during the late 1970s and through the 1980s, most drug misusers were housed in public housing estates, often with their families of origin, partners and / or new families. At the time drug users / dealers were perhaps tolerated because they were perceived as having functional value in depressed local economies. However, the situation has now changed. Those residents who might previously have supported a drugs-crime economy through the illegal purchase of consumer commodities are, as a result of an improved local economy and an increase in employment and income, more likely to obtain such goods lawfully¹⁸⁰. Consequently drug users may be perceived as having lost their economic value and be increasingly castigated as nuisances, outcasts and as a threat to the local community and formal economy. Their position with regard housing availability has become more precarious especially as a result of decreasing supply of subsidised public housing and also as a result of the operation of the Housing (Miscellaneous Provisions) Act (1997). Some community groups have collaborated with the implementation of this housing legislation, permitting the exclusion of drug users / dealers, leading to concerns that the legislation is “open to abuse” and could potentially

.....institutionalise the way more powerful voices in communities informally picked people out and isolated them as difficult tenants, rather than establishing a coherent and sensitised process of negotiation¹⁸¹.

Arising from these developments there is now evidence of increased correlation between drug misuse and homelessness. These relationships require further investigation and in particular there is a need to explore the effects of new housing legislation, as these relate to children and families, and, the social and health needs of homeless drug misusers.

¹⁷⁹ Kierans, C., McCormack, P. (2001) *Ballyfermot Consultation Feedback Report*, Dublin: Ballyfermot Local Drugs Task Force (limited circulation).

¹⁸⁰ Field, S. (1990) *Trends in Crime, and their Interpretation: A study of recorded crime in post-war England and Wales*, Home Office Research Study, London: HMSO, cited in I. O’Donnell, E. O’Sullivan, *Crime Control in Ireland: The Politics of Intolerance*, Undercurrents Series, Cork: Cork University Press.

¹⁸¹ Murphy-Lawless, J. (2001) *Motherhood and Drugs: Women, Family Life and the Impact of Heroin in North Inner City Dublin* (limited circulation).

It is clear that many of the communities that were central to the experience of drug problems over the last twenty-five years are now going through a period of intense, rapid change. Some neighbourhoods that were worst affected by drug problems are in the process of large-scale demolition, reconstruction and renewal¹⁸². A government programme, RAPID¹⁸³, is designed specifically to speed up the process whereby designated communities, including neighbourhoods within local drug task force areas, can more speedily draw down the resources of the National Development Plan, in order to facilitate change. Although, with announcements of controls in public expenditure it seems likely that there will be less resources available from such programmes than initially promised.

The wider, community effects of new treatment policies should not be understated for not only have they resulted in direct benefits to drug users, but, according to one review of crime in Ireland, they have also contributed to a 29% decline in property crime in Dublin, between the years 1995-1999¹⁸⁴. With the decrease in property crimes, alongside physical change, there is the prospect of more substantial social and psychological change. As neighbourhoods improve so too does their residents' social outlook: their social networks are reconfigured and potentially new arrangements can provide both new opportunities and new marginalities.

This is an important point in concluding this paper. Use of drugs is never randomly distributed in populations but, to some extent, always occurs in clusters: more in some groups than others. One reviewer of drug trends over the last century uses the example of three groups in US history who during their time showed highest rates of opiate addiction: Middle-class housewives around the turn of the century; white working class men in urban areas during the 1920s and African-American communities in the cities immediately after World War 2¹⁸⁵. Three different groups in terms of gender, class and race and each at different times constituted the main risk group for opiate addiction.

All three groups during their time, shared a particular position which is described as "open marginality": group members are not visible at centres of power and influence, although access to such positions remained theoretically, and practically, if not realistically, possible. It was clear to members of each group that a way out of their marginality in society was possible, but that way out was not very wide and few had managed to move through it. Things could be different but it was more probable that they would not be.

¹⁸² Ballymun Regeneration Ltd. (1998) *Integrated Area Plan under the Urban Renewal Scheme, submitted to the Department of the Environment*, Dublin: Author.

¹⁸³ Programme to Revitalise Areas by Planning, Investment and Development (2001), *Explanatory Leaflet*, Dublin: Area Development Management.

¹⁸⁴ O'Donnell, I., O'Sullivan, E. (2001) *Crime Control in Ireland: The Politics of Intolerance*, Undercurrents Series, Cork: Cork University Press

¹⁸⁵ Agar, M. (2000) "Towards a trend theory" in EMCDDA *Scientific Monograph Series, No. 4, Understanding and responding to drug use: the role of qualitative research*, Lisbon: EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

Risk groups for opiate addiction, it is argued, change over time: the conditions of marginality remain more or less the same. Members of such groups would find:

...in the effects of opiates, some relief from the existential contradictions of open marginality, and that, therefore, a higher proportion of group members would continue to use to the point of physical dependence. In short, changing historical situations, also explain why trends shift¹⁸⁶

This historical analysis of opiate trends has application to community drug problems in Ireland. It should be clear from the above review that for the last twenty-five years opiate-use has been spatially concentrated in urban neighbourhoods in Dublin and that in turn these marginalised neighbourhoods have been characterised by unemployment and generalised deprivation.

What is not clear is whether this known experience of opiate-use will continue as the dominant pattern, or whether new patterns of use and related marginality, emerge. Provided drug problems persist in those communities where it is already extant policy needs to focus on providing these areas with an appropriate community response. However, if anything is to be learned from the failure to respond to community drug problems in the past, then the next policy challenge must be to ensure there be no such failure with respect to new drug problems, if and when these emerge. The best way to meet this challenge is to understand the perspective, the position, the circumstances and the needs of those who are most marginal and who are most vulnerable for it is among these groups that drug problems are likely to be most serious and most prevalent. At times this focus will overlap with current community concerns, but not necessarily, and not always. Communities can and do change and drug problems shift between different groups and populations. Of course, a targeted response hinges on the ability of policy-makers to differentiate drug use from drug problems, with the former tending to be more randomly distributed in the population while the latter more inclined to be clustered. A related challenge therefore is to ensure the overall discussion of community and drugs is informed by knowledge backed up by research and analysis.

ENDS/.....

¹⁸⁶ *Ibid*