NACD
National Advisory Committee on Drugs

A Community Drugs Study: Developing Community Indicators For Problem Drug Use

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Ballymun Community Case Study: Experiences And Perceptions Of Problem Drug Use

Bray Community Case Study: Experiences And Perceptions Of Problem Drug Use

Crumlin Community Case Study: Experiences And Perceptions Of Problem Drug Use

A Community Drugs Study: Developing Community Indicators For Problem Drug Use

November 2006

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Designed by **first impression**

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Foreword Minister Of State

I wish to welcome this report from the National Advisory Committee on Drugs, which is primarily focussed on the development of community indicators that reflect the impact of problem drug use in local communities. This report will, I hope, make a substantial contribution towards the debate on the development of such indicators, as this development would significantly assist with future service planning and delivery.

Within the communities researched, it was heartening to see that so many improvements have been achieved with regard to school leaving age, the reduction in crime, the expansion of drug treatment services and employment over the period researched.

This research clearly illustrates the merit of the National Drugs Strategy 2001-2008 approach, which stressed the need for community involvement through local and regional drugs task forces. The more local knowledge and services come together to tackle issues, the greater the likelihood of success.

Of course there is still work to be done and the report sets out various issues arising for the communities that have concerns and fears about changing patterns in drug use, binge drinking, anti-social behaviour and violent drug related crime.

I am aware that a first step has already been taken to develop these indicators with a meeting of key stakeholders convened to look at developing and implementing Community Drugs Indicators and I look forward to a successful outcome of these deliberations.

Finally, I would like to extend my gratitude to the researchers and community contributors for producing this report. I also acknowledge the research and analysis provided by the NACD and the ongoing work of its members, in particular, Dr Des Corrigan, Chairperson, and Mairéad Lyons Director and all her staff in the NACD.

Noel Ahern TD

Minister of State with Responsibility for the National Drugs Strategy.

Foreword Chairperson NACD

The NACD is tasked with advising Government about the consequences of problem drug use in this country. In approaching this part of its remit, the Committee recognised that drug use had consequences for individuals, their families and the community within which they live. This research was commissioned in order to further understand the consequences of drug taking for communities. The study set out to examine how communities' experiences of the drug situation have changed since 1996 and to identify possible indicators of a community drugs problem.

This excellent research so ably conducted and completed by Dr Mary Ellen McCann and Dr Hilda Loughran with the help of a team of local researchers presents valuable insights into the experiences of three communities (Ballymun, Bray and Crumlin) which have borne the brunt of drugs problems over the last 10 years. The report also presents possible indicators of a community drugs problem which would enable Government and local planners to react quickly to changing trends.

This report provides evidence of the impact and effectiveness of Government policy on drugs since 1996. In the first instance, investment in education has paid off with each community showing improvements in the number of children under 15 who stay in school and an increase in those staying up to Leaving Certificate. Secondly, employment opportunities have increased over the 10 years and this has had an impact on the local economy and community optimism. Thirdly, the large investment in the provision of drug treatment and ancillary support services has improved access to drug treatment locally. Finally, all of the above have had an impact on the experience of crime in local communities which decreased for a number of years.

However, there is also bad news. Whilst, initially the perception was that crime levels went down, the later phase of the study revealed a re-emergence of growth in local crime. In addition, the level of alcohol related problems such as under-age drinking and public nuisance/disturbance was increasing. Polydrug use which includes alcohol use with substances such as cannabis and cocaine, was an issue for all communities, whilst the over-use of prescribed benzodiazepines was highlighted as a growing concern in two communities. School absenteeism has replaced early school leaving as an issue of concern and is a feature of all schools in the three communities studied.

In considering this report the NACD made recommendations to Government which foresees the development and introduction of Community Drugs Indicators, which it believes will strengthen the future evaluation of the National Drugs Strategy 2001-2008. The importance of relevant agencies producing localised data in anonymised format cannot be over-stated. Creating a fit between different data or variables enables policy and service planners to present a more comprehensive picture of risk and can lead to communities with an emerging drug problem being identified earlier.

I want to thank and congratulate all those involved in the preparation of this excellent report because the enthusiasm with which each community embraced participation in this study is to be commended. Publications take much time and effort in proof-reading, cross checking and editing before the final product emerges. Thanks to our Director Mairéad Lyons and to Catherine Darmody at the NACD and to Barbara Connolly for their work in the process.

Dr Des Corrigan
Chairperson NACD

Acknowledgements

Many people contributed to this report. We are deeply indebted to the community groups who joined us in the research – Addiction Response Crumlin, Ballymun Youth Action Project, and Bray Community Addiction Team. From the time they committed to the study, they supported the process of gathering the data with us. Susan Collins, Anne Marie Hughes, and Vivienne O'Brien were always available when we needed them, and we thank them for the knowledge they contributed.

We cannot thank the people who took part in the focus groups and in the interviews enough. They did this, at times, at great inconvenience and disruption to themselves. We hope the finished report does justice to their contributions.

Elaine McManamly was our research assistant for over a year of the study. She worked steadfastly to produce what we asked of her, and contributed in no small way to the establishment of the research team.

Participating in the research team was a very rich experience for us. Rose Lynch, Eileen Griffin, Keelin McDonald and Joanne Davey undertook the research with tenacity and great interest. They reminded us of just how important it is to capture the real experiences of people, and to value their knowledge. They challenged us, supported us; we argued, laughed and many times got confused together! Thanks to all of them. We hope you all learned as much from the process as we did.

The Research Advisory Group of the NACD was of great support to the research also. Its members contributed extensive knowledge from their fields, and took great pains to reflect on the research reports, and give detailed feedback. The research is richer because of their involvement.

We are grateful to Mairéad Lyons and Dr Aileen O'Gorman, NACD Director and former Research Officer, for the many hours of work they dedicated to supporting the study. We appreciate the work of Una Molyneux of the NACD, who prepared the executive summary and Catherine Darmody who edited this report.

Finally, we thank our colleagues in UCD for their support while we undertook this research. In particular, thanks to Dr Pauline Faughnan and the Social Science Research Centre, Dr Nessa Winston and Martina Reidy of the School of Applied Social Science and Dr Ian O'Donnell of the Institute of Criminology.

Glossary

A&E	Accident and Emergency Department
ARC	Addiction Response Crumlin
BRL	Ballymun Regeneration Limited
CAFTA	Community and Family Training Agency
CAT	Community Addiction Team
CDP	Community Development Programme/Project
CE	Community Employment
CLAD	Community Links Against Drugs
CPAD	Concerned Parents Against Drugs
CPF	Community Policing Forum
CSO	Central Statistics Office
DART	Dublin Area Rapid Transport
DCC	Dublin City Council (previously known as Dublin Corporation)
DMRD	Drug Misuse Research Division
DTMS	Drug Trends Monitoring System
EDs	Electoral Divisions (previously known as District Electoral Divisions (DEDs))
EHB	Eastern Health Board
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESRI	Economic and Social Research Institute
GMR	General Mortality Register
HBSC	Health Behaviour in School-aged Children
HIPE	Hospital In-Patient Enquiry
HRB	Health Research Board
HSE	Health Service Executive
ICD	International Classification of Disease
IDG	Inter-Departmental Group on Drugs
KWCD	Kimmage Walkinstown Crumlin Drimnagh Area Partnership
LDTF	Local Drugs Task Force
LES	Local Employment Scheme
NACD	National Advisory Committee on Drugs
NCVS	National Crime and Victimisation Survey
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NESF	National Economic and Social Forum
NEWB	National Education Welfare Board
NPIRS	National Psychiatric In-Patient Reporting System
QNHS	Quarterly National Household Survey
RAPID	Revitalising Areas by Planning Investment and Development
RDTF	Regional Drugs Task Force
STFA	Strategic Task Force on Alcohol
UCD	University College Dublin
VEC	Vocational Educational Committee
WHO	World Health Organisation
YAP	Youth Action Project
YPFSF	Young Peoples Facilities and Services Fund

Executive Summary

The goals of the study were to capture the experiences of communities of the drug problem since 1996 with a view to informing the development of a set of community indicators of a community drug problem. An innovative methodology of community participation in research was used; the lead researchers recruited local people as research assistants through community-based projects in the three communities under investigation: Ballymun, Bray and Crumlin.

These communities varied in their social and economic environments. Twelve themes, producing valuable snapshots of change amongst these communities, contribute to the growing awareness that polydrug use is an issue within Dublin.

A portrait of a community drugs problem emerges from the study as follows: a) increasing polydrug use; b) alcohol misuse, public nuisance/disturbance and underage drinking; c) open drug dealing associated with violence and intimidation; d) drug related deaths; e) sense of fear/safety in public places leading to restricted use of local amenities; f) frustration over treatment waiting lists, poor access to treatment; g) frustration over the provision of policing services leading to a deterioration in relations between local community and local Gardaí. Current indicators of drug problems do not capture this picture. They are limited in various ways. Firstly, there is a lack of consistency in defining boundaries for Datasets. Secondly, they don't measure what communities are concerned about. In this Community Study, people spoke about what matters to them, when considering what changes have taken place since 1996.

Aims Of The Research

1. To explore their experiences of drug issues from 1996 to 2004
2. To describe initiatives developed between 1996 and 2002 which the communities perceive to have influenced any change
3. To explore how the communities experienced their involvement in planning and implementation of such initiatives
4. To assess how the then community infrastructure affected the community's experiences.

Method

Qualitative participatory research was employed in three communities across Dublin: Bray, Crumlin and Ballymun. To ensure the validity and rigor of the research, core data triangulation methods included focus groups; key participants; desk research; grey literature; review meetings; and oral diaries.

Local contacts were recruited and trained as community researchers because they lived in and/or worked in the three communities in the research. A richness was brought to the research through the mixed involvement of the researchers. Data were analysed qualitatively with the assistance of the community researchers.

Participants were categorised into four groups: Level 1 (direct experience of drug-use issues); Level 2 (indirect involvement with the issue); Level 3 (involvement in community activities but not drugs issues); and Level 4 (voices not normally heard). Despite strenuous efforts to recruit participants, the focus groups had mixed results. Attendance in some focus groups was low due to competing demands to attend other community meetings on housing and regeneration. Some participants also cited intimidation as a factor. Nonetheless, recruitment was increased through 'Community Championing' i.e., networking with a chain of 'personal' contacts of the community researchers.

One-to-one interviews were carried out with 20 participants comprising members of the Bray (n=5), Crumlin (n=7) and Ballymun (n=8) communities. Nine focus groups were undertaken with a total of 28 members of the Ballymun community, 28 members of the Bray community, and 20 members of the Crumlin community. Participants were recruited to participate in the study by the community researchers – thus giving their experiences a voice in the project.

The importance of accessing a range of voices has been verified by the data collected. The researchers were able to reach a point in the gathering of data where the issue of repetition of data began to arise. This ***data saturation*** *indicated that the research had been successful in capturing comprehensive pictures of experiences from each of the three communities.*

Notes and tape recordings taken during interviews and focus groups were fully transcribed. All the comments made on a particular issue were collated and analysed thematically to construct community profiles using 1996 as a baseline year, and according to the themes that most consistently arose and that are pertinent to the project's aims. The analysis is therefore firmly grounded in the data received from informants during the study. The use of a thematic analysis makes it possible not only to report on common threads and issues surrounding drug use that arise for the three communities, but also to identify areas of difference on specific issues. For validation, findings were presented to participants, to confirm or challenge the interpretations of the research team, and most attendees were both surprised and pleased with the analysis.

Findings

The study showed that there is a lack of consistency in defining boundaries for Datasets; (1) Bray is in fact three communities, with some of the most advantaged and also disadvantaged areas in the country; (2) Crumlin, although an old and relatively settled area, is perceived by residents to be different to the widespread image held by many outsiders of the community. In particular, concerns were voiced over the continued disadvantage, and the repetition of past mistakes, which create stigmatised pockets of housing. As in Bray, deprivation in these small housing schemes can be hidden in Electoral Divisions (ED) statistics, because of the new privately owned houses surrounding them; (3) In Ballymun, the overriding topic was the current regeneration. Very mixed feelings were expressed about the changes, with some hope and excitement, and many fears that mistakes of the past were being made again. There was a concern that the social environment was not being given enough thought and planning.

The Range Of Drugs Being Used

The incidence of treated heroin misuse fell sharply between 1996 and 1997 and has remained to date (O'Brien et al, 2003). However, the proportion of drug treatment contacts presenting with other primary drug problems was relatively small due in part to Drug Services focus on opiates.

Results showed that substance use and patterns of use as experienced by these local communities are not reflected in the national treatment statistics. The 1996 focus on heroin is no longer the only concern, as these communities now identify polydrug use as the main problem and are concerned with the range of substances, in particular cocaine and benzodiazepines, available. The use of cannabis was seen as widespread, with limited awareness of any dangers associated with the drug.

The Place Of Alcohol As One Of These Drugs

In all communities, alcohol use, in particular high-risk, under-age drinking and disturbances, was a serious concern. There was concern about alcohol in connection with cocaine use taking place in pubs, and among an older age group and at the increased availability of off-licences.

The Local Drug Markets

Evidence indicates that when dealers feel free to deal openly in an area and are organised enough to protect themselves from police intervention, then the community inevitably feels vulnerable. Such was the case for the three communities in this study.

- In one community, the only shopping centre was badly affected in 1996.
- In another, drug dealing in public parks directly affected the quality of life.
- In another, there was fear of using the local DART station.
- In all communities, there was fear of letting children out to play in local parks.

There have been changes in local drug dealing since 1996:

- Use of mobile phones, the development of a cocaine market, have reduced visibility of drug dealing.
- Greater violence is associated with drug dealing.
- There is a greater sense of intimidation from street gangs; dealing is witnessed outside homes.
- There is some loss of faith in Garda ability to respond effectively to the problems related to drug use.

Drug-Related Deaths

All communities had experienced drug-related deaths, including some very high profile shootings and death in prison. Once again, official figures for drug-related deaths do not record the extent of deaths in these communities. Critically, what matters to local communities is that people are dying, and that drugs are a major part of the reason for the deaths.

Apart from accuracy of records, what emerges is that the impact of deaths is not considered. Participants spoke of the devastation to families where children had died because of drug use. The impact on these families has a ripple effect on the community as a whole. There is a depth of community pain caused by the loss of young people, and of young parents. This pain is compounded by under-reporting, and can be perceived as a lack of care from the authorities.

Efforts to redress under-reporting are being made, with the launch of a National Drug-Related Deaths Index in September, 2005.

Crime

All groups and interviews discussed crime, which was perceived as directly linked to drug use, and which had led to local decline.

- Some crime types seemed to be down, but there was a sense that crime in 2004 was more violent.

- Local drug dealers might get a warning or a beating in 1996; now people were being shot.
- It was more dangerous now to have local community patrols to control drug dealing, as communities had done in the early 1990s.
- It was more dangerous now to be a drug user than in 1996; drug users were being beaten locally by gangs of younger people. These gangs were using different types of drugs, and did not see themselves as "junkies".
- High-profile cases of public brawls which resulted in death, often after the closing of night clubs, were seen to be more common now.
- Polydrug use, particularly alcohol and cocaine, were seen to be directly connected to this.
- Improved service provision and an improved jobs situation were seen to have contributed to crime reduction locally.
- Nonetheless, the 1996 fear of house break-ins was now a fear of going out, of encountering anti-social behaviour – very often drink related, rather than drugs related.
- People were now living in a barricaded society, afraid to come out at night.
- While robberies and jump-overs (robbing, usually shops and other business offices, by jumping over a counter) seemed to have lessened, the sense of safety in public places had decreased. This was related to groups of young people congregating, drinking and using other drugs.

Relationships With The Gardaí

In all communities, there was concern about deteriorating relationships with the Gardaí.

- People in general welcomed the community Gardaí but again felt there were not enough of them and that young people in the community did not know them.
- If they had to act as a regular Garda, it undermined their position as a community Garda.
- Criticisms of the Gardaí included: (1) they were unresponsive to people who called them; and (2) they knew what was going on but seemed unable to do anything about it.
- Respondents commented on a loss of respect and trust.

Mulcahy and O'Mahony (2005) argue that this loss of trust may impact on crime and community safety in two particularly significant ways. First, when levels of trust diminish, the information flow from the public to police is reduced, and with it police effectiveness. Secondly, as the police seek ways of compensating for this reduced information flow, they often resort to more intrusive and abrasive measures, such as stop-and-search measures. This may lead to a further loss of trust, in particular, among marginalised areas and groups. Moreover, Mulcahy et al; (2005) found that local assessments of policing are strongly informed by the historical legacy of conflict surrounding drugs, vigilantism and community action, and also by the ongoing efforts to secure meaningful community input into policing.

The Sense Of Fear/Safety

Many people expressed changes in how they felt in their own areas:

- Fear of groups of young people congregating, drinking and using other drugs
- In response to the fear, many participants described putting up a barrier against neighbours, becoming more insular, avoiding shops at night, not carrying a handbag
- Fear amongst elderly people who were now seldom seen walking around during the day or night, and who no longer went to bingo, "because they will not walk up that road".

These perceptions certainly highlight a community drug problem. Not only are people using drugs in the areas, but their behaviour around drugs is impacting on the quality of life locally, determining people's activities and how they use their local amenities:

- Some participants had actually experienced threats from dealers, when they took part in community action to control activity around their homes
- However, there were mixed opinions on this issue, as some participants felt that they experienced very little negative consequences from the drug problems
- Reasons for being afraid had changed from fear of house break-ins in 1996, to a fear of going out at night, of antisocial behaviour, which was very often drink related, rather than drug related.

Restricted Use Of Local Amenities

Participants reported:

- That they didn't use public spaces as much as they did in 1996, particularly after dark
- Some concerns about the activities of gangs and drug users
- In some cases, local amenities had improved, and in Ballymun, working in a local shop was described as "a different place to work", "it's 100% different"
- Concern at a lack of amenities locally for young people. Even though the YPFSF (Young People's Facilities and Services Fund) has invested in capital facilities, many activities for young people are still under-resourced. In particular, those working with youth clubs and groups like bands, expressed great frustration at the lack of support from government, and the fact that in spite of all the money about, they still had to scrape around looking for funds. There was a sense that young people who did not get into trouble were missing out!

The Impact On Families

Participants expressed concerns for families living in the areas worst effected by drug use. They also spoke about their own attempts to safeguard their families in the current climate.

- Many families had lost children to drug overdoses or AIDS. Regardless of the numbers involved the impact on families has been devastating.
- Parents did not know who to turn to, and couldn't get treatment places for their children

- Fear among parents for their young children was also common, e.g. who they were playing with, where they were playing, and the possibility of finding needles in fields.
- Families also suffered from the stigma attached to living in areas known for drug problems even where they were not involved, which had a known effect on job applications, prompting them to give a grandparent's address.
- Families turned inward to protect themselves from what they perceived to be going on around them. Groups in all areas discussed how families were looking to themselves rather than the community to safeguard their children. Families felt that they could protect their children by keeping them away from other children, by not letting them play on the street or in local parks.
- The Community Addiction Team (CAT) service in Bray reported a serious concern as service provision is not extensive for the under-18 age group.

The Profile Of Local Housing Development

- The most serious drug problems still seem to be concentrated in local authority housing estates, in some cases in particular streets of a housing estate.
- Local dealing seems to be a central part of this problem. While this has changed since 1996, it is still very visible in some areas, and can be intimidating.
- Alcohol was seen to be involved in much "anti-social behaviour", which can seriously affect the quality of people's lives.

Each area has different issues around housing. This is another example of the need for indicators to be able to deal with diversity in a community.

- Bray is experiencing a waiting list for local authority housing.
- In Crumlin, housing is now very expensive. Often local people can't afford to buy there.
- Ballymun is undergoing a major regeneration project.

There were concerns that the local authority housing estates (sometimes only a couple of streets in an area) were still vulnerable to concentrations of drug problems. While drug use is widespread in all the areas, with an older age profile those in areas characterised by cumulative disadvantage are still more at risk of local drug use becoming community drug problems.

School Attendance

Young people not attending school, and the importance of keeping them at school, were points prevalent in the data.

- Participants drew attention to the importance of staying in education.
- There were concerns about non-attendance at both second level and primary level.

Evidence suggests that early school leaving is associated with treated drug misuse, and in each of the areas this association was noted. However, there are signs of increased longevity in education. While it is encouraging that the numbers leaving under 15 years-of-age show such a decrease, levels of educational disadvantage are still a major issue for concern. The retention is still lower than in areas not characterised by disadvantage.

All communities commented on the limitations of focusing on early school leaving as, in their experience, poor attendance is the precursor for dropping out. Early identification and intervention with children who have poor attendance records was seen as important. However, participants noted that the Educational Welfare Act covers children aged 6 and over. There was agreement that this was already too late for many children. The connection between poor attendance and drug use in the family was seen as an issue for children as young as 3 years-of-age (pre-school). Task Force support for school liaison personnel emphasises this fact. In all three communities, there are breakfast clubs and homework clubs which might offer some insight into the needs of young people with drug-using parents.

Increase In Services/Interventions

Perceptions were of much positive change with the increase of services for drug users:

- Methadone programmes, combined with better security measures in some public places like shopping centres, were credited with reducing levels of petty crime (in particular, theft). This was largely attributed to the national economic improvement which made it more possible to open up and fund services, which had "improved immensely".
- However, there were concerns about the appropriateness and satisfaction with services available to people. There were mixed views about available services with less concern about quantity of services and more concern about effectiveness, accessibility, choice and gaps in service provision.
- The major advancement due to provision of services was recognised, but some disillusionment and frustration remains that the drugs situation has not improved. It has changed and continues to change. Part of the changing face of drug problems is the emergence of cocaine as an easily available and popular drug of choice. Concerns regarding the structure of methadone programmes and the lack of facilities for young people, in particular around alcohol, were also evident.
- Despite positive remarks about the introduction of the school programmes and the potential of them, it was perceived that this has happened *too late*. Another participant stated that the Schools Completion and Stay in School projects, while very good, were understaffed, "but again, they're only targeting a very, very minor number of the young people. They're not targeting the big numbers".

Across the three communities, attitudes to the success in providing such activities differed; some participants felt that things on this front had not improved at all.

- In Ballymun, there was great frustration at the lack of basic services for the general population. For example, the new Health Centre was built as part of the Civic Centre, yet it lay empty for a long time while a dispute continued between agencies and departments about who would fund the fit-out of it. In the meantime, the people and the staff were using a building which had major flaws. Delays like this add to the loss of trust in agencies, and to a feeling of insignificance for the population.

Communities themselves have contributed greatly to the establishment and development of services. In all three areas, statutory services were preceded by community services.

- In Ballymun, the *Youth Action Project (YAP)* has been developing services since 1981.
- In Crumlin, *Addiction Response Crumlin (ARC)* campaigned tirelessly to raise awareness locally of the need for services, and has developed a comprehensive range of services for drug users and their families, in spite of major local conflict.

- In Bray, community activists, sympathetic to the plight of users, were working to provide some response to their needs. They described the complete lack of services and facilities in the area throughout the '90s. A group of local people initiated the first community-based response service. In 1996, without designated funding, Bray as a community successfully organised and continued the campaign for recognition and funding, until it got a LDTF in 2000.

People talked about the fight to get services, and about the disillusionment surrounding methadone use.

- In Crumlin, they described marches and protests attempting to influence the government. In the early days they did not even think about methadone; then they fought to have methadone clinics locally. But drug users get stuck on methadone maintenance, so the pressure is off to get services since they are then seen to be receiving treatment.
- Community activists and some service providers voiced dissatisfaction with this as an outcome of treatment. There was some debate among participants about maintenance. A number of individuals knew people who had been stabilised and got back into work and a stable lifestyle. However, others were aware of long-term methadone users who seem to be stuck.

Interestingly, there was a lot of community commitment to helping drug users. There was consensus that the establishment of treatment services in communities was a huge step forward. However, many felt these treatment-based facilities were not having any impact on preventing the problems.

The Role Of Community Volunteers And Professionals

This role was generally perceived to have changed since 1996, when there were very few resources available. With the increase in services, statutory service providers, and the establishment of a layer of local bureaucracy, a question was raised about where local people fitted in relation to the changing nature of community responses to concerns about the drug scene. With the growth of the economy since 1996, many jobs have been created in local social services, including the drugs services. Structures have changed. Where people worked voluntarily before, are jobs which are now the domain of paid workers. Some of the paid workers are local people. However, evidence points to local people being in the lower paid, vulnerable positions in agencies (King, McCann and Adams, 2001).

- While many of these services are welcomed, local people feel they are no longer important, no longer needed, and that their role has become one of assisting the paid professionals.
- Also some growing cynicism existed as to whether the structure and workers could actually make any difference in the long run. There was some evidence of a loss of trust in the institutions of the state.
- A number of dedicated volunteers steered attention towards the needs of drug users in all three communities, from 1981 onwards. This resulted in a range of services being developed in all LDTF areas, which participants valued. However, there was discussion that the professionalisation of the response had in some way undermined or devalued the bottom-up community effort. Some participants commented that it was difficult to engage people in a voluntary capacity because it all fell to the same few people in the community.

It is interesting that people in Bray and Crumlin responded to drug problems in the absence of any community development infrastructure. Responding to such a serious issue seems not dependent on existing community infrastructure. However, such infrastructure can assist in improving life in the

community, essential for positive change in drug problems. These communities' responses to drugs have played a vital role in the ongoing development of their communities, leading to more community advocacy and support.

Different Perceptions

The study showed different perceptions among community members as to the prevalence of drug use in their areas, and the consequences of different patterns of drug use. This is further evidence of the diversity of communities, and the difficulty in gathering community perceptions of drug problems. However, it is something which needs to be measured, as these perceptions can affect the responses which are made, and how early interventions can happen.

Developing Community Indicators

The core information systems used to monitor the drugs problem in Ireland and to inform policy making are in the health and law enforcement areas. While data collected from these sources gives some information, limitations mean that establishing accurate pictures is difficult. The information presented often bears little or no resemblance to the reality of community drug problems.

Current units of measurement (EDs) are not accurate enough to capture the complex nature of community drug problems. From this study, it is apparent that 'community' can be as small a unit as one or two streets, or a particular small housing area within a larger area. It is difficult to obtain an accurate picture of the situation in communities because of (i) the lack of standardisation of reporting; (ii) the different administrative boundaries used by various bodies; (iii) the lack of clarity regarding the collation of information; (iv) statistics are not disaggregated to local areas; and (v) the difficulty in collating data from different sources such as Health regions and Garda regions which can differ substantially from EDs. The latter, in particular, hinders the process of understanding local trends, making it almost impossible.

The issues outlined in the findings of this report have been selected as those which matter most to the communities who took part, and those which should be measured. This section details the elements of a set of community indicators which would more accurately capture what is important to these communities.

A Set Of Community Indicators

Indicator 1: The Range Of Drugs Being Used

The study found that widespread **Polydrug use** has superseded problem **heroin use**.

Indicator 2: Alcohol Use

All three communities agreed that alcohol use is a fundamental problem. In particular, high levels of at-risk drinking among the under-aged, and young drinkers were making them more vulnerable to drug use. In addition, there are no dedicated alcohol services for young people. No such service existed in any of the three communities and where some level of service had been initiated it was as an adjunct to another service.

Indicator 3: Profile Of Local Housing Development

The relationship between local authority tenure and community drug problems needs to be further investigated. It seems that tenure alone is not the sole indicator. Attention needs to be given to children to ensure that they grow up healthy and safe in their environment, e.g. where they play; how their environment is maintained; how exposed they are to explicit drugs/alcohol paraphernalia; how their parents get support with their responsibilities; and how they are cared for when things are difficult. Hence, in proposing indicators for the profile of local housing development, elements are included to do with maintenance, tenant involvement and satisfaction with housing and public parks/areas.

Use of public spaces

Results showed that public spaces, so important for the creation and development of social capital, are the very places affected by community drugs activity. Hence, indicators should pay close attention to the state of public spaces, the levels of use by local people, and changes over time.

Indicator 4: Drug-Related Deaths

In all three communities, drug-related deaths requires more accurate recording. The National Drug-Related Deaths Index will provide better measurement of this.

Indicator 5: Crime

Results showed that the greatly extended use of methadone maintenance since 1996 has been credited with contributing to an overall reduction in crime. Yet crime is still an issue. There was a sense that much of the crime experienced locally is unreported.

- The most important element to highlight is the need to disaggregate local data from the collected Garda statistics and to provide this information regularly. A small Central Statistics Office (CSO) unit has been established to commence work on crime statistics. Contact should be made with this group to discuss the need for drugs and crime statistics.

Community safety

Perception of crime is often as important as experience of crime (Ballymun Partnership, 2003). It is important to take findings from small local areas, e.g. a couple of streets, or one group of houses, to capture clusters of problems. If the area being measured is too large, it is likely to miss out on important experiences of local drug problems.

- National and local surveys need to be complemented by regular, qualitative gathering of data. This study suggests that local groups would welcome the opportunity to be involved, and would feel empowered by being able to monitor change in a planned, systematic way.

Indicator 6: Social Capital – Informal Social Support Networks/Informal Sociability

Examples of what could be measured (NESF, 2003) are:

- Informal social support networks including their structure, density and size and composition by age, class, gender, ethnicity, etc. (e.g. who knows who).

- Informal sociability – regularity of social contacts with others (speaking, visiting, writing, emailing).
- Use of local services – e.g. sending children to local schools, participating in local activities, etc.
- It would be important to investigate what is accountable for the family's position either for, or not, for community involvement.

Community participation/volunteering

Results showed that people withdraw and become insular when they perceive drugs to be an issue in their area. They also indicate that people now feel ignored, and that community involvement has changed since 1996. Professionalisation of the response has to some extent excluded them around drugs issues, but also around other issues, for example, regeneration.

Involvement in the response to drugs in the area is an important indicator. Examples of community involvement in the drugs area that could be measured are:

- Community engagement – social networks and volunteering effort; but also efforts to reduce the demand for drugs.
- Community efficacy – a shared sense of empowerment and capacity to effect change at local level; in general, but also particularly in improving the situation re drugs.
- Trust in institutions (public, corporate, voluntary) particularly around their effectiveness in improving the situation re drugs.
- Political participation; patterns of active citizen engagement, voting, etc.
- Norms of trust and reciprocity; mutual credits, expectations and obligations as well as sanctions on opportunistic or anti-social behaviour.

National data needs to be complemented by collection at local level, to learn about the other two levels, micro/individual, and intermediate/community. The *Census of Population* five-year interval is too long for measuring community drugs issues. Local information could be collected, utilising community participation in the design, collection and data analysis to provide valuable feedback for policy makers. Local modules need to be designed to complement national modules, for comparison purposes. Local modules could be collected twice yearly.

Indicator 7: School Attendance

Results link early school leaving with areas of disadvantage and indirectly with a high risk of drug use. All agreed that poor school attendance was a precursor for ongoing problems including drug use. The National Education Welfare Board (NEWB) Annual Report 2003 noted absenteeism as an early warning.

- A community drug-indicator mechanism should be integrated into Education Welfare data gathering, which would offer specific data on the role of drug problems in the context of school attendance. Contact should be established with the NEWB at this stage in their work of standardising reporting systems on attendance and absenteeism.

A Set of Reporting Systems

Rather than one instrument which can gather all the information needed to measure change in community drug issues, we recommend a set of reporting systems which, when presented together, can "communicate the pervasiveness of alcohol and other drug abuse across all sectors of the community" (Gabriel, 1997). Some of the systems are already in place, but require development so that community drug issues can be captured in a timely and meaningful way.

Operationalising the indicators

The indicators are drawn from the most prevalent issues identified by the three communities, when considering what change can be measured. Some are already part of our data gathering, but require development to capture more comprehensive data. For example, Garda statistics would be more useful if disaggregated to local level, and made available regularly. Others require new instruments to be developed, for example Social Capital modules.

Local focal points

Ongoing work in this area needs the identification of local focal points for gathering information, and collating it. The design of local surveys, and qualitative modules, the collection and collaboration of data, needs to be named as an important function for the local response to drugs. It seems obvious that there should be involvement of Local Drugs Task Forces (LDTFs) and Regional Drugs Task Forces (RDTFs). However, some geographical areas could be too large, as has been apparent in this study. There is a need for a few local groups from smaller areas to be identified. The information then needs to be fed to a central point for collaboration. There could be a regional central point, perhaps the RDTF, or the LDTF, and a national central point.

National and local collaboration

The second important infrastructure to be developed concerns collaboration between drug data-gathering agencies and The National Statistics Board, The Senior Officials Group on Social Inclusion, The Central Statistics Office, The National Education Welfare Board, The Health Services Executive, An Garda Síochána, and The Health Research Board.

Conclusion

The Community Study was designed to explore three communities' experiences of drug issues in greater Dublin from 1996, and to describe initiatives developed since then which the communities perceive to have influenced any change. In spite of increased investment, community drug problems still persist. Neither communities themselves, nor patterns of drug use, stand still. They are living, moving phenomena. There is a need for more developed instruments to measure change. Several indicators emerge from this study. Current indicators do not adequately portray the lived reality for local communities. The areas which need to be measured in order to more accurately monitor the benefits to the community of action around drugs are identified in the study. Researchers need to further develop their instruments to measure change. The next step is that of collaboration with the various data collection agencies, and local community groups; but most critically, the establishment of an infrastructure for data gathering, with national, regional and local focal points, to obtain a clearer picture of the reality of community drug problems over time.

Chapter One
Introduction

Introduction

Until the 1990s, Irish drug policy viewed the 'drug problem' as predominantly an individual and medical problem. Socio-economic and socio-cultural factors relating to drug use were largely ignored by the Government. It has been argued that at this time, drugs policy in Ireland was fragmented and unresponsive to the social context of drug use (Coveney et al, 1999:78).

The current National Drugs Strategy in Ireland (Government of Ireland, 2001) is grounded in an analysis from 1996, when the government accepted the link between problem drug use and socio-economic disadvantage (Government of Ireland, 1996). The problem of heroin dependence was recognised as being predominantly confined to socially and economically disadvantaged areas in Dublin (Bryan et al; 2000:2). In 2001, the Government positioned the National Drugs Strategy firmly within the context of wider social inclusion policy. A review of the strategy (Government of Ireland, 2005) has framed its recommendations in this context.

Since 1996 various Government initiatives have been implemented to respond to the issues identified. Local Drugs Task Forces (LDTFs) were set up as inter-sectoral bodies, with the central involvement of the communities most affected. Integrated Services Projects (ISPs) were piloted in four areas. A Young People's Facilities and Services Fund (YPFSF) was established.

These initiatives were developed against a background of considerable public unrest. Frustrated with years of lack of response to the problem, people took to the streets and marched in protest. Local meetings were held in many areas, with those accused of drug dealing being named publicly. Some of the action focussed, as it had done previously, on the need to rid communities of drug dealers. However, some activists who had been involved in similar marches a decade earlier were attempting to exert influence in a different direction. Citing the futility of moving the problem around, they proposed working collaboratively to come up with more long-lasting ways to deal with the problems.

The focus of Irish drugs strategy continues to be on illegal drugs that do most harm, and on the most vulnerable drug misusers, families and communities (Government of Ireland, 2005:1). With the exception of the eastern region, where opiates predominate, cannabis is the drug for which most people present for treatment in all other regions of the country. Trends show that polydrug use is very much a feature of drug-use patterns (Drugnet Ireland, 2002:6).

Types Of Drugs Used In Ireland

The table below presents some results of a drug prevalence survey of households across Ireland carried out by MORI MRC in 2002/2003;

Table 1.1 Drug prevalence Ireland – lifetime prevalence

Drug	All Adults	Male	Female	Young Adults 15-34	15-24	25-34	35-44	45-54	55-64
Any illegal Drugs*	18.5	24.0	13.1	26.0	24.9	27.1	17.7	10.6	4.2
Cannabis	17.4	22.4	12.3	24.0	22.8	25.2	17.3	10.1	3.6
Heroin	0.5	0.7	0.3	0.7	0.4	1.1	0.5	0.2	-
Methadone	0.3	0.4	0.3	0.6	0.2	1.0	0.3	-	-
Cocaine (including crack)	3.0	4.3	1.6	4.7	5.1	4.2	2.8	0.9	-
Crack	0.3	0.5	0.1	0.5	0.5	0.5	0.4	-	-
Cocaine Powder	2.9	4.1	1.6	4.6	4.9	4.2	2.6	0.9	-
Amphetamine	3.0	4.0	1.9	4.8	4.4	5.3	2.2	0.8	0.4
Ecstasy	3.7	4.9	2.6	7.1	7.7	6.4	1.6	0.1	-
LSD	2.9	4.4	1.4	4.6	3.9	5.3	2.2	1.2	0.3
Magic Mushrooms	3.9	5.7	2.0	5.9	5.5	6.3	4.2	0.8	0.3
Solvents	1.7	2.2	1.4	3.3	3.6	3.1	0.4	-	0.2
Poppers**	2.6	3.9	1.3	4.7	4.7	4.8	1.3	0.4	0.1
Sedatives, Tranquillisers, Anti-depressants	12.1	9.3	15.0	8.2	6.5	9.9	12.2	15.3	21.9

** For the purposes of this study, illegal drug use refers to the use of amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.*

*** Poppers i.e. amyl or butyl nitrite.*

Source: NACD & DAIRU (2005:7) 'Drug Use in Ireland & Northern Ireland'

As illustrated in the above table, cannabis was the illegal drug most commonly used. Lifetime prevalence rates for cannabis were 17.4% for Ireland. After cannabis, the most common drugs ever used were magic mushrooms (3.9%), ecstasy (3.7%), amphetamines, cocaine and other opiates (3%).

Young males are more likely to have used illegal drugs in their lifetime than young females, 24% of males compared to 13.1% of females reported this. Young adults in the 15-34 age bracket (26%) are more likely to have used illegal drugs than those in older age brackets. Drug prevalence appears to follow a sliding scale in inverse proportion to age (35-44: 17.7%, 45-54: 10.6%, 55-64: 4.2%).

While not classified as illegal drugs, more than one in five (21.9%) of 55-64 year-olds in Ireland report ever taking sedatives, tranquillisers or anti-depressants. Lifetime prevalence for such drugs was the highest in this age category and was also higher among female participants (15%) than males (9.3%).

As in most European countries, service provision has grown dramatically. The programme of expansion embarked on by the then Eastern Health Board (EHB) during the 1990s, was described as "probably one of the more innovative community drug service programmes in Europe" (Farrell et al., 2000). Local drug treatment programmes were seen in 2001 to have contributed to a significant decline in property crime (O'Donnell & O'Sullivan, 2001). In 1996 there were 4,865 people reported in the NDTRS (National Drug Treatment Reporting System); by 2000 this number stood at 6,994 (Health Research Board; 2003: 3). In March 2005, the figure stands at 7,390 places, surpassing the target set in 2001. Since December 2000, there has been an 18% increase in the numbers of clinics delivering the service, from 56 to 66, of which/are located outside the old ERHA region (Government of Ireland; 2005:34).

In total, the Government has allocated over €65m to implement the projects contained in the plans of the Local Drugs Task Forces since they were established. In addition to the monies available under the action plans, the Premises Initiative is designed to meet the accommodation needs of community-based drugs projects, the majority of which are in LDTF areas. To date, over €11.5m has been allocated to projects under this initiative.

The acceptance of the link between drug use and disadvantage opened the way for a more serious debate about the place of the community in drug issues. In line with this developing discourse the NACD commissioned this study to examine communities' experiences of the drug situation since 1996.

The NACD set 1996 as the baseline date. The tender was advertised in 2002 and the study began in 2003 to run over a two-year time frame.

The **key objectives** of the research were:

- **to identify and explore how the communities themselves perceive change since 1996**
- **to develop an understanding about how they attribute any change**
- **to develop profiles of three communities in the Greater Dublin area**
- **to identify the indicators of a community drug problem based on the communities' experience of drug problems in their neighbourhood and the socio-economic and structural issues which are seen to facilitate these problems.**

The study sought to describe the various initiatives that were developed in the intervening years which are perceived by the communities to have influenced any change, and how the communities experienced their involvement in the planning and implementation of these initiatives.

It sought to assess how the community infrastructure that was in place in 1996 influenced or affected the communities experiences of the different initiatives and their outcomes, and to examine the capacity of these initiatives for community participation and involvement.

Definition Of Terms

In this study "community" is seen as a moving, living, web of relationships, group networks, traditions and patterns of behaviour that develop against the backdrop of physical neighbourhood and its socio-economic situation (Flecknoe and McLellan 1994). Seeing the community in this way, i.e. as a set of relationships as well as physical units, means that we need to remain open to gathering data on a variety of perceptions. Further discussion of community will help to illuminate the complex nature of community and the nuances this brings to research which attempts to capture community perceptions of drug problems.

The task of defining and interpreting drug problems has tended to create a major barrier to exploration in this field. 'Many attempts have been made to arrive at a universally acceptable definition of addiction but the matter remains unresolved and contentious' (Barber 1995, 13). Drug problems in the context of this research will incorporate the generally accepted notion of drug dependency as defined by the World Health Organisation (WHO). The WHO International Classification of Diseases ICD.10 (WHO, 1992 F10-F19) defined dependence syndrome as it relates to a range of substances. Dependence syndrome is classified as 'a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or class of substances takes on a much higher priority for a given individual than other behaviours that once had great value. A central descriptive characteristic of dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol or tobacco'.

This definition of dependence is further complicated by the addition of levels of severity. Heather (1995: 8) clarified this point when he suggested that 'dependence should not be regarded as an either/or phenomenon but as a continuum of severity running through the population. This definition of drugs problems falls short of capturing the more complex aspects of drug use/abuse as it relates to families and communities. Such definitions draw largely on ideas rooted in medical and psychological theories that drug dependence is predominantly an individual problem based on psychological and or physiological vulnerabilities in the individual drug user.

For the purposes of this research the term drug problems take account not only of the actual act of drug use and the impact on the individual in terms of dependence but also the related problems that pertain to the array of ancillary activities around the procurement, sale, distribution and impact of the drug use in general on the community. This involves then, not only the drug user themselves, but any member of the community who perceives that drug use is impacting negatively on their lifestyle and life choices. This research employs this much broader notion of drug problems and the difficulties regarding theoretical frameworks will be considered in more detail in reviewing the literature on theoretical influences on our thinking about dependence.

It has already been noted there has been a shift in thinking in relation to the nature of drug problems. The growing recognition of the socio-cultural influences as distinct from the dominance of individualistic definitions of drug problems underlies this shift. However we are still struggling to conceptualise the notion of a 'community drugs problem'.

The following chapter will detail the methodology employed for the study. Then an overview of the drugs situation and relevant policy and literature reviews will be presented followed by chapters on the findings of the study and the development of community indicators of drugs problems.

Chapter Two
Research Methodology

Introduction

This research set out to study three communities and their experiences of drug issues from 1996 to 2004. The researchers choose to employ two central methods, qualitative participatory research and documentary research to address the key concerns of the study;

- To identify and explore how the communities themselves perceive change since 1996, and to what do they attribute any change
- To develop indicators of community drug issues from this data.

Three communities were selected by the researchers based on their experiences of dealing with drugs issues in the greater Dublin area, consultation with NACD and discussion with a number of contacts based in communities in and around Dublin. The communities of Bray, Ballymun and Crumlin were finally selected to be the focus of the study. Local contacts within the drug service communities in each of the three areas negotiated agreements with the researchers and within their own communities and became partners in the research process. While the researchers sought to follow principles of participatory research, it is acknowledged that the UCD researchers were more instrumental in selecting the communities than participatory research would suggest. The communities did not approach the researcher nor did they decide on the central research question. However, once agreement in principle was reached about which communities were to be involved, efforts to redress this limitation as far as possible were made.

The three communities were selected for a number of reasons:

- Local community-based contacts were enthusiastic about participating in the study
- Based on the knowledge of the UCD researchers it was agreed that each of the three communities would potentially offer the research good insights into how communities experience drug problems over time
- They also offered their own unique and individual experiences of the drug problem since one area was in the north of Dublin, the other in the south and the third area was a satellite town in the south-east of Dublin. This geographical spread was adjudged to be beneficial to the goals of the study
- Two of the communities had been designated as Drugs Task Force areas in 1996 while the third was not given a Task Force until 2001.

Documentary Research

Blaxter, Hughes and Tight (1996) clarify that documentary research includes critical analysis of writing of others in the field. As well as accessing computer-based databases, examination material relevant to a particular set of policy decisions and an historical orientation making use of archival and other documentary evidence were examined. This method also involved analysis of secondary data including government papers, central statistics and reports and institutional documents.

Qualitative Methods

Qualitative research does not imply the use of one single methodological approach. Rather it supports use of multiple methods. This methodological diversity or triangulation – which Denzin and Lincoln (2000: 3) define as 'use of multiple methods' – enables the study to address the requirements of validity and rigour. Qualitative methods are more concerned with in-depth and 'rich' data than statistical relevance but must also be able to address standards and validity issues. Patton (1990:187) suggested that 'one of the most important ways to strengthen a study design is through triangulation'. In this study rigour was ensured by employment of methodological triangulation and data triangulation. Denzin and Lincoln (2000) suggest that there are five phases of the research process, recognition of the place of the researcher as a multicultural subject, appreciation of theoretical paradigms and perspectives, research strategies, methods of data collection and the art of interpretation and presentation. The framework for this research was based on this notion of research as a process. The focus of the process is to design a strategy for addressing the research questions in a way that will maximize the validity of the findings.

Qualitative research methods offer opportunities to develop participatory processes within the research. The task of conducting research in communities should hold as an organising principle the belief that communities themselves are a source of data but are also invaluable in terms of interpretation of that data and developing further areas for investigation. The task undertaken in this study was not researching a community but researching with a community.

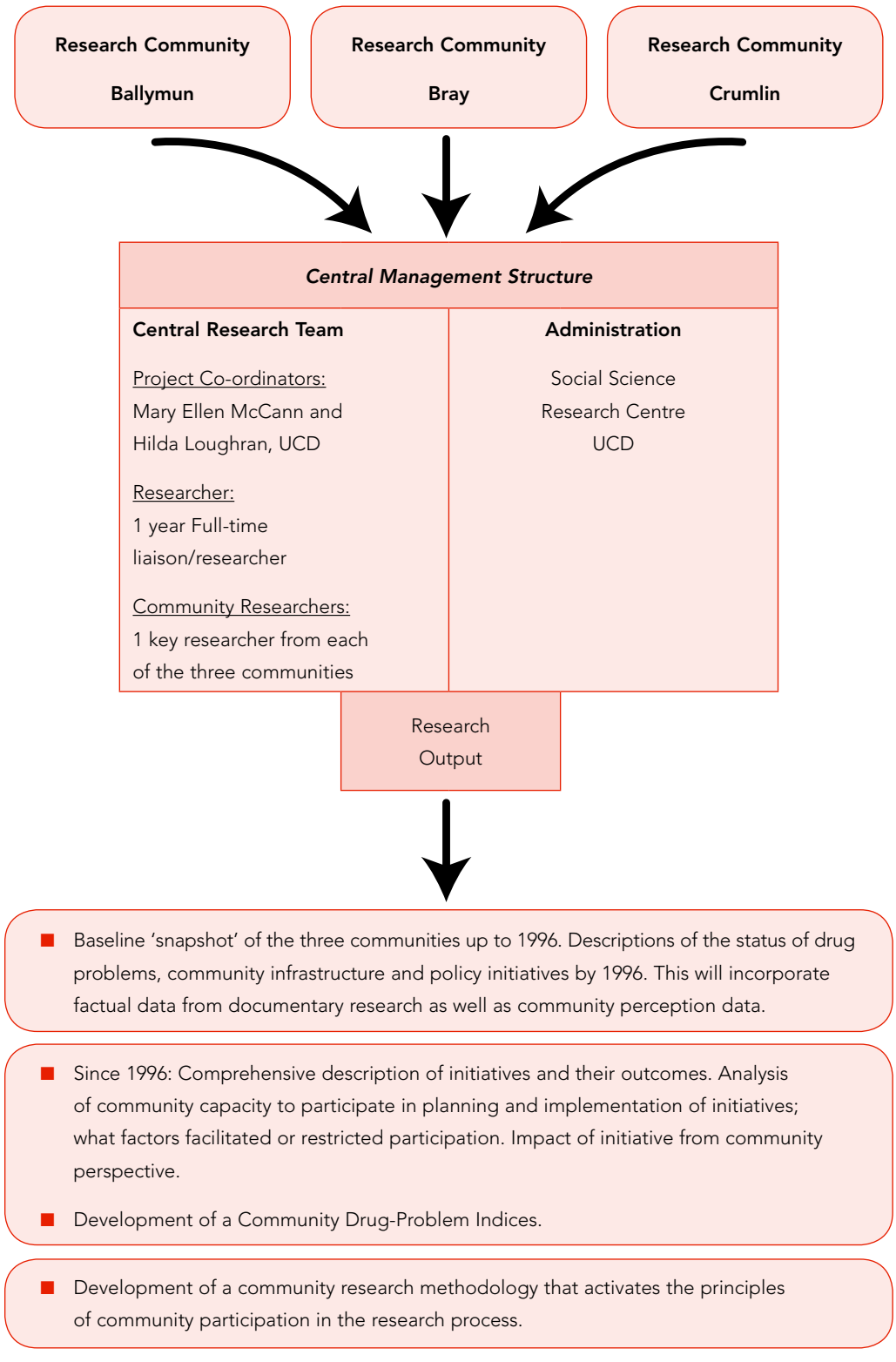
Qualitative Participatory Research

This study recognised that community-based research can best be conducted with the participation of the communities in question. Participatory research should be distinguished from participant observation. In participant observation, the researcher objectively observes the subject under investigation. Participatory research envisions a more active role for the subject of the investigation i.e. the community. Doyle (1996) describes attempts to build 'a community development model, emphasising the broadest possible participation of all interests or constituencies, consumers and founders needed to be involved as stakeholders in all aspects of the project'. This type of participatory approach required that the process of the study evolve over time in order to be responsive to issues as they emerged from the consultative process. The approach is not without its problems. Ingamells (1996), in discussing participatory approaches, comments on the difficulties of engaging members of a community in the process. In this research a structure was developed which reflected the philosophy of the researchers and their commitment to community participation.

Structure

The research was structured by a number of organising activities. These are illustrated in Table 2.1.

Table 2.1 Overview of research structure



Stages in the research process:

- The collection of data from key informants in the identified communities. The communities were selected on the basis of purposeful sampling – hand-picking supposedly typical or interesting cases (Blaxter, Hughes, Tight 1996: 79). The three communities engaged in the study, Bray, Crumlin and Ballymun, met the criteria of communities that had experienced problems with drug use over the period of time 1996 to date. They offered three unique experiences of the development of drug problems and of the responses, both central and local, to those problems.
- The interpretation and analysis of the data collected then formed the basis of a more extensive investigation of groups and agencies within the community in order to access their views. Snowball sampling (Blaxter, Hughes, Tight 1996: 79) allowed the team to build up a sample through community informants.
- Finally three main sources for this qualitative data set were employed, focus groups, in-depth interviews, and the reflections of researchers.

The Central Research Team

The central team of researchers as detailed in Table 2.1 was established. The co-ordinators agreed that the notion of having a formal contract and making payment to the partners was best for empowering these local agencies. Each community partner was then subsequently responsible for allocating resources for the work. Each of them did this in a different way. One partner allocated time from their full-time professional staff; another paid someone to work on the research a day a week; one community agency decided to sub-contract the work to a local research group. Some difficulties did arise in terms of continuity of personnel. For example, the local research group resourced its work through use of a Community Employment Scheme, a government-funded scheme for the employment and training of long-term unemployed people. These schemes are time limited, and are designed to move people on to regular employment. At the time of the beginning of this research, some of the participants were reaching the final stages of their entitlements on the scheme. This meant that there were changes in researchers during the project. It was frustrating and time consuming to have to train up new people and something of the experiences of the researchers was lost in each change over. However, one of the original researchers (who had been on maternity leave) did subsequently return to the team, and quickly picked up on the process at that stage.

In attempting to operationalise community participation in identification of participants the researchers employed the concept of levels of participation in the community. This sampling issue will be discussed later. The concept was also helpful in making sense of the similarities and differences between the community researchers. Reflection on the nature of community participation of the researchers resulted in the conceptualisation of a Dual Model of community participative research.

Model One 'Affiliated Participation'

An approach which places emphasis on utilising the training and skills of professionals working within communities. Model one in action was epitomised by one of the partners. They chose to undertake the research project themselves by allocating staff time to the research. The researchers were professionals who did not live in the area. They were very familiar with local services and service users. This model

would include professionals working in an area such as social work, nursing or community work. One of our partners chose this approach.

Model Two 'Immersed Participation'

An approach which places emphasis on utilising and valuing the personal experience and contacts of members of the community regardless of specific professional qualifications. Examples of model two in action were the partners who engaged locals or people who were personally engaged with the community. Two of the community agencies had what we later defined as 'immersed participation' researchers. It was recognised that some crossover would be possible where local people became professionals perhaps as a development of their voluntary work in their area. We resisted creating a third model as the significance of both professional and local experiences places such researchers in model two (immersed participation).

Reaching Different Voices

The research co-ordinators developed a framework to reflect the idea of levels of involvement within a community. In conjunction with the team, they conceptualised a four-level model of community participation for participants. In order to create a broad base for the study, it was envisaged that participants' different levels would be identified and they would be invited to participate. A matrix based on four different levels of engagement in community was developed, and is set out in detail later in this chapter.

In terms of the sample of participants, the goal was to conduct a total of 10 focus groups with around 10-12 participants and 18 individual interviews. Focus groups would ideally represent a mix of participants from at least two levels and individual interviews would be used when deemed more suitable.

We described the participatory research approach employed in the study and will reflect on its success in terms of maximising community participation. It became evident very quickly that the project was breaking new ground in terms of methodological advances. In order to capture this experience, the co-ordinating researchers kept a reflective journal and all team meetings were audio taped and transcribed for analysis. The advantages and disadvantages of the methodology will be considered specifically in terms of reaching the 'hard-to-reach' in the community.

Training And Support

Working with this methodology means that university researchers must do more than primary research. They become trainers, mentors, facilitators. They design the team 'architecture' – the communication channels, the flow of information – and provide leadership. There were times in this process when things did not go according to plan. The work was often unpredictable, as plans had to be changed at the last minute and groups rescheduled, with different efforts made to engage people. A seemingly simple task like organising a full-team meeting became quite complicated, because of the various levels of involvement and other commitments. The organisation of the work was not always tidy!

In spite of the changes in personnel, procedures were quickly established to provide training and support opportunities for the local researchers. This work was undertaken as part of team building.

The whole team met regularly throughout the project. The meetings involved progress reports from all team members, discussion of plans, and difficulties, and developing ideas about the direction of the project, both overall and in each community. These meetings also served as opportunities to input training as requested by the community researchers or as seen as necessary by the co-ordinators. It became clear that establishing and maintaining effective communication was a very important task for the success of the project. There were, at times, up to 16 individuals directly connected to the project, including the partners, the community researchers and the UCD-based team and the NACD research advisory group. Of these, communication with community-based researchers became the most crucial. The community researchers worked best when they felt supported by the team and had easy and immediate access to the UCD researchers. To facilitate this, each of the three UCD-based researchers took responsibility for one community. This allowed the UCD-based researchers to become more familiar with one area and created a sense of unity with the community-based researcher.

The richness of experiences being brought to the project by the community researchers was noted early in the process. In order to capture this, the co-ordinators requested that all the team members keep a reflective journal. This was felt to be a legitimate way of recording data from the team that could then form part of the project analysis and interpretation process. It would also be significant in directing decisions throughout the project. Training was given in how to record things in the journal. This great idea was a disaster. Some of the community researchers were undermined by the journal. They were unsure of what to record, they undervalued their own ideas and were in some cases embarrassed by their writing styles. In one case researchers felt they just did not have the time for the journal. The early attempts at keeping journals did not produce the richness that had emerged in team discussion. In consultation with the team it was decided that instead of individual journals the co-ordinators would keep a project journal and that all team meetings would be recorded and transcribed. It was a lesson to formally trained researchers in the privilege of the written word. This approach did not have the same meaning for the community researchers.

Personal Experiences Of Community Researchers

The community researchers were selected because they lived in and/or worked in the three communities in the research. This gave rise to a number of concerns that had to be handled in the project. Primarily the issue was that many of the community researchers were very close personally to the issue of drugs problems. Some had close family and friends who either had drug habits, had died from drug-related illness, had served time in prison because of drug-related offences or had been directly affected by drugs problems. This meant that the community researchers were bringing a unique perspective to the project but that the project also had to create and respect boundaries between personal experiences and the goal of the research. It led the co-ordinating researchers to consider the distinctions between rigour and validity. There was no doubting the validity of these experiences nor their appropriateness for the subject matter of the project but ensuring rigour in dealing with this dimension of the project was an ongoing task. The co-ordinators considered including the community researchers as participants in the research but decided that this would raise more difficulties. Instead it was decided to allow their contribution in team discussion to speak for them and give their experiences a voice in the project.

Evaluating The Success Of Community Participation Approach

In judging success we asked if the approach was successful in:

- Presenting a community perspective of drugs issues
- Instilling a sense of ownership of the research
- Accessing community participation in the identified communities.

Researching The Profiles And Instilling A Sense Of Ownership

The team was looking for any type of local documentation which would give a picture of community views of the drugs problems in 1996/2004 (Blaxter, Hughes and Tight, 1996). This included newspaper reports, minutes of local meetings, reports to government, policy strategies both local and national, even such items as letters to local government and other agencies. Some of the team learned to use library and computer resources. All discovered the importance of direct contact with people who had access to this type of data. One of the most important aspects of training for the team was learning to evaluate the difference in terms of validity of different data sources. One of the challenges for the team was to investigate information they had themselves but which needed verification.

The community researchers regularly underestimated the significance of local information. They were drawn to seek data that represented national statistics. However it was the local information that was needed to give a community, rather than a national, perspective. Some of the most insightful data gathered came from local contacts and community sources that the co-ordinators would have had no access to without the community researchers. In one community, for example, locally made videos gave information on the status of drug problems, and local responses to them, over the period of interest to the research.

In another, the community (immersed) researcher, inexperienced in documentary work, enrolled ten volunteers to assist in the library research. This, incorporated with the response to feedback, the generosity of local informants and the continuing interest of the communities in the research is indicative of success in instilling ownership.

The community profiles were adjudged in community feedback to be a true reflection of the community, indicating success in the profiling criteria.

Accessing Community Perspectives

It was clear from the outset that local knowledge and being known locally were parallel aspects of the successful recruitment of participants. It was evident that the local researchers did very well putting the participants at ease. There appeared to be a bond of understanding there that might have taken more time with an outsider. On the other hand this same factor created some difficulties for the researchers as they sought to stay on track with the task in hand and had to work hard to avoid being distracted into other discussions of shared interest.

All three areas had equal success in reaching participants at levels one to three. The community researchers' own level of engagement e.g. affiliated or immersed, did appear to have some relevance in terms of knowledge about who to contact and how to engage them. This became more evident when recruiting the 'harder-to-reach' people defined as level fours.

We had hypothesised that 'immersed researchers' would have more success with this group. In some ways this was true. They certainly knew more ''hard-to-reach'' locals and had a wider network of contacts. The affiliated researchers acknowledged this drawback. The combination of affiliated and immersed researchers appeared to facilitate pooling of knowledge and resources, to the benefit of both. In practice both had similar difficulties in encouraging identified potential participants to engage. For example, being known in the community did not always serve to overcome reluctance from fear of intimidation.

It was decided to attempt to connect with level four participants through a more informal networking process. Through use of extended personal networks two participants were recruited, both level four, in one of the areas. This process appeared to inspire all the researchers about innovative ways to access participants. Some adjustments were also required in the design, as it became evident that sometimes these harder-to-reach participants could best be engaged in individual interviews, rather than focus groups. However, one area was successful in holding a level-four focus group. In another, an attempt was made through a local group involved in tenant training, as part of the regeneration process, to access people. The timing didn't suit access to a tenant training group (there weren't any on-going at the time of the data collection); however, access was granted to a training session for people on a community employment scheme. Without this contact, access to this group of people would not have been possible. The participants in this group, while recorded as level three, would have had very little community involvement otherwise. Their involvement in this training was as part of their "job".

So, while numbers reached in the level four category were disappointing (n:12) findings in the data collected gave some indications that people who fit the category of 'voices not heard' may be in that position by choice. A number of the people interviewed felt they had nothing much to say on the subject. There was a sense that they lived their lives by keeping out of the drug scene and that may even have included denying knowledge such a problem exits in their area. For example, a participant interviewed, who lived in the heart of the Crumlin, an area reputed to be a drug gang area, felt that the drugs issue did not affect the participant at all. Some commented that they only knew about the drugs from listening to chat among others. This data was invaluable to the research. We also have to consider the possibility that some people who have been personally affected by drugs, may choose to stay out of any kind of local structures, preferring instead to get on with their lives away from drugs.

The researchers found that the most likely factor ensuring attendance was some personal connection to the researchers themselves or to someone who had been involved in recruiting the participants. The community-participation approach employed did appear to be more successful in accessing these 'hard-to-reach' people and offered some invaluable insights for research in the future when trying to capture the voice of the wider community.

In addition, in one community, Ballymun, there is considerable preoccupation with the regeneration process. Most people are involved in one way or another in this, as it affects where they will live in the future. Naturally, people's energies are engaged in such a fundamental issue, therefore they are not so available for other discussions.

Focus Groups

Focus groups were one of the main methods of data collection employed in this research. The use of focus groups as a qualitative method of generating rich data gives rise to a synergy that is lacking in individual interviews. A mutually supportive environment is created in which sensitivities, feelings, beliefs, experiences, insights, and problem-solving strategies are facilitated through exploration, challenge, clarification and reformulation (White & Thomson, 1995).

Although there are many definitions of a focus group, in short it may be defined as:

> *A group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research.* (Powell and Single, 1996:499)

It was recognised that some identified participants were already very involved with drug services and had contributed to the development of community responses to drug issues. Engaging them in this project was an important aspect of capturing one perspective on the drugs issue. However the researchers wanted to attempt to broaden the base of the study.

To this end, four levels of possible participants were conceptualised:

- Level one included those with direct experience of drug-use issues
- Level two referred to people involved indirectly with the issue
- Level three included people who were involved in community activities not related to drugs issues
- Level four represented an attempt to draw people whose voice is not normally heard into the study.

A matrix based on different levels of engagement in community was developed. Criteria for allocation to each level were outlined as above. The goal of the data collection was to access a number of people in each category. All participants signed informed consent forms.

Limitations Of The Use Of Focus Groups

There are some limitations associated with focus groups. Among these is the fact that the researcher has less control over the data produced than in either quantitative studies or one-to-one interviewing. By its nature, focus group research is open-ended and cannot be entirely predetermined.

From a practical perspective, focus groups can be difficult to assemble for a variety of reasons. It may not be easy to get a representative sample and focus groups may discourage certain people from participating. The method of focus group discussion may also discourage some people from trusting others with sensitive or personal information.

The organisation of focus groups usually requires more planning than other types of interviewing, as getting people to group gatherings can be difficult and setting up appropriate venues with adequate recording facilities requires a lot of time (Gibbs, 1997).

Organising The Focus Groups

Once identified, possible participants were approached to participate in either a focus group or a one-to-one in-depth interview. The initial concentration was on holding focus groups. The plan was to

have focus groups which brought together people from at least two different levels of engagement in their community as described by the notion of the four levels. It was recognised that some people, for practical reasons, may have to be seen in a one-to-one and that there were some people who might feel more at ease in the one-to-one. Each team of community-based researchers engaged in a process of identification of possible participants. This involved presentation and discussion of the rationale for including those participants and resulted in a joint decision about whether to include the individual in a focus group or a one-to-one. If the decision was a focus group then the mix of levels, experiences and availability of the participants was discussed and plans for holding the group were developed. The local community researchers took responsibility for contacting participants, engaging them with the idea, setting up a venue and generally communicating information to group participants. Constant discussion and debate occurred as plans progressed. It was agreed that the goal for each group would be 12 participants. In order to ensure this degree of participation between 15-20 people were invited. On one occasion, when it appeared that the extra numbers invited were all going to attend, arrangements were made to hold two concurrent groups. In spite of these precautions turn-out for some groups was very disappointing.

The proposed aim was to run three focus groups in each community. These would reflect the mix of participants at all four levels as already described (Table 2.2).

Topic guides were developed for interviews and focus groups.

Table 2.2 Sampling of participants

Area	Focus Group	Individual Interviews	Total number of proposed participants
Ballymun	3 x 12 = 36 participants	6 individual interviews	42
Bray	3 x 12 = 36 participants	6 individual interviews	42
Crumlin	3 x 12 = 36 participants	6 individual interviews	42
			126

Conducting Focus Groups

Since none of the community researchers had experience with this type of approach it was agreed that each focus group would be run jointly by a community researcher and one of the co-ordinators. The local community researchers took responsibility for contacting participants, engaging them with the idea, setting up a venue and generally communicating information to group participants. They became familiar with what the focus group would involve and some of the issues that might arise. They became aware of ethical issues, like the use of consent forms, and ensuring full understanding of the research by those they were inviting to the focus groups. The team reviewed all plans for focus groups including participants, location and timing. Each pair of researchers reviewed the group and subsequently reported to the team. Much of the learning took place in these reviews and since there were at least three focus groups in each area there was plenty of material to consider.

The community researchers faced obstacles in assembling the groups as indicated earlier. In one community there were fears of intimidation by gangs, in another there were other pressing community issues that were demanding time and attention from local residents. There was evidence from the documentary research that it was routine for people holding meetings in the one area, to emphasise

on any publicity that DRUGS WOULD NOT BE DISCUSSED at the meeting. This was done to ensure a sense of safety for people participating.

On one occasion the group had to be cancelled when a local young adult died unexpectedly and the community was in mourning. Another time the community researchers had agreement from 18 participants and had arranged to facilitate two groups but only 10 people arrived. The unexpected scheduling of a local political meeting resulted in the cancellation of another group. In one group a local resident 'took over' the group with an unrelated issue and the facilitators had to work hard to get the group back on track.

In all these situations the experience of the co-ordinators and the social and interpersonal skills of the community researchers resulted in congruent and effective responses. The affiliated researchers may have been somewhat advantaged in this area since they had greater access to, and experience, of the administrative demands of contact and follow up phone calls and provision of premises. However the location of groups did become an issue as researchers felt that using 'drug agency' premises might prove unattractive for some participants. The immersed researchers appeared to manage alternative locations more easily.

Individual Interviews

While the focus groups offer a rich source of data there are some practical difficulties in terms of gathering a large group together at a time and in a place that is suitable. The quality of the data and the richness of interaction make it worthwhile. However in some incidences one-to-one interviews were deemed either to be the only feasible option for accessing a particular participant or alternatively deemed to be the most suitable way of getting information from a particular participant.

Table 2.3 presents the numbers of participants/informants accessed through focus groups and interviews. In spite of strenuous attempts to organise the focus groups there were mixed results. The numbers for levels 1 and 2 in focus groups were more successful than levels 3 and 4. It emerged from one of the focus groups, and also in feedback to researchers as they recruited possible focus group participants, that many were reluctant to get involved in a 'drugs' thing. Certainly the results of attempts to recruit level 4s was initially disheartening as discussed.

Table 2.3 Numbers of participants/informants accessed through focus groups and interviews

	Ballymun	Bray	Crumlin	Total
Focus Group Level 1	14	14	8	36
Focus Group Level 2	4	9	4	17
Focus Group Level 3	10		8	18
Focus Group Level 4		5		5
Interviews Level 1	2		1	3
Interviews Level 2	3	2	3	8
Interviews Level 3	3			3
Interviews Level 4		3	4	7
Total Participants	**36**	**33**	**28**	**97**

Some of the factors which contributed to the smaller turn out have been identified by the community researchers. However in some instances there was no definite reason. Two groups, one in Ballymun and one in Crumlin, had particularly disappointing attendance. In the case of Ballymun the local researchers were able to report that the focus group had clashed with a meeting about regeneration. Even working with local informants, it was not possible to account for all such eventualities. Many of the people who had agreed to attend the focus group later made contact to explain their non-attendance.

In the case of one of the Crumlin focus groups it appears that there was a last minute meeting held in the area by a political party concerning housing issues. Again, even with local involvement, the last minute nature of this event precluded rearranging the focus group, and only four participants attended. In a second focus group the researchers had recruited 15-18 participants. The team was prepared to run two separate groups. The participants were mostly intended to be at level four and we felt the bigger group might be too much for people. A total of eight people attended. Some of those had hoped to bring neighbours and friends who would not normally be engaged in this type of activity. At the outset of the group participants claimed that there was some intimidation going on in the area at the time and less vocal members of the community had decided not to attend because of the fear of such intimidation. This type of problem appeared to be an issue in only one of the community areas. Nonetheless the research team reviewed the situation. It was decided to attempt to connect with level four participants through a more informal networking process. Personal contacts succeeded in recruiting two participants, both level four. There were clear indications that reluctance to participate in some areas was related to a sense of intimidation on the part of potential participants.

According to the literature on focus groups, and consistent with our findings to date, the most successful way to engage participants is through personal contacts. All level fours were contacted through a chain of personal contacts. Given that the criteria for level fours is that they have no allegiance to community groups or activities then inevitably the contact point has to be a personal one.

Even in the other two communities, the researchers found that the most likely factor ensuring attendance was some personal connection to the researchers themselves or to someone who had been involved in recruiting the participants. In Bray a level four focus group was held in a neighbourhood-based amenity. For the most part level four people were interviewed in their own homes. The participants appeared to be satisfied with this arrangement.

The importance of accessing a range of voices has been verified by the data collected. The researchers were able to reach a point in the gathering of data where the issue of repetition of data began to arise. This data saturation indicated that the research had been successful in capturing comprehensive pictures of experiences from each of the three communities.

Analysis And Interpretation

The process of analysis of the data in this type of research begins as the data starts to be collected. It was through initial analysis of the data that other possible informants were identified and that areas of interest emerged.

The process of data analysis and coding got underway as soon as the focus group transcripts were available. The computer-based text-analysis package ATLAS.ti was used for coding and retrieval purposes. This programme also enabled categories of information or 'themes' to be identified across

both interviews and focus groups. The identification of themes is a prerequisite to the development of community indices. Interpretation of themes is more informative if researchers not only identify common threads and issues, but are also sensitive to differences. Sometimes in research, it is the anomaly, or the unusual, that leads to the unravelling of possible meaning in the data.

This participatory interpretation acts as a check on the research to ensure that it continues to appreciate the experiences of communities and that this is reflected at all stages in the research process from collection, through analysis and interpretation and in the final presentation of findings.

Initial Analysis: Profile Of Each Community

One of the first tasks of the analysis was to produce a community profile for each area. The profiles were constructed using 1996 as a baseline. Primarily the study attempted to access community perceptions of drug issues. A profile of each community was drawn from a variety of sources. The research questions focused attention on views of 1996 and perception of the current situation. The data gathered from various sources was employed to give an in-depth picture of the communities.

Developing A Coding Frame

The transcripts of in-depth interviews and focus groups were prepared and loaded into a software programme, ATLAS.ti. The qualitative data analysis programme was chosen because it allowed for flexibility in developing the coding framework while still providing the analytic tools required.

A number of questions in the study were accommodated by coding all the data chronologically. The data was packaged on a time line using 1996 as a central point and all reference to pre- and post-1996 are coded as such. This was further refined to identify 2003-2004 references.

Other families of codes were selected. The transcripts from each community were coded by community. The transcripts were then also coded into families of codes for all focus groups, all in-depth interviews, and the four levels of participants, levels 1-4. This facilitated comparisons across communities, data sources and level of participants' engagement with the community.

Having decided on these codes as basic variables in the study, the transcripts were subjected to an initial analysis by two of the UCD researchers. Through separate analysis, a series of themes emerged. The researchers then compared themes and ensured that the themes were comprehensive enough to address the research questions. As more in-depth analysis was conducted, further themes were identified.

Local researchers were given training in the coding process and the identification of research themes. They were then asked to code one focus group and one interview transcript from each of their respective communities. The research officers and assistant also coded the same transcripts independently. This process served to add rigour and validity to the task as well as to harness the local expertise of the team.

A team meeting was then held, attended by research officers, research assistants and local researchers. The coded transcripts were discussed at this meeting and any agreed amendments were made, resulting in a final coding frame.

Feedback Sessions

The importance of offering feedback was emphasised by the community researchers from the beginning, and was built into the project. All participants were informed that it was the goal of the researchers to meet with all participants later in the research in order to present the findings and offer participants an opportunity to confirm or challenge the interpretations developed by the research team. This adds to the rigour of the study and is an important aspect of any participatory research model. Where participants agreed to the follow-up contact (and all participants did agree), they were notified of a meeting in their local area. Summaries of the profiles and an explanation of extracted themes were produced. These were circulated at the feedback meetings. The goal of a feedback meeting is not to gather new data but to draw on the participants' understanding of the issues to validate the findings of the study.

The feedback sessions proved difficult to arrange as other factors intervened such as meetings about other local issues, deaths in the community and bad weather. The level of work and organisation required was almost as extensive as organising the focus groups in the first place. While the turnout for the feedback sessions was disappointing (Table 2.4), the participants who came to the sessions reported that they were both surprised and pleased to be given the chance to see what had been done with their information. Their comments further encouraged the team to persist with the feedback sessions.

The feedback was designed as a check on the teams' interpretation and accuracy and not as a venue for gathering new data. However the sessions were taped and transcribed and added support or clarification to the final report. The co-ordinators were convinced that the feedback would have been very difficult without the hard work and commitment of the community researchers who agreed that this aspect of the work was particularly important. The process was invaluable and served as an important milestone in the research. Reflection on the difficulties with attendance suggests that, in addition to the local issues already discussed, delay in getting back to people due to the 2-year brief of the project may have been a problem.

The turnout for the feedback sessions was mixed (Table 2.4). Two meetings were arranged in Ballymun. In the first, only one person attended; a second meeting was arranged and 3 participants attended. In Bray and Crumlin there were participants from all 3 focus groups as well as some of the participants who had been interviewed individually.

Table 2.4 Feedback sessions

Community	Participants
Bray	12
Ballymun	4
Crumlin	6

Ethical Issues Arising From The Research

It was evident from the outset that ensuring confidentiality in reporting the findings of the research would be crucial. This is always an expectation of research but with some participants, fears of local intimidation required that data-gathering strategies be adjusted to ensure confidentiality. The focus-group format was therefore not suitable for some participants.

The significance of the oral tradition for researchers in one of the communities has became very clear to us. It is more important and accessible to them than the written form. Reflections on the importance of this difference for research which privileges the documentary information have led to a consideration of how the project could value this position while ensuring that the research is not undermined. We discussed taping weekly meetings of the community groups, where the research would be getting discussed, and submitting this as a record of ideas and information as it emerged. This raised issues for the community-based researchers in terms of their freedom to discuss concerns at these meetings. In the end it was agreed that all research team meetings would be taped and used to facilitate the generation of ideas for the analysis of the data.

Personal experiences permeated and enriched the contribution of the community researchers to the project. The incredible privilege of working with them struck home and it is hoped that the research reflects this even if the more traditional documentation was a problem.

Disclosure of the names of the three communities was given consideration at all levels in the research process. The co-ordinating researchers were willing to present the data using fictitious names. However maintaining anonymity would also have required distortion of many facts which distinguish these communities and if not done would reveal the identity. Community participants agreed that there was sufficient information already in the public domain to justify naming the communities. Maintenance of the anonymity of the participants would not be affected by naming the communities. The participants were eager to have their community story discussed. In addition, this was one research study, not three separate studies. The communities should be appreciated for contributing to such a research study, in which an attempt is being made to develop indicators of a community drugs problem which matters to local people. Ultimately, it is hoped that their contribution will assist in the development of tools which can be used across communities, to measure change. Of course, those involved hope that the issues of concern in their areas will be highlighted through their participation. They hope that the findings of the study will lead to enhanced support for their efforts.

The research can at best only reflect the perceptions of the people who participate in the research. Clarity on this issue ensures that others in these communities do not feel that the research attempted to speak for them.

Chapter Three
Literature Review

Understanding Drugs And Drug Use

The literature indicates that there is no agreement on exactly what defines drug problems. It supports the notion that definition of drug problems is inextricably linked to theoretical preferences and cultural influences. These preferences have, inevitably, influenced progress in developing clearer understanding of drug problems. In spite of the continued debate about the nature of drug problems, attempts to explain the nature/causes of drug problems remain controversial. Different theoretical paradigms privilege different explanations and at times these contradictory views have fuelled concerns that nothing works in relation to dealing with drug problems. It is important to note that the most influential of the theoretical positions continue to favour the individualistic ideas about the development of drug problems, and so, hold limited value for the exploration of community drug problems. Foremost among these in the Irish context is the medical model of drug addiction. The theoretical ideas informed by more sociologically sensitive systemic thinking provide some insight into what could be more broadly seen as community drug problems.

This research adopted a broad-base view of drug problems, to incorporate the WHO defined drug-dependence syndrome (WHO, 1992 F10-F19) but to seek understanding beyond this to the socio-cultural factors that contribute to, and are impacted on, by drug issues. Somewhere in this broad view of drug-use issues may lie the pointers to defining a community drugs problem.

Problematic Drug Use

In the Irish context, drug treatment has been dominated by the disease concept of addiction (Butler, 1994; Velleman et al., 2001). The tensions between more traditional and alternative interpretations of 'addiction' result in concerns regarding the privileging of one interpretation over the other. The dominance of the traditional 'disease' concept understanding in the Irish setting has had implications for defining or re-defining problems. This dominant view is instrumental in defining both the problem and the perceived response to that need. Over-promotion of the disease concept has elevated the role of expert, particularly medical, out of all proportion to its real significance (Orford, 1985). Over-emphasis on the physical addiction neglects the psychological mechanisms involved. The notions of dependence and addiction are very restrictive in that they direct attention to drug use at the most severe end of the continuum. Other critics of the dominant drug-use discourse point to the impact of the disproportionate emphasis on individual pathology. Moore (2002a:2) presents the thesis that this problem is born of an ignorance of the social context within which alcohol and drug use takes place. Drug use that may be seen as non-dependent but problematic should also be addressed particularly when dealing with policy and service development. It is within these categories of use that many early-phase users may be located.

The developing credibility of alternative theoretical positions (Sobell and Sobell, 1978; Heather and Robertson, 1989; Heather 1995; Miller and Rollnick, 2002) add to the debate. The possibilities opened by these shifting paradigms are challenging, and threatening. Addictive habits are seen as challenges, learned habits which can be changed, so the person can move on leaving the addiction behind (Marlatt, 1990).

Tucker (1997) has elicited how two clear approaches promoting holism are practised in health. Both have tended to function somewhat separately from each other. One focuses primarily on the individual organism. The second version encompasses economic and political systems as well as biological and environmental systems and is based on the notion that health and illness are not simply biological phenomena but are socially produced. These two approaches to holism, functioning somewhat separately from each other, leave each with its own particular weaknesses.

Systemic thinking does attempt to distinguish between individual and socio-cultural influences on drug use issues. For the most part, the systems-based ideas that have been employed within the field relate to a family-systems paradigm. The contribution of theoretical developments, such as the post-modern theory of social constructionism, have had little impact on the addiction field (Loughran, 2002).

This is not to say that the broader connotations of social, cultural and neighbourhood networks have not been used in Ireland and elsewhere in analysing opiate use, particularly problem heroin use. There is recognition that the development of long-term and damaging drug use is most often associated with social marginalisation and exclusion. According to Moran et al: (2001:79), over the past two decades research in Ireland has consistently demonstrated a link between concentrations of drug use and various indicators of poverty and social exclusion including unemployment, poor housing, one-parent families and low educational attainment.

EU data on social conditions among the treated population show that socio-economic factors related to drug use include low educational levels, early school leaving and drop-out, low salaries and difficult jobs, low income and debt, insecurity of accommodation and homelessness, mortality and drug-related diseases, poor access to care and social stigma (EMCDDA, 2003:67).

Parker, Bakx and Newcombe (1988) were critical of the contribution made by sociological thinking to the drug-use debate. Although promoting change in the community has much to gain from the sociological tradition, the literature in Britain was found to be deficient for assisting in the response to the sudden rise in heroin use in a working-class community in the North-West of England (Parker, Bakx & Newcombe, 1988). Based on clinical populations, there was very little in the literature which a community-based case study could recognise and embrace. It does appear that such theoretical movements as the social constructionists have at least struggled to recognise the dangers of marginalising the marginalised through the dominant way of discussing the issues.

While the influence and power of individual focused-pathological approaches to understanding substance use do offer a roadmap to dealing with some aspects of drug use in particular, dependent or addictive use, they fail to demonstrate an appreciation of the social and cultural context of drug use. A working party from the Royal College of Psychiatry in their 2000 report discuss the history of drug/substance use. They suggest that 'characteristically each culture accepts the use of one or two of these substances, usually those with which it is most familiar. (2000:23). Other 'alien' substances are viewed with suspicion and attempts are made to control their use. 'Current international legislation reflects the cultural traditions and economic interests of the politically dominant countries of Europe and North America' (2000:23). They quote some findings which reported that use of all drugs is more common among people, particularly those under 30, living in neighbourhoods classified as reasonably well off or prosperous rather than in disadvantaged areas. However, injecting, dependence, polydrug use, heroin and crack cocaine are more commonly found among socially deprived and homeless populations (Royal College of Psychiatry 2000:66).

From a social construction perspective the question is why are some drugs prohibited while others are promoted. Such a perspective addresses the way in which we as a society can and do decide that alcohol and tobacco users can be tolerated but heroin users must be pursued and criminalised. The recognition of the harm related to both alcohol and tobacco suggests that we are not using harm as an indicator of what drugs should be banned or criminalised but rather we are creating an intolerant environment for other drugs based on tradition and familiarity. Normative drug use is culturally bound. If a society, for whatever reason, deems a drug/drugs or levels of use of any drug to be unacceptable then sanctions will be drawn down on those who do not conform. What the report of the Royal College of Psychiatry suggests is that while this process is understandable in terms of the needs of society to establish and maintain norms not all members of that society have an equal opportunity to influence that selection process.

Hence in reviewing different communities' experiences of drug use it is essential to consider the issue of power, social isolation and marginalisation of those communities, independent of the drug-use issue. This consideration leads to a questioning of not just the levels of drug use within those communities but also the level of related difficulties experienced by those communities as a result of normative standards which are insensitive to the realities of their social context. Already marginalised communities, experiencing economic deprivation, are further marginalised as problems within their communities form the basis for social and moral panic. This interpretation of drug use considers the possibility that harmful effects are induced on the individual and the communities in which they live not by virtue of the intrinsic harmfulness of the drugs themselves but rather through the social response to their use. Problem drug and alcohol use does not occur in a vacuum and what constitutes "problems" is by no means universally agreed, being influenced by values, cultural norms, attitudes, and social conditions.

For the purposes of the current research these challenging ideas present a forum for considering drug-use issues divorced from the dominant drug-use discourses. A perspective that incorporates critical social analysis would act as a safeguard to interpretations that simply reflect widely held positions instead of struggling to understand the lived experiences of communities in which drug use has been labelled as problematic. Indeed, at times the communities themselves are labelled problematic.

The social construction approach allows one to value unique experiences but also to investigate resilience and resourcefulness within communities. These communities have survived and continue to survive what are potentially destructive forces. These forces are inevitably the presence of seriously problematic levels of drug use and the impact of that on individuals, families and the community. But they also include the unhelpful responses of political, legal and other systems which serve to reinforce the marginalisation of those communities.

The legacy of ideas that focused on individuals and their drug dependence has supported a reliance on the criminal justice system as a control mechanism for dealing with drug use while achieving limited success in providing caring health-based responses that recognise the broader community dimensions of drugs problems. While these responses have a place in overall policy development, they reflect a limited acknowledgement of the lived experience of people in communities, where the problem is not just about individual drug users, but rather about the wider impact on social interaction, social networks, and community cohesion. Perhaps the most critical failure in current theoretical discourse on drug issues is the relative absence of exploration of community perceptions of their own situations. Theories can and do assist in making sense of social phenomena but if the dominant influences privilege individualistic interpretations of the problem, and therefore support individually focused treatment responses, these may undermine the need to identify and address fundamental community concerns.

The absence of an illuminating literature on community drugs problems within the addiction field underlines the tensions between the individually focused 'addiction' models for treatment and the policy formulations which acknowledge the community dimension. It is unclear how a government strategy can provide a unifying lead in the light of such diverse views. What is clear is that no single theoretical approach is sufficient on its own.

In light of this limitation, the research turned its attention to the literature on community, community development and social capital. This literature offers varying perspectives on the notion of community and the research sought to employ this in interpreting the data gathered from communities about their perceptions of drugs issues.

Community

The focus of the current study is to progress understanding of drugs from a community perspective. This demands some clarity of how the term "community" is used in the study. Consideration is then given to Community Development as it is a central plank of national drugs strategy. It represents the most clear indication that while addiction literature has limited contribution to understanding community drugs issues the adoption of a community development strategy in response to drugs issues does imply a level of acceptance of the significance of community. The research is based on a hypothesis that understanding the community's perceptions of drug issues is a critical step in the development of a more effective set of community indicators.

Finally, Social Capital is addressed briefly, as this has been taken up as a way of exploring new policy and partnership approaches to addressing social inclusion and the quality of life (NESF 2003:3). As the research progressed, it became clear that the interlinking dimensions of social capital may offer a framework for developing some community indicators.

"Community" is not a precise term (Tucker, 1990). Community can mean a physical place; or it can mean a group/groups of people with similar interests; we often hear the term "religious community"; or it can be used to describe a service, e.g. community school, community care. 'Community' has taken on many different meanings in social and public policy (Hoggett, 1997). Difficulties can mean that the concept is undermined, and its efficacy questioned. Lack of definition and unrealistic expectations can compound confusion (Ó Cinnéide, 1989). It has been suggested that the ambiguities which surround terms like "community development" and "community work" create a major handicap to progress, leading to agreement on "*the basis that it can mean anything you like*", or disagreement "*on the basis that its advocates are not clear about what they are proposing*" (Ó Cinnéide & Walsh, 1990).

In spite of these difficulties, Loughran claims that 'community' is a persistent idea, because it refers to our social experience (2003:9). After years of being out of favour in the UK, it began to make a come back as "a new generation of sociological and geographical researchers appear to have registered the fact that outside of the seminar room the idea of community appears to remain alive and well" (Hoggett, 1997:6).

For this study, three communities who have experienced significant drug problems were selected (as per tender brief), based on physical, geographical location. This is appropriate for such an Irish study, since the *Ministerial Task Force on Measures to Reduce the Demand for Drugs* in 1996 concluded that the numbers of drug addicts were "*concentrated in communities that are also characterised by large-scale social and economic deprivation and marginalisation*" (Government of Ireland 1996). The LDTFs and the RDTFs have geographical boundaries and this selection recognises that 'place is important' (Powell and Geoghegan, 2004).

However, communities are not things. They are made up of people who live, work and interact in different ways on a daily, weekly, monthly basis. People learn, celebrate, work, play and change with this geographical location as their reference point. New parents bring their babies home, children go to school, young adults go out into the world, meet partners and set up new homes, grow old, die and are buried.

The areas chosen for this research are also seen as important social and political units. From the outside there is a perception that they share common experiences. As has been outlined in Irish drug policy documents, particularly since 1996, one of these experiences is that of drug problems. These drug problems did not develop in a vacuum. The conditions for fostering the growth are to be found in the socio-economic situation of many communities. These conditions form the backdrop for the personal relationships, the group networks, and developing patterns of behaviour.

Some commentators, for example Navarro, highlight the power differentials in these relationships, based on class.

> *"But a community is* ***not*** *only an aggregate of individuals; it is more than that. A community is a set of power relations in which individuals are grouped into different categories, of which classes are the key ones. And power is distributed according to those categories." (Navarro, 1984)*

In this study "community" is seen as a moving, living web of relationships, group networks, traditions and patterns of behaviour that develops against the backdrop of physical neighbourhood and its socio-economic situation (Flecknoe and McLellan, 1994). The research is also cognisant of the fact that drug problems can both create and fragment bonds between the residents of the area, thereby simultaneously building and undermining community cohesion (Connolly, 2002). For community workers, this division can prove difficult to manage. The apparent ambiguity is difficult to reconcile.

The study seeks to represent an analysis that would deepen our understanding of "community", and highlights how important the focus of this tender brief is, i.e. to identify what changes, if any, have come about in the drug situation since 1996, *from a community perspective.*

Informed by the definitions above, this study set out to capture the perspectives particularly of those whose views do not normally inform decision making. It took into account the relationships in each community between the people who live there, people who work there, and the institutions who serve them.

Seeing the community in this way, i.e. as a set of relationships as well as physical units, means that we need to remain open to gathering data on a variety of perceptions. The literature highlights the diverse nature of the term community and so, capturing community perception was an ambitious task. However what is most significant here is the distinction between perceptions from outside and from within communities. It would be impossible to fully discover a community perception given that this would involve listening to all voices in that community. What this study has done is to listen to voices within these communities and, from this, to extrapolate a community perception of drug issues.

The review of literature on drugs and community did not offer a clear picture of community drugs problems. It was evident that drug problems impact on communities in a variety of ways. There was no one theoretical framework which offered a unifying model for understanding the many dimensions of a community drugs problem. This makes it difficult to respond to the consequences experienced by communities because of drug problems such as stigmatisation, discrimination, deterioration of public spaces and withdrawal/closure of services. What did emerge was that communities are diverse entities. Even the task of geographically defining a community is complex. Added to this is the fact that people

living within a community may have very different perceptions of what is happening in their community. The literature review offered limited assistance in the search for a definition of community drugs problems. It became clear to the researchers that to explore this issue the study would have to access a wide range of voices from within the community and to seek some convergence of ideas across the range of community perceptions of drugs problems.

Community Development

In Irish Social Policy community development commands an important position. 'Community' is promoted in response to rising levels of need, which outstrip the state's capacity to provide services (Taylor, 2003:9). Local communities have been presented as being able to solve a range of issues – even being the means of revitalising local government and regional planning (Varley & O Cearbaill, 2002). Not only in Ireland, but in many parts of the world, ideas of 'community', 'social capital', 'civil society', 'participation' and 'empowerment' have moved to the centre of the political agenda (Taylor, 2003:xii).

Hustedde & Ganowicz (2002) claim that what makes Community Development different from other interventions is that it builds capacity. The idea of 'agency', of the capacity of people to order their world, is central to Community Development. In the UK, community involvement has been a requirement of virtually every policy about local development introduced since 1997 (Chanan, 2002). Many who were disenchanted by the failure of 'left' or 'liberal' political parties to respond effectively to the widening gulf between rich and poor turned to community politics as a new alternative (Robson, 2000). There was a growing belief in the power of community to initiate change.

In Ireland, community development has been used to describe activist-driven responses to various issues, including unemployment and meeting social needs, particularly those of children and young people. Since 1987, the development of a model based on Social Partnership has increasingly influenced the organisation of welfare (Rush, 1999). Including public consultation in the policy process, it is believed, is likely to produce better social policies that lead not only to improved services, but also to identifying and addressing problems that are important to people (Iredale, 1999).

Community development, both as an idea and an area of work, is more vigorous now in Ireland than ever, but is also much more complex. Throughout the 1990s and into the new millennium, there has been rapid expansion in community development activity (Lee, 2003). 'Community' and the ideas which surround it offer resources, social glue, alternative ideas and knowledge which are now seen as essential to society (Taylor, 2003). Community development can be viewed from diverse political positions. The Right can lend it support because of its self-help ethos and link with self-determination. The Left like it because of its role in countering structural inequality. However, the proponents of each political ideology also have suspicions of community development – the Right view it as a "potential vehicle for pursuing a radical agenda, while the Left perceive that it can be used to placate communities, and that it can be used as a subtle means of social control" (O'Neill and Douglas, 1999:4).

In Irish drugs policy, three major interpretations of community participation have been identified and described (McCann, 1998). Each interpretation, valuable in its own right, leads to different actions in reality for local communities. Two major approaches can be seen in community development work in Ireland. One approach, influenced by sociology, often does not involve itself directly in the work with individuals, concerned more with analysis of economic and political systems. Others, working at community level, concerned with individuals and the building of caring communities, and coming from

various backgrounds, have not engaged with the wider analysis. This "fundamental fracture" (Collins, 2002) in the community/voluntary sector in Ireland weakens, it is claimed, the capacity of civil society to reflect on the complex myths, rituals, attitudes, economic and political factors which are central to the role of alcohol and drug taking in the state (McCann, 2003).

Communities in Dublin, some of them well educated in community development, did not wait for official invitations to participate in the resolution of issues which directly affected their lives. Many of them organised around the drugs issue, among other issues, throughout the 1980s, and the 1990s. It could be claimed that communities led the way in promoting collaborative structures through their creativity and willingness to experiment.

Communities were recognised as important by the Irish Government, formally, in 1989. This is evidenced by the adoption of area-based partnerships in response to crippling rates of unemployment. These partnerships had, as a central element in their structures, the involvement of the community sector.

In 1996, seven years later, the government formally recommended similar structures for responding to drugs, through the establishment of LDTFs. The involvement of the communities most affected was seen as crucial to any effective response (Government of Ireland, 1996). The National Drugs Strategy Team, made up of personnel from various government departments, also has among its number two members who represent the community and voluntary sectors. These members have been seen as important to the credibility and effectiveness of this cross-cutting body (Boyle, 1999).

While there are positive developments as a result of locally based interventions, questions have been raised about community participation in social partnership (Duggan, 1999; Murphy, 2000). The dilemma centres around whether or not the presence of community activists is a force for significant social change, or reduced to supporting the decisions and actions of the more powerful actors in the process.

Powell & Geoghegan (2004) examined the experience of social partnership from a community development perspective. While it was a generally positive appraisal, they expressed considerable reservation. Following the last partnership agreement *Sustaining Progress*, the Community Platform, which represented many of the more excluded groups in society, was excluded from the national social partnership process. The Platform found that they could not sign the agreement, as the needs of their constituency were not adequately catered for. This was interpreted as opting out of the process.

It has been claimed that the Irish State has a crisis management mode of operation where Community Development is concerned. This mode of operation is seen as having encouraged a view that community interests are a means of contributing to the achievement of crisis management, rather than as an end in themselves, worth supporting as an "indispensable element of the civic culture of democratic societies" (Varley & O Cearbaill 2002:63).

Similar fears abound in the community drug sector. There is a sense that the drugs issues do not command the same political commitment as they did in 1996. During the last general election in 2002, for example, there was little mention of the issue in manifestos and canvassing. The Irish Presidency of the EU in 2004, unlike the last presidency in 1996, paid little attention to drugs. Since 2002, community representatives on LDTFs have been expressing serious concerns about the lack of commitment by government to ongoing support and resources for the LDTFs (CityWide Drugs Crisis Campaign, 2004). As this present study got underway, a major film, *Veronica Guerin*, based on the events leading to her shooting, was released. This brought back memories of 1996 and what was happening then (CityWide Campaign 2003).

While it can be said that community development has much to offer in responding to social issues like drugs, it can look very different to different people, and requires understanding of complex processes and contradictions.

Social Indicators

The research aimed to identify indicators of a community drug problem, from a community perspective. To assist in this task the research drew on general literature on social indicators. A definition of social indicators which reflects a consensus among most researchers is that of Andrews and Withey (1976):

> *'….a limited yet comprehensive set of coherent and significant indicators, which can be monitored over time, and which can be disaggregated to the level of relevant social unit…..The set of indicators should be 'limited' so that a substantial portion of the most salient or critical aspects of society is included. They should be "coherent" in that it would be helpful to our understanding if they hung together in some form that would eventually lead to a model theory about how society operates.'*

A social indicator is basically a statistic which tells us something about an aspect of well-being within an area or group. Moreover, if it is tracked or monitored over time it should give an accurate idea of whether or not things are improving, static or declining with respect to the aspect of well-being that is being measured (http://www.gisca.adelaide.edu.au/kra/cp/).

As well as monitoring change over time, indicators can also record differences between population groups and areas (Palmer & Rahman, 2002:6). The whole idea of indicators is to use the same set of clearly defined and regularly produced numbers over a period of time to give an overall 'headline feel' of the direction in which things are moving (Palmer & Rahman, 2002:23).

Social indicators which are designed to monitor the effectiveness of policies to tackle poverty, for example, can provide important information for effective decision-making in two main ways:

- As a source of information for assessing the potential impacts on poverty at the formulation stage of poverty, and
- As a tool for measuring the extent to which specific policies or programmes have impacted on poverty (Palmer & Rahman, 2002:1)

There is a long-standing controversy in social indicators research between the 'objective' and the 'subjective' approach (Veenhoven, 2002:33; Cummins et a.,l 2003). The objective approach focuses on 'hard' facts – e.g. income in dollars; number of dwellings, etc., whereas subjective indicators focus on matters of satisfaction with income, and perceived adequacy of dwelling (Veenhoven, 2002:33).

In the late 1970s and early 1980s, planners and policy makers were disenchanted with social indicators (Beer, 1994). Indicators were not often made available in a timely way so that they reflected historical rather than contemporary situations. They were not available for spatial units which were relevant for social planning. And they were not meaningful in terms of the combination of variables used in deriving the indicators which were usually from census sources (www.gisca.adelaide.edu.au/kra/cp/ accessed 16/10/02).

Much of the literature emphasises the importance of gathering subjective data. Research and press representations can flatten an area into statistics, into the single image of 'trouble' (Brent, 1997). Through the lived experience of people, we can depict the richness and depth of an area, rather than a 'flat' picture. There are difficulties in attempting to do this. The key characteristic of an indicator is that it is a number. This requires that the indicator be clearly defined so that it can be quantified (Palmer and Rahman, 2002). There are obvious difficulties in doing this when we consider some of the factors which make up what is called "quality of life". One of these difficulties concerns who defines the indicator. What constitutes a good quality of life will vary from person to person, from area to area, from town to town, from country to country. Our study set out to identify indicators which are important to local people, indicators that reflect community perception. In particular, we were interested in how local people judge whether there has been any change, for better or worse, in community drug problems since 1996.

Community Indicators

Chanan (2002:9) argues that assisting communities to flourish is one of the most enlightened things a Government can do, helping to assist a deepening and internalising of democracy. If Government is to assist communities to flourish, then Government and communities alike need authentic ways of judging whether this is happening. The most practical way of specifying the people whose quality of community life we are focussing on is by locality. Chanan therefore suggests that it makes most sense to measure community involvement at ward, aggregate ward and local authority (district) level as these could be correlated with Government statistics on local deprivation. We have used EDs, as these are the units which are used in Irish national data collection. We have, however, also paid attention to the locality as defined by the local researchers.

Community Indicators provide a vehicle to understand and address community issues from a holistic and outcomes-oriented perspective (Swain, 2002:1). The impetus towards community improvement originates with how a community values itself and what vision it has for its future. Community indicators tell graphic stories about specific aspects of life and well-being in the community. If tracked over time, they offer a moving picture of community trends in the recent past. These trends can be followed for understanding. They can also be compared with the community's vision. The attempt here is to tell these graphic stories about three communities' experiences of drugs from 1996 to 2004.

The use of indicators to track the involvement of people in interventions, assess the strengths of communities, their inclusiveness, level of organization, capacity and influence, would provide evidence for reflection and review of priorities and work practices (Community Development Foundation, 2000). The findings of this study support the importance of developing indicators of people being involved in their own communities, either through volunteer effort, or social interaction, using local services, in paid employment in a community agency, or on management boards of local structures.

Community Level Indicators are derived from observations of aspects of the community other than those associated with individual community members (www.faculty.washington.edu/cheadle/cli). So the numbers of drug users in a particular community, while valuable information, are not so central to this study as the issues that the drug use raises for those living there. For example, one area may have a considerable number of drug users, but not have open public dealing. The issue for those living there is different than it is for a community where there is such activity going on.

It is important to adopt a participatory approach to the construction of indicators, involving those at risk of social exclusion and organisations that represent their views. Overall, the indicators must have intuitive validity (Atkinson et al., 2002:21). Veenhoven claims that objective indicators alone do not provide sufficient information for social policy formation, or for assessing policy success. There is a challenge to combine the strengths of the two approaches, and to make sense of the discrepancies they show. Objective indicators alone fail to measure how people feel about their lives. This requires subjective indicators (Australian Unity Wellbeing Index, 2003).

For a community drugs study such as this, this means that the objective indicators show only part of the picture, and may not have much meaning for the people dealing with the issues every day in their communities. Increases in drug treatment numbers, for example, do not say anything about changes in the everyday life of a community. Connolly, in one local area in Dublin, has shown that existing surveys are unable to provide an adequate impression of the way in which crime can impact on different areas or sectors of society (Connolly, 2002). Local surveys, using a triangulation of methods, can yield a more accurate picture of the quality of life in an area.

In this study, we are concerned about who defines the indicators; who decides what is important to measure. Through an inductive process, issues of importance to local people have been identified, which can become the basis for a set of community indicators.

Recognition Of A Drug Problem By The Community

As Swain (2002) suggested, an important role of indicators is to raise consciousness of citizens and decision-makers. The findings of this study show that this work is ongoing, and it is suggested that regular local surveys could help to raise awareness.

To determine whether community recognition of a substance abuse problem exists, the following are examples of the types of questions that can be posed:

- To what extent does the community believe there is a drug problem?
- What are the perceptions of the drug problem? How accurate are they?
- Has there been an event or incident that has aroused concern?
- How do key leaders perceive the drug problem?
- How are drugs portrayed by local media?
- Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?
- How often do stories disclose the consequences of drug-abuse related problem behaviours?
- What type of drug abuse problems are currently reported?
- What are perceptions of the causes of/possible solutions to the problem?

(National Institute on Drug Abuse, 1997:36)

A set of indicators tells a story (Groundwork, 2000:17). Of interest to this research study are the two major steps recommended by Groundwork, to make sure that all the important parts of a story are told. Firstly, they need to be organised according to issues. This provides a focus for subsequent indicators, and reduces the chances of missing out the things that matter. Instead of trying to deal with what to measure and how to measure it at the same time, it is useful to separate these steps. The first one is to agree issues, the second is to choose indicators to measure them.

There is great value to be accrued by communities being involved in establishing indicators for measurement, and subsequently being involved in their collection and refinement. Understanding of the complexities of the problems will deepen, with an appreciation of the difficulties of accurately portraying the area so that it can be compared over time (Join Together, 1996). Also, for planners, while some of the information on its own may not be statistically relevant, when taken as part of a more comprehensive framework of indicators, a more accurate picture of change will emerge.

A sense of community is a widely valued indicator of quality of community life (Perkins, Hughey, Speer, 2002). But what constitutes 'a sense of community' may vary depending on interpretation. Subjective well-being is difficult to measure, but more especially so if indicators are identified by sources outside those whose quality of life is to be measured.

Experience of gathering this data with the communities involved leads us to believe that the opportunity to be involved in regular local data gathering would be welcomed. A system for the design, implementation and analysis of data would be empowering for local people, and their structures. These systems should be part of a macro system, but with the flexibility needed to incorporate issues of local concern.

Social Capital

The term *social capital* describes important social processes and relationships – informal social support networks, friendship, neighbourhood generosity, interpersonal trust and volunteering activity. It also describes aspects of local and community development, public-private-voluntary partnerships and civic spirit. Although the term is relatively new in Ireland, the underlying concepts are not (NESF, 2003). It is an important consideration when attempting to document and explain increases in community-level crime and violence (International Narcotics Control Board, 2003). Indicators of social capital have significant independent effects on perceived health (Institute of Public Health, 2004:5). It is also of interest to this study, because of the possibilities it offers for providing a framework through which the issues identified by the research, for example, withdrawal from local involvement, decreased use of public spaces, lack of trust in institutions, can be measured. Social capital is a set of resources inherent in communities, networks and relationships. By contrast, community development describes a process and outcome arising from a whole range of community-level resources (NESF, 2003:31).

There are different levels of social capital:

- micro/individual (the impact of interpersonal relationships and support)
- intermediate/community (the presence of community-wide norms of trust, belonging and co-operation)
- macro-societal (the presence of generalised norms of mutual help civic responsibility and engagement in the wider political processes); (NESF, 2003:115).

While it has been noted that the Irish Voluntary Sector has reached a position in policy making unmatched in the rest of Europe, it took the State a long time to define its relationship with the voluntary/community sector (Harvey, 2004). Empowerment of local communities to develop their own solutions and models of self-help is an important challenge in the design of public policy (NESF, 2003).

Community Development is an important context for applying social capital in Ireland (NESF, 2003:25). Care needs to be taken to ensure that measures take account of socially excluded groups, so that social capital is not used against them, to exclude them further; measures should include issues of gender, social class, race, ethnicity, social position or other identities.

The interrelated and overlapping dimensions associated with social capital are important to measure from a community drugs perspective. The International Narcotics Control Board claimed in 2003 that "the relationship between loss of social capital and increased violent crime, including violent drug-related crime, cannot be ignored" (2003:7).

Chapter Four
Summary Of Research Findings

Three different communities assisted in gathering the data for this research. This chapter will summarise the findings from the area profiles, which will assist in the development of more accurate indicators for use across a wide range of communities (for full profiles see Loughran and McCann, (2006)). Such indicators need to be able to accommodate a wide range of diversity, within communities, and among communities. This diversity was very evident in carrying out the study.

Lack Of Consistency In Defining Boundaries For Datasets

This problem was illustrated across a range of data. For example, Bray is in fact, at least three communities. It has some of the most advantaged and also disadvantaged areas in the country. O'Sullivan & Roche (1998:10,11) have pointed out, however, that it is difficult to disaggregate meaningful data on disadvantage for some local authority estates because of the existence of large privately-owned estates in the same EDs.

This diversity may have contributed to the ambivalent response from government in particular in the early days of the LDTFs. It may also account in some part for the reluctance of some people in Bray to acknowledge the growing problem with drugs that was evident in 1996. There may also have been community ambivalence due to the fact that in the early– to mid-1990s drugs problems, and in particular the heroin problem, were more or less 'contained' within the most disadvantaged areas of Bray.

In contrast to Bray, the bulk of the housing pool in Crumlin and Ballymun is local authority housing. Much of that stock in Crumlin has now moved into the private market. Crumlin is an 'old' and relatively settled area. Built in the 1930s and 40s it was well established before the onset of the drugs problems in Dublin, yet the area lent itself to being a popular location for organised crime. Many participants highlighted the fact that the reality in Crumlin is different to the widespread image which many outsiders have of the community. As commented by one:

> *Nowadays 90% of the people in Crumlin own their own houses, or are in the process of buying their own house. So it's come a long way insofar as an awful lot of the people, I mean you won't have a house for sale for very long. It will be grabbed up, because people want to come back into it* (18:392).

Another participant stated:

> *I think it was perceived as being a very rough area [10 years ago], although according to this participant things have changed, I think people are buying their own houses now and they're not going to take it* (22:80).

Discussion of housing issues did emerge in the data. There was particular concern regarding the continued disadvantage related to new housing schemes which appeared to benefit very little from the experiences of the past in terms of proceeding in such a way so as to avoid creating stigmatised pockets of housing. As in Bray, deprivation in these small housing schemes can be hidden in the ED statistics, because of the existence now of privately-owned houses surrounding them. Added to this is a difference in how local boundaries are defined.

ARC defines Crumlin as an approximately rectangular area bounded by Parnell Road, Crumlin Road, Saint Mary's Road, Saint Agnes Road, Kimmage Road West, Kimmage Road Lower and Harold's Cross Road. This is how the Crumlin area is defined locally and is ARC's catchment area as defined in its constitution (McKeown & Fitzgerald, 1999: 15). However, official statistics are gathered for differently defined areas. There is a lack of clarity about what is Crumlin and what is Kimmage when using EDs.

Similar to Crumlin, the housing stock in Ballymun was built originally by two local authorities. Much of this stock is in high-rise flats, with some in traditional two-storey houses. However, while in other areas people tended to buy their houses over time, this did not happen in Ballymun to a similar extent. In the main, this was due to the fact that it was not possible to buy the flats. In addition, the economic downturns of the '70s and '80s, the general decline in Ballymun, and policy decisions such as the Surrender Grant Scheme of the mid-1980s, have left the area with Dublin City Council (previously Dublin Corporation) being the landlord for most residents. Situated on Dublin's north side, near Dublin Airport, it is a very identifiable geographical area, known throughout Ireland, and Europe, as a "problem area" (Power, 1999). It is now one of the areas widely recognised as having a high level of drug problems. The housing tenure in Ballymun in 2001 was made up as follows: 58.5% local authority rented, 0.96% private rented, 6.2% tenant purchased, 33.6% owner occupied/other (Dublin City Council, 2002:22). Use of EDs is not so problematic in Ballymun, because the areas are more easily identified locally. Whether this remains so with the radical changes underway for this community remains to be seen.

The overriding topic in this profile was the regeneration which is happening in the area. Major changes are taking place, in people's housing, and in the level of population. Very mixed feelings were expressed about the changes, with some hope and excitement, and many fears that mistakes of the past were being made again. There was a concern that the social environment was not being given enough thought and planning.

The process of organising and categorising the data resulted in the selection of the following issues, from among a wide range of issues, which were prevalent in the discussions related to drug problems in these three areas, and what changes had occurred since 1996.

The Range Of Drugs Being Used

It was evident that the focus on heroin in 1996 is no longer the only matter of concern to these communities. Communities have moved on to identify polydrug use and are concerned with the range of substances available. Particularly, cocaine was discussed in all three areas. People were also aware of benzodiazepine use, and named "benzos" as among the range of drugs being used in their areas. The use of cannabis was seen as widespread, with limited awareness of any dangers associated with the drug.

The incidence of treated heroin misuse fell sharply between 1996 and 1997 and has remained to date (O'Brien et al, 2003). However, the proportion of drug treatment contacts presenting with other primary drug problems was relatively small due in part to Drug Services focus on opiates.

Consequently, treatment statistics for the period of the research do not reveal this range of drugs for non-opiate users. For example, the following table shows that the predominant drug being used by those who sought treatment in Bray is heroin. Cocaine and benzodiazepines barely appear as the main problem drug and cannabis numbers are also small.

Table 4.1 Main types of drugs used by those who sought treatment in Bray from 1996-2002:

Year	Main Type of Drug Used							Total
	Other Opiates	Heroin	Ecstasy*	Cocaine	Benzodiazepines	Hallucinogens	Cannabis	
1996	1	19	1				1	22
1997		37					1	38
1998		16	1		1		4	22
1999		19				1	1	21
2000		63		1	1		1	66
2001	2	138		1	1		2	144
2002	3	122			1		5	131
Total	**6 (1.4%)**	**414 (93.2%)**	**2 (.45%)**	**2 (0.45%)**	**4 (.90%)**	**1 (0.22%)**	**15 (3.4%)**	**444 (100%)**

** and other MDMA*

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

The situation is similar for Crumlin and Ballymun.

Table 4.2 Main types of drugs used by those who sought treatment in Crumlin from 1996-2002:

Year	Main Type of Drug Used											Total
	Other Opiates	Opiate substitute	Heroin	Ecstasy*	Cocaine	Amphetamines	Benzodiazepines	Hallucinogens	Inhalants	Cannabis	Unspecified drug	
	5		113	3						2		123
1997	9	1	90				1	1		6		108
1998	7	5	132	1	5					2	1	153
1999	6		104	1			2					113
2000	20		143	1	1		1			3		169
2001	4		154	2	1					1	1	163
2002	2		159							1	1	163
Total	**53 (5.3%)**	**6 (0.6%)**	**895 (90.2%)**	**8 (0.81%)**	**7 (0.71%)**		**4 (0.4%)**	**1 (0.1%)**		**15 (1.5%)**	**3 (0.3%)**	**992 (100%)**

** and other MDMA*

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

Table 4.3 Main types of drugs used by those who sought treatment in Ballymun from 1996-2002:

Year	Main Type of Drug Used								
	Other Opiates	Opiate Substitute	Heroin	Ecstasy*	Cocaine	Hypnotics & Sedatives#	Benzodiazepines	Hallucinogens	Volatile Inhalants
1996	52		224	1	1	1	7		
1997	14		185		2				
1998	30	1	334		3				
1999	45		256						
2000	21		360		1		1		
2001	16	3	377	1			1		
2002	10		275	1	4		1		
Total	**188 (8.4%)**	**4 (0.18%)**	**2011 (90.3%)**	**3 (0.13%)**	**11 (0.49%)**	**1 (0.04%)**	**10 (0.45%)**	**0 (0%)**	**0 (0%)**

** and other MDMA*

 # Excluding benzodiazepines

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

It is important to highlight that these statistics represent only those who present for treatment and hence do not accurately reflect the true extent of the drug problem. As seen in each of the areas these statistics resulted in some clear data regarding heroin but were not sensitive to polydrug use due in part to lack of service provision for those not using heroin.

Also, it is important to note that, in Crumlin for example, the LDTF and the local community believe that the statistical information does not accurately reflect the extent of the drug problem. An unofficial estimate suggested that there could be over 600 heroin users in Crumlin alone (http://www.kwcd.ie).

The qualitative data support this criticism of the treated drug misuse statistics. Participants reported that use of hash was commonplace. It has become an accepted drug. There was some difference of opinion about the place of ecstasy in Crumlin. Discussion indicated that younger participants who may have been closer to the drug scene were aware of the extent of ecstasy use in night clubs and discos. Because it was not as visible on the streets, many may either not have recognised the symptoms of its use or were not exposed to it in the way they were to heroin. Crumlin's links with organised crime served to highlight the heroin problem, as regular newspaper articles reported drug seizures and dealing in the area. It was through some such reports that information about cocaine seizures in Crumlin were gathered. This may have indicated that the dealing of cocaine even in 1996 was through the Crumlin criminal gangs. However it is possible that cocaine, at that time an expensive drug, was destined for a more upscale market and not for the users in Crumlin itself.

In Ballymun, the participants in this research reported increased cocaine use, ongoing ecstasy use, widespread cannabis use, widespread benzodiazepine use, with alcohol causing problems for people who live in Ballymun. It was also pointed out that the users were mixing a lot of the drugs above, and that very few were abusing just one drug. The picture which emerges from the qualitative data highlights the polydrug use which predominates over the years in this community.

An example is given from the 1994 Annual Report of the community response to drugs, the *Youth Action Project*. An outreach worker gave a rundown of other drugs being used in Ballymun on the occasion of the launch of the annual report, 1st July 1994. He talked about them in the order of those that were the most abused. The list reads: *alcohol, cannabis, ecstasy, tranquillisers (Valium had become routine), heroin, naps, physeptone, rohypnol, temgesics, acid, solvents (YAP, 1994).*

Heroin use was the focus of community and government interventions. This may be explained by the different nature of heroin use including injecting behaviour and of course the illegal activity associated with its procurement and use. The focus was justifiable from a health perspective, given concerns about HIV/AIDS among injecting drug users. Of all the people who died of AIDS between 1983 and 1999, 166 had injecting drug use as a risk factor (O'Donnell et al., 2001). The proportion of injecting drug users who died was higher than both the proportion of heterosexuals and the proportion of men who have sex with men. Behind this figure were many families who had lost their children to heroin. Grandparents were parenting young children, where parents had died, many of them of AIDS (McCarthy & McCarthy, 1997).

However, it is clear that heroin was distracting many people from the widespread use of a range of other drugs. While interventions, specifically methadone and community-organised responses, appear to have had some impact on the use of heroin, the failure to attend to the other drugs would emerge as a serious mistake in the 2004 profile. Over-reliance on drug treatment statistics misses, for example, the growing concern around cocaine use. Current treatment agencies are not going to pick up accurate figures for this, as many cocaine users do not present to drug treatment centres. It is clear that other mechanisms need to be found to highlight such trends, and monitor them.

The findings on polydrug use in this research are supported by reports from other communities. CityWide Drugs Crisis Campaign notes the "emergence of cocaine as a danger drug; the extension of the drugs crisis beyond the main urban centres; the increasing prevalence of polydrug use; the increased usage of prescribed drugs such as benzodiazepines" (Rourke, 2005:31). The emergence of cocaine was highlighted by the NACD in 2003 (NACD. 2003), and the Mid-term Review of the National Drugs Strategy 2001-2008 also recognised the changing patterns of drug use (Government of Ireland, 2005:35-39).

The Place Of Alcohol As One Of These Drugs

Across all three communities the issue of alcohol use was a serious concern. This related to high-risk, under-age drinking and disturbances created by drinkers. Alcohol was identified as an issue in its own right, used extensively by a wide age range in the communities. Issues like disturbances after pub closing times were commonly discussed. Also, alcohol was named as one of the drugs used in conjunction with other drugs. It was discussed regularly in connection with cocaine use, for example, which was described as taking place in pubs, and among an older age group, at the same time as drinking.

> *The first-choice drug here in this community is alcohol, but I just think it's so sad to see kids. And they can't wait to get themselves buckled. They don't go out to drink, they go out to get drunk…..Alcohol plays a major part in the problems of this community* (23:66/68).

> *Cocaine and alcohol, manifests itself for us or for the guard on the street, is generally aggressive behaviour after pubs close down, or nightclubs close down. Aggressive behaviour into the early hours of the morning. When I say aggressive we always had a kind of drink culture there, and a little bit of aggression, but it seems to be far more serious aggressive behaviour* (7:54).

There was some concern at the increased availability of off-licences. Interestingly, and alarmingly, the Youth Action Project has drawn attention to the increase in alcohol off-licence outlets, directly as a result of the retail plan of Ballymun Regeneration (YAP submission for the Review of the Regeneration). Where there were two off-licences before, there is now a total of seven.

In Crumlin also, this was noted:

> *But I know alcohol is more readily available because we have more off-licences in Crumlin village. I mean, three off-licences within spitting distance in Crumlin village……*(23:43).

It is not clear from the data if the licences are full off-licence certificates, or the more easily obtained wine off-licence. National data shows that the numbers of the latter have increased substantially in Ireland in recent years (STFA, 2004:11). The increased outlets in Ballymun illustrates the lack of co-ordination in policy and planning. The off-licences have grown in number as a result of the retail plan for the area under the regeneration programme. However, no account seems to have been taken of the Strategic Task Force on Alcohol's (STFA) recommendations for restricting availability of alcohol.

Communities' concern about increased availability is backed up by international research. This shows that levels of availability, and of per-capita consumption, are directly related to the levels of alcohol-related problems in a society (STFA, 2004). When we consider that these communities are also trying to deal with various other major changes, for example the upheaval surrounding the regeneration programme in Ballymun, their frustration at the lack of understanding on the part of those planning their environment is perfectly understandable. It is the people who live in the areas who will directly experience the result of increased availability of alcohol.

This concern about alcohol also came through during the consultation process for The Mid-term Review of the National Drugs Strategy.

Local Drug Markets

The drugs markets are perhaps the clearest indication of the extent of the drugs problem's infiltration into a community. When dealers feel free to deal openly in an area, and are organised enough to protect themselves from police intervention, then the community within which the dealers operate inevitably feels vulnerable. Such was the case for our three communities.

> *And it was being dealt openly. I remember my son coming in from school. That school around the corner. He came from school and came home giving out yards about these fellows who were outside the bakery ….. and the cop shop, and he was disgusted that this was happening. And everybody was. Everybody was fed up with it* (4:24).

In one community, the only shopping centre in the area was badly affected in 1996:

> *It was like in the wild west, when the baddies took over the town. But that's the way … Shopping Centre was, because the druggies ruled the roost there* (5:29).

In another, concern about drug dealing in public parks was expressed by one participant who commented:

> *It has progressively got worse. I mean, the park is a place that I wouldn't let the kids go into. I mean, I would have let the older ones, when they were younger [in 1989/90], but the younger two wouldn't have been up in the park at all. When I used to bring them up to the park [in 1996], there was drug dealing going on* (23:13).

Such activity has had an impact on people living in the community to such an extent that they are fearful of letting their children out to play in local parks.

In another, it was the local DART station:

> *Not so much drug addicts, but what was coming into and out of Bray. It was very much in-your-face in 1996/1997. there was a big presence of undercover guards.*
>
> *Well, obviously if the DART station was being hounded by the guards and being watched, these guys know that, so they just found a different way of doing it — taxis couriering drugs* (14:185).

There have been changes in local drug dealing since 1996. With the use of mobile phones, and the development of a cocaine market, there isn't the same visibility. Public spaces, like the local shopping centre in Ballymun, have improved greatly since 1996. However, respondents reported greater violence associated with drug dealing, and a greater sense of intimidation from gangs on the street. There was some loss of faith in the Gardaí being able to respond effectively to the problems.

A Garda study (Furey and Browne, 2004) recorded an increase in the number of people stating that they sourced their drugs from a local dealer, when compared to an earlier study (Keogh, 1997). People in this community study reported being able to sit and witness dealing outside their homes. For some, there is a strong sense of intimidation surrounding this activity. People expressed opinions that the police must know, yet nothing seemed to happen. People in the study reported having rung the police, with no apparent response.

Patterns of drug dealing have changed. A participant described how drug dealing in Crumlin has changed from once being handled by barons to now involving local people, as this participant put it:

> *Instead of one or two major gang leaders dealing in Crumlin… that vacuum that they left was filled by little local mini-dealers, for the want of a better word, obviously being supplied by … dealers from wherever in the area, or in town. But now, instead of a major gang leader bringing heroin into the Crumlin area, you've local working-class or unemployed families seeing that as a way of making money. So the whole tenor has changed from the gang to the little local people, or local street dealers* (24:37).

In another community, the same thing was noted:

> *Up in our estate there's about ten different coke dealers. Just in one estate. It's more scarier now than maybe the heroin, because it's done by mobile phones. There's a lot of younger kids are doing the running. Yeah, there's more risk* (3:325).

Another described the change like this:

> *Over time, it has developed into a case that it's not as in-your-face-I suppose for one reason, mobile phones, cameras. The CCTV cameras would have contributed in some way to it, in Ballymun. And now, the shift towards cocaine use has certainly changed things, insofar as they're not out on the street corners looking for their heroin. They're doing coke – a lot of the young people are doing coke in the clubs and pubs. They're going out, they're drinking at the weekends. They're taking their cocaine, and the general public as such doesn't see it happening* (7:44).

Another interviewee was pessimistic about change, saying:

> *No, that was in the early 90s. I mean, it was rampant, I'd say up until – I think it's still rampant – still invisible. It may not be down in the shopping centre. It may now be over at …. or at the steps of …. But I don't think it's fundamentally changed. That's why I – that's my concern about it all* (8:129).

A speaker in a focus group agreed with this view:

> *(woman) The drugs problem in Ballymun now is exactly like the 80s, despite all the resources thrown in, despite the amount of very good initiatives. Despite the amount of intervention work. Despite all that going in, we are actually back to where we were in the 80s* (2:294).

Local drug markets contribute to damaging community confidence. In particular, it has been identified in the UK that if drug markets have become established, they are a serious impediment to regeneration (Lupton et al., 2002:vi).

The statistics available from the Gardaí tell us very little about the consequences for people living with the kinds of activity described above. For example, statistics for drug offences where proceedings commenced show us that the Gardaí have information on some different kinds of drugs – cannabis, heroin, LSD, ecstasy, amphetamines and cocaine. 2,719 proceedings in total were taken in the Dublin Metropolitan Region in 1999, and 2,757 in 2002. For Wexford/Wicklow (which would include Bray activity) the numbers are 201 for 1999, and 212 in 2002. The year 2001 has most proceedings taken in both the Dublin Metropolitan Region and Wexford/Wicklow.

Police data for two of the communities show the great discrepancies in trying to build a picture of an area. Information (Tables 4.4 and 4.5) was made available, by request, from Ballymun and Crumlin Garda stations. The information from both stations is very different.

Table 4.4 Police data on drug detections for Ballymun 1996-2003

Year	Garda Searches*	Drug Seizures	Value of Drugs Seized in Euro
1996	33	161	n/a
1997	58	250	n/a
1998	60	192	n/a
1999	65	140	n/a
2000	87	239	n/a
2001	42	185	n/a
2002	40	79	n/a
2003 (May)	27	101	n/a

** Please note the low number of Garda searches for this area is by virtue of the fact that these searches relate only to searches on warrant and does not include 'on street searches' as well as searches in a police station.*

Table 4.5 Police data on drug detections for Crumlin 1996-2003

Year	Garda Searches	Drug Seizures	Value of Drugs Seized
1996	1,173	n/a	755,850
1997	6,257	n/a	929,088
1998	7,757	n/a	532,750
1999	3,510	140	2,626,915
2000	2,888	219	716,671
2001	2,942	229	1,784,510
2002	3,265	218	743,020
2003 (May)	1,669	109	1,565,905

As will be obvious, such data is not an accurate indicator of the levels of drug use in an area. They are more an indicator of Garda activity, and priorities. Compounding this for the purposes of tracking change over time is the fact that administrative districts for the Gardaí differ from HSE districts, and from EDs.

Deaths

Drug-related deaths and deaths among drug users is one of the five key indicators of drugs misuse in Europe. All three of these communities had experienced drug-related deaths. During the course of the research, such deaths occurred.

> *A lot of our friends have died in the last three years.*
>
> .....
>
> *I'd say about 8 in the last three years. Maybe more.*
>
> *Probably even more.*
>
> *I can think of at least ten people* (3:363).

Some of these were very high profile, for example, as the result of shootings, and death in prison. Currently in Ireland, the CSO collates data on drug-related deaths from the General Mortality Register. Between 1995 and 2000 there was a substantial increase in the number of drug-related deaths nationally, from 43 to 119. 2001 saw a decline to 88, and in 2002, rose slightly again to 91. Between 1995 and 2000, there was a substantial increase in drug-related deaths in Dublin, from 39 to 90. In 2001, there was a sharp decrease in the number of drug-related deaths in Dublin, to 55. These statistics follow trends in treated problem opiate use (Long et al., 2005:13).

However, once again it is very obvious that the official figures for drug-related deaths do not record the extent of deaths in a community. These figures generally do not include deaths related to drug use, but not recorded on death certificates. Only deaths which are as a direct result of drug use are systematically recorded. Deaths where the cause is defined as indirect are not systematically recorded, e.g. accidents, illnesses. However, to local communities what matters is that people are dying, and that drugs are a major part of the reason for the deaths. Dublin CityWide Drugs Crisis Campaign, for example, hold a memorial service every year for families to remember those who have died. The attendance is very large, and attempts are made to estimate the numbers who have died, using the family support network. The first such ceremony, in 2000, estimated that 800 young people had died from drug related issues. The reported figure from CSO for 1990 – 2000 is 573, with 2000 being the highest in their record (Long et al 2005:34). At the ceremony in February 2004, it was stated that there had been more drug-related deaths in Dublin's inner city in the previous year than any other year (Holland, 2004).

In Bray, those who worked in the field felt that Bray had suffered from huge losses and that the impact on the community was tangible.

> *I think that in the period that we're talking about, I can think of twelve who died as a result of drugs ……*

This participant went on to describe the impact of such deaths, which goes completely unrecorded in current indicators:

> *There is a great deal of community support for the families when that happens, but it's different from other kinds of deaths, it's more subterranean, and I think that there must be huge hurt out there, very significant number of people, now, as a result of that bereavement going on and on and on, which, you know, isn't really spoken about* (13:200).

Information from the national statistics indicated that only 2 people from Bray died from drug-related deaths between 1996-2003. Local participants would suggest that this is under-reported. Apart from the accuracy of such records, what emerges from this study is that the impact of deaths is not taken into account. Participants spoke of the devastation to families where children had died because of drug use. The impact on these families has a ripple-effect on the community as a whole. This effect is not just about the unnecessary loss of life, but is reflective of the cumulative loss to the community as it attempts to deal with drug use.

In Crumlin, the impact was described very graphically. This participant remembered:

> *An old photograph of a football team…of young lads, all 13 at the time….and three of the young people in the photograph, and they were all Crumlin, all that area, had died from heroin abuse – or related diseases. And the fourth was actually in a wheelchair after taking an E at a rave in Tallaght. And that's all in the last six years that that happened* (24:20).

Drug-related deaths often act as a spur to action. According to one participant, one of the first signs of drug use in Crumlin was:

> *People dying, a few young deaths* (18:85).

In Ballymun, the YAP was established in 1981 following three young deaths at the end of 1980. A participant remembered these deaths:

> *And there were three children died that long weekend – between two weekends, and one of them was a long weekend, and there were four or five taken into hospital. But three of them died. And the community was flabbergasted by this. And I remember it very well. There were questions – what's happening here* (4:3).

However, there was a view that the deaths were fewer since 2000:

> *My impression, and it's just anecdotal, is that there were fewer deaths in the last year or two, than there have been in the former years we were talking about. I think there were fewer than there were from '96 to 2000* (13:200).

An example of the discrepancy in statistics due to recording issues is given through a local study conducted by Byrne. The study showed that the annual numbers being investigated by the Dublin City and County Coroners' Office, from the years 1998 to 2001, were consistently higher than those reported by the GMR. 332 opiate-related deaths in Dublin were investigated in that time, a period of interest to this study. Byrne's analysis of this data showed that 90 per cent (300/332) of the coroners' cases lived in local drugs task force areas. Of particular interest to this study, Ballymun, along with the Ballyfermot and Canal Communities Drugs Task Force areas, had the highest rates of opiate-related deaths for the reporting period, approximately 16 times the rate experienced in areas of Dublin not designated as drugs task force areas (Long et al., 2005:43). Crumlin figures are part of Kimmage West, Crumlin Drimnagh. Part of Dublin 12 Task Force, the recorded rate was over 4 times higher than areas not designated as task force areas. Byrne's analysis included a broader range of opiate-related deaths than that recorded by General Mortality Register (GMR).

Also of interest here is the finding that two-thirds of the opiate users who died tested positive for three or more drugs, while just over 11 per cent tested positive for one drug (Byrne, 2001 cited in Long, 2005:44). Two distinct patterns were observed among the eight most commonly implicated in drug-related deaths: benzodiazepines, opiates (heroin and methadone), and alcohol were by far the most common substances implicated drugs in these deaths, while cannabis anti-depressants, and stimulants (ecstasy and cocaine) were less commonly implicated.

These statistics support the views of the people in this study that drug-related death is a significant part of life in their communities, that polydrug use is involved, and that the impact is considerable.

In terms of alcohol-related mortality rates, between 1992 and 2002, increases were reported for cancers related to alcohol; alcohol dependency; alcohol abuse and psychosis; chronic liver disease and cirrhosis; alcohol poisoning; and suicide (Drugnet, 2004c:2).

It is important that drug-related deaths are recorded more accurately. There is a depth of pain felt in communities through the loss of their young people, and of young parents. This pain is compounded by under-reporting, and can be perceived as a lack of care from the authorities. Efforts to redress this are being made, with the launch of a National Drug-Related Deaths Index in September, 2005. It is intended that detailed and accurate data be provided to facilitate a reliable decision as to the cause of death and

its link with drug misuse (Speech by Mr Sean Power, Minister of State at the Department of Health and Children, at the launch of the National Drug-Related Deaths Index 26th September 2005). It is important to note that the index has been developed with the involvement of CityWide Family Support Network.

> *(man) Another thing you have to remember is, people died before this. I think the ones that are called suicide, that is drug-related. Even now you don't know the numbers, you won't be told the numbers and you can understand the family not wanting to talk about it* (12:150).

> *(woman) Yes, there's been a huge amount of deaths, suicide or overdoses or whatever* (13:199).

Crime

The relationship between loss of social capital and increased violent crime, including violent drug-related crime, cannot be ignored (International Narcotics Control Board, 2003:7). The official crime statistics in Ireland are to be found in the Annual Report of the Commissioner of An Garda Síochána to the Minister for Justice, Equality and Law Reform. Since 1999, the way these figures have been recorded has changed. The introduction of the PULSE system, with a recategorising of crime, means it is difficult to compare across the time of the research. However, the rise in recording of lethal crime can be assumed to be accurate, since few unlawful killings go unreported to the authorities. In the 1960s, there was roughly one killing a month; in 2001 and 2002, there was more than one a week (O'Donnell, 2005:113). This rise in lethal crime at the end of the 20th century has been related by O'Donnell to three main causes:

1. *Demographic change*. The population in Ireland swelled by 290,000 between 1996 and 2002; this was the highest level of growth since the 1970s and almost four times the EU average.
2. *Increased alcohol consumption*. Between 1989 and 1999 there was a 41 per cent rise in per capita consumption.
3. *Anomie*. The sudden and swift increase in prosperity and inequality may have created the conditions for crime. One criminal career that leads to great financial rewards is the drug trade. But the risks are high and market domination is sometimes established through fearsome violence (O'Donnell 2005:114).

Crime was discussed in all the groups and interviews. People in the study perceived that crime was directly linked to drug use, which had led to local decline. For example:

> *People were being attacked and robbed. Handbags gone. I do think drugs destroyed Ballymun. It could have been a good place* (5:52).

While some crimes were seen to be down, there was a sense that the crime in 2004 was more violent. The picture in 1996 was where local drug dealers might get a warning and possibly beaten up, now it was that people were being shot. There was a sense that it would be more dangerous now to have local patrols to control drug dealing, as communities had done in the early 1990s. Also, there was a sense that it was more dangerous to be a drug user now than in 1996; drug users are being beaten locally by gangs of younger people. These gangs are using different types of drugs, and do not see themselves as "junkies". High media profile cases of public brawls which resulted in death, often after closing of nightclubs, were seen to be more common now. Polydrug use, particularly the mix of alcohol and cocaine, was seen to be directly connected to this. However, the improvement in service provision, and the improved jobs situation were seen to have contributed to less crime locally.

As participants recalled:

> *If you were to encapsulate the feeling of the community, the fears of the community – like in whenever, '96, and now – I think there is one big change. The fear was break-ins in your house in '96, … now the fear is of going out at night, of antisocial behaviour. And very often, drink-related, rather than drugs-related (agreement)* (11:97).

> *Oh, yeah. I think where I live now, it wouldn't be really – you'd include alcohol in this. But there would be – there's loads of metal shutters up and they're not very aesthetically pleasing. It's like everybody has to pull down these metal shutters at night. And that sort of thing. That has changed.*

> *…….I think it would be almost like a kind of barricaded society, barricading themselves up at night, sort of. Now, as I said before, where I live, it has improved immensely…*(13:37).

Experience of crime in one of the communities is higher than national averages (Ballymun Partnership 2003, Summary:8). While robberies and things like jump-overs seem to have lessened, the sense of safety in public places has decreased. People are more afraid to go out:

> *I think that the symptoms of drug addiction are more apparent, which would be things like street crime, a sense of tension, increased violence, more antisocial behaviour. I think it's much more--?? — I think it's — from my experience, and I've been around for 20 years, it's the worst it's ever been. And unfortunately these are young people, these could be the future adults of Ballymun* (8:106).

> *Five-ten years ago I would have been happy to walk through Crumlin Village in the evening. Now, there's no way I'd walk through it. You know, once it goes past 8:00 at night, I wouldn't… the gangs that congregate in both of those parks, then, you know – drinking and taking drugs – this goes on til all hours in the morning down there* (20:007).

Another added:

> *Now, I wouldn't be easily intimidated, but in the same breath-I would be wary, I wouldn't carry a bag through the village, or any of the roads, because it's just dodgy, I think* (20:41).

This participant goes on to say that this has changed, commenting:

> *I was never afraid…I'd never be afraid if someone approached me…now I wouldn't walk through the streets* (20:41).

Two Garda studies of interest here are the Keogh study (1997), and Furey and Browne (2004). Both studies combined the use of official Garda statistics, and interviews with drug users. The 2004 study concluded that drug users were responsible for 28 percent of detected crimes, while the figure from the earlier study was 66 percent. The unemployment rate among the sample had gone down, and more of those interviewed were holding down a job. This is credited to the fact that fewer people said that crime was their main source of income. In addition, drug treatment had greatly increased over the period in question, and the drug users themselves claimed that this was one of the main factors in their reduced criminal activity. There are difficulties in doing this type of study, where the police attempt to research a group which has been involved in criminal activity (see Connolly, 2004). In addition, it has to be pointed out that reporting levels in the general population are down (CSO, July 2004). However, it is useful information, and perhaps corroborates the perception in this research that some crime has gone down.

The concern of the people involved in this research was not only about direct drug-related crime, for example dealing, but about behaviour which made life locally difficult, the image an area would have, the media-reported coverage of an area. The local people associated much of this crime with drug use.

In general people felt that there was probably a loss of confidence in the Gardaí. Criticism of the Gardaí included comments that they were unresponsive to people who call them, they know what's going on but seem unable to do anything about it. People in general welcomed the community Gardaí but again felt there were not enough of them and that young people in the community did not know them. If they had to act as regular Garda in the area it undermined their position as a community Garda.

In the Quarterly National Household Survey (QNHS) crime and victimisation module 1998 and 2003, (CSO July 2004) while satisfaction with the work of the Gardaí was generally high, Dublin people were least satisfied, with one in seven rating it as either poor or very poor. The incidence of personal crime had doubled over the five years from 2.4% to 5.2%. The experiences were of theft with violence, theft without violence, and assault. While these incidences had risen, reporting rates for burglaries, vandalism and personal crime had gone down.

A participant in this research described what he saw happening:

> *After once or twice ringing the police and nothing being done, they won't say anything or do anything. They just put their head down and probably don't say nothing. Because the effects, if they don't, would be detrimental to them or their family or neighbours, or anyone else that was willing to stand by them. So they just plod along and say nothing. And they can keep going. And that's …*
>
> *(woman) Or they take the law into their own hands* (1:134).

The perception was that the attitudes of the Gardaí was linked to the area, and to people from certain places:

> *…..It's just worth pointing out that I think that there's not a lot of trust in the Gardaí. And as I pointed out, that when my children were younger and they hung around in groups together, they had several bands from estates in Bray, council estates, and if they were open – the children as a group, or if they were just hanging around as teenagers do, because they didn't have a place or a hall where they could go and play – they were often hassled by the guards. They were often told to move on. Even sitting on their own wall, they were told to move on. The guards often stopped them and talked to them, and assumed that they were up to things, when they weren't. And if the children, my children, gave their address, they were left alone. But often the children who gave addresses in other areas of Bray, like (names an area) – they were hassled. They were given a lot of rough treatment by the guards.*
>
> *But definitely in most areas, people wouldn't trust them. There is definitely a big lack of trust. And occasions like that, you know, those occasions better-off people, so they don't realise that those occasions are happening quite a lot (in other areas?). There's a huge mistrust.* (15:159)

Mulcahy and O'Mahony (2005) have discussed how this loss of trust may impact on crime and community safety in two particularly significant ways. First, if the public trust the police, this is reflected in a steady flow of information from the public to the police. When levels of trust diminish, the information flow is reduced, and with it police effectiveness. Secondly, as the police seek ways

of compensating for this reduced information flow, they often resort to more intrusive and abrasive measures, such as stop-and-search measures. This may lead to a further loss of trust (Mulcahy and O'Mahony, 2005:2-3).

> *This loss of trust seems to be related to marginalised areas and groups. Stark differences in experiences of policing have been found in different divisional areas (Garda Research Unit, 2002:20). Gratifying for the Force is the finding that 87 percent of respondents expressed an overall satisfaction with the Gardaí. However, particular areas could be identified, where figures for dissatisfaction were higher. Most of these areas were in Dublin. Mulcahy and O'Mahony found that local assessments of policing are strongly informed by the historical legacy of conflict surrounding drugs, vigilantism and community action, and ongoing efforts to secure meaningful community input into policing* (2005:11).

The Sense Of Fear/Safety

People expressed changes in how safe they felt in their own areas. While some of this may be to do with perceptions of crime levels generally in the area, much of the fear seemed to be related to groups of young people congregating, drinking and using other drugs.

Fear of drug use and its associated behaviour had a significant impact on people living in the community in 1996. As commented by one participant:

> *It was around 1996 when we found the needles, and after that I wouldn't let the kids go into the park. It engenders a lot of fear, yeah, and it's animosity and it's sort of – you develop I suppose a certain – you put up a barrier. It's a barrier to sort of dealing with people who are basically your neighbours. Because I mean the people who are using drugs in this area, live in this area. You know, they're not coming in from outside* (23:29).

The reaction of people becoming more insular was commented on by numerous participants. As stated by another:

> *People start to keep things to themselves. They start to close their door and not become involved in the area. It's fear and it's sort of stimulates fear in people. I mean, you're afraid of what the consequences of your involvement would be. I mean, even me ringing the police. I mean, you're doing it – you're not sort of standing at the door ringing them, because you're afraid they'll see you. So even, you're sort of doing it here, behind the door. But it's just to protect your own* (23:36).

Fear also prevented people in Crumlin from carrying out everyday chores. As commented by one participant:

> *You wouldn't go to the shop at night. Or even old people going out, you very seldom see the old people walking around – even during the day and you certainly wouldn't carry a handbag* (20:212).

Another participant says of the fear amongst elderly people:

> *Very few elderly people now go to the bingo, because they will not walk up that road. There used to be loads of people walking up that road* (20:217).

These quotes more than adequately highlight a community drug problem. Not only are people using drugs in the areas, but their behaviour around drugs is impacting on the quality of life locally, determining people's activities, and how they use their local amenities. There were participants who had actually experienced threats from dealers, when they took part in community action to control activity around their homes. These participants were very scared.

However, there were different opinions about the issue of fear in the community. This may be in part attributed to the success in reaching those not directly affected or involved in drugs. Some felt that they experienced very little negative consequences from the drugs problems.

> *Well, for me, living in Bray …the uses of the drugs …very little, quite honestly. I don't think they have much impact, really* (15:151).

It was suggested that the face of a place can change due to this fear. As put by one participant:

> *It was always busy.* [now at night the village would be] *Empty. Desolated. Nobody, except for teenagers…. And that's very true – any night of the week – even Saturday or Sunday night.*

Another commented:

> *The amount of shops that have closed, like the-it's actually taken away a lot of the business. It actually looks like a ghost town now* (20:217).

Restricted Use Of Local Amenities

As some of the quotes used in this summary of the findings show, people reported that they didn't use public spaces, for example local parks, as much as they did in 1996, particularly after dark. Some concerns were expressed that this related to the activities of gangs and drug users. In some cases, local amenities had improved, and working in a local shop was described as "a different place to work".

> *Maybe there still is a lot of drugs and drug deals being conducted in Ballymun, but it's definitely not in the Centre, and it's a different place to work. It's 100% different* (5:25).

The decrease in use of local amenities can be evident in people sending their children to schools outside the area. While this wasn't discussed in any great length in the data, surveys like the one done by Ballymun Partnership gather such evidence. Parents can feel that if there is a concentration of problems in a school, their children won't get the same chance in education. They also feel sometimes that more will be expected of their children in schools outside the area. Of course, this can contribute to the cycle of marginalisation experienced by some schools.

People also expressed concern at a lack of amenities locally for young people. Even though the YPFSF has invested in capital facilities, the base was very low to begin with, and many activities for young people are still under-resourced. In particular, those working with youth clubs, and activities like bands, expressed great frustration at the lack of support from government, and the fact that in spite of all the money in the economy, they are still having to scrape around looking for funds. There is a sense that young people who do not get into trouble are missing out!

The Impact On Families

Families are affected in many ways by drug problems. Some families experience difficulties directly when a family member develops a drugs problem. For others the effect is more indirect in terms of the consequences of drug use in their community, school or social group. Participants expressed concerns for families living in the areas worst affected by drug use. They also spoke about their own attempts to safeguard their families in the current climate.

Many families lost children to drug overdoses or AIDS, as discussed earlier. Regardless of the numbers involved the impact on families has been devastating:

> *We've had one family in our particular area [referring to the death of a son]. But it was through drug addiction and that. And that had a huge effect, it's a huge loss for the family and it does have a huge impact on the community around* (13:62).

> *….. I think we have seen it firsthand for families, like, basically it was destroying families. It was eating away slowly, but surely, it was eating away at families. While we knew it was happening, there wasn't a lot – I suppose from the Garda point of view – we knew it was there. There wasn't a lot you could do in relation to it. You could try and help out families as best as possible. And I'd say we built up strong links with a lot of families as a result of their problems. They'd ring you and they'd say, look, we have a problem* (7:31).

> *Anything that's saleable, out the door with it, Christmas clothes – you couldn't leave them anywhere. The minute he saw anything that looked saleable, it was gone. Gone* (27:238).

Participants recalled that parents did not know who to turn to:

> *Parents were coming up saying, well, my son has a problem. I can't get treatment. I can't get places for him. I can't get him away to Trinity Court. There's a waiting list. .. and those things were coming up, even at that stage* (16:117).

Fear among parents for their young children was also common. As remarked by one parent:

> *You're fearful for who your children are playing with. I fear, like, I have a field beside me, and there has been needles found in it. In the summertime, you have the young fellows from the top of Crumlin village, a very well-known criminal gang coming in, and they will come in and play football with the kids that would be in the field already – ah, givuz a game of football. Until they're waiting for their stuff to be delivered* (19:77).

Families suffered from the stigma attached to living in areas known for drug problems even where they were not involved:

> *In the community where I live, where I come from, it was a known factor that if you gave the address, ..., on your application form, you wouldn't get called back. But if you gave your grandparents' address, you certainly were in with a shout for the job. Even to go to work in ... or places like that, you had to give somebody else's address* (13:136).

Families turned inward to protect themselves from what they perceived was going on around them.

> *I think a lot of people have just kept away from it. I think that's sort of the reaction. A lot of people would be very, very angry with it. A lot of people would be protecting themselves very much* (15:7),

Groups in all areas discussed how families were looking to themselves rather than the community to safeguard their children. Families feel that they can protect their children by keeping them away from other children, not allowing them to play on the street or in local parks.

The CAT service in Bray reported experiencing an increase in the number of referrals, queries, phone call and meetings with parents in relation to alcohol and drug misuse by teenagers. This is a serous concern as service provision is not extensive for the under-18 age group.

The Profile Of Local Housing Development

The concentration of the most serious drug problems still seem to be in local authority housing estates, in some cases in particular streets of a housing estate. Local dealing seems to be a central part of this problem. While this has changed since 1996, it is still very visible in some areas, and can be intimidating. Also, alcohol was seen to be involved in much of what is called "antisocial behaviour", which can seriously affect the quality of people's lives.

Each area has different issues around housing. This is another example of the need for indicators to be able to deal with diversity in a community. Bray is experiencing, like the rest of the country, a waiting list for local authority housing. In Crumlin, housing is now very expensive. Often local people can't afford to buy in the area. Ballymun is undergoing a major regeneration project.

There were concerns that the local authority housing estates (sometimes only a couple of streets in an area) were still vulnerable to concentrations of drug problems. While drug use is widespread in all the areas, with an older age profile, those in areas characterised by cumulative disadvantage are still more at risk of the local drug use becoming community drug problems. Some in Bray, for example, felt that the way in which housing had been developed and handled had contributed to the problems. As mentioned earlier, people were concerned that large developments were constructed without thinking through the implications of such big estates. In 2004 some participants reflected on other problems related to housing issues. In Bray, 1996-onward, the areas of most significant economic disadvantage were also the areas where the drug problem took hold and thrived. Some of this was to do with the size of the estate:

> *They do not appreciate that the bigger the estate, the bigger the problem. There are 239 houses in ... Estate and to be honest with you, if there never such a thing as drugs – it's just too many houses* (14:37).

And some with the design:

> *Lanes at the back of houses are just 'loitering holes'* (14:37).

One participant commented on how one estate had not been given support to settle:

> *If they hadn't of built substandard housing in the first place, that … could have been one of the best estates in Bray now. Because it could be settled. But it never got the chance* (14:147).

And how official action has disrupted communities:

> *When they took people out of … and put them into …, they were nearly ready to settle, the kids were grown up …..* (14:149).

In Ballymun there is a fear that the centre of the new town will look very nice, be kept clean and safe, be where most of the new owner-occupiers are; but that the edges of the new estate will still have all the same problems. Some felt these will be worse than ever, because they will be even more marginalised. There were mixed views expressed on the success of regeneration from those who were happy to be rehoused in new houses instead of flats, to those who felt that the social structure of the community which had been achieved through much hard work and commitment had been neglected in the move towards the physical regeneration. The disruption of the area due to demolition of the high-rise block and even more importantly, the delays in knocking the block thus leaving numerous vacant properties available for drug-related activities were cited as contributing factors to some of the disappointment expressed by residents. The participants in general were sceptical about how regeneration would contribute to the resolution of the drug problems in the community.

There was anger at the way the blocks which had been emptied, waiting for demolition, were being openly used for drug dealing. In some places, there were a few families still living in blocks which were predominantly empty. They reported very intimidating anti-social behaviour. That their safety was compromised through such a large official scheme for the regeneration of the area caused great anger, and is leading to a loss of trust in the authorities who claim to be improving their area. In the main, the agencies who were criticised for this were the police and Dublin City Council (the landlords), and Ballymun Regeneration Limited (BRL), the company charged with overseeing the regeneration.

In Crumlin, there was particular concern regarding the continued disadvantage related to new housing projects which appeared to benefit very little from the experiences of the past, in terms of setting up projects in such a way as to avoid creating stigmatised pockets of housing.

While housing tenure is an important aspect of cumulative social problems, it is important to note that local authority rented tenure alone is not sufficient explanation (Fahey, 1999). The explanations seem to be more in management, maintenance, tenant participation, and issues like support for children. In the areas worst affected, it has been shown that of the families with children, the majority are lone-parent families. Housing alone will not be enough to ensure that these children grow up healthy and safe in their environment. Attention needs to be given to where they play (Government of Ireland, 2000) where they go to school, how their parents get support with the responsibilities, and how they are cared for when things are difficult.

Participants in Bray identified the issue of homelessness as a growing concern. Some of the people living on the streets in Bray, it was suggested, may have come from Dublin because they felt it would be safer in Bray. This issue was reinforced at the feedback session. The numbers are still relatively small but for Bray, it is an expanding problem that people are taking very seriously.

School Attendance

Discussion on young people not attending school, and the importance of keeping them at school, was prevalent in the data. Participants did draw attention to the importance of staying in education. As put by one participant,

> *You can see it, with their* [kids whose siblings are using drugs] *attitudes. They know – you'd be lucky to get the junior cert, some of them. And I think if they get past the junior cert and you get them back in, even into Leaving Cert Applied, now. To me, that's a great way of getting them to do their Leaving. It's great, because them kids just sitting on the wall – nothing. And then they're not entitled to anything, because they're within the age. Between 16 and 18 they're not entitled to nothing. And that was something that was a problem in '96 as well* (21:217).

This perception is backed up by some findings of the ESRI (2003). Savings of at least €14 million a year on unemployment costs, crime, etc; could be made if young people could be prevented from dropping out of school before their Junior Cert (ESRI 2003, cited in NEWB Annual Report, 2003).

The concerns about non-attendance were not only at second-level schooling, but at primary level. Early school leaving is associated with treated drug misuse, and in each of the areas this association was noted. For example, as illustrated in table 4.6 below, the percentage of the population in Bray 1 and Rathmichael who left school under the age of 15 years is substantially higher than other EDs in Bray. Although the percentage for these two EDs fell significantly between 1996 and 2002: from 31.8% to 21.7% for Bray 1, and from 30.1% to 18.3% for Rathmichael, they still have notably higher rates of early school leaving than other Bray EDs. It is also evident that both Rathmichael and Bray 1 have the two lowest levels of entrants to third level education, at .91% and 2.6% respectively in 2002.

Table 4.6 Level education ceased for Bray EDs 1996 and 2002*

ED	Ceased Under 15 yrs		Ceased at 15 yrs (Lower Secondary)		Ceased at 17 yrs (Leaving Certificate)		Ceased at 20 yrs (Primary Degree)	
	1996	2002	1996	2002	1996	2002	1996	2002
Bray 1	31.8%	21.7%	12.6%	10.3%	9.7%	9.7%	1.3%	2.6 %
Bray 2	10.2%	5.5%	6.1%	5.4%	11.5%	8.3%	3.4%	3.3%
Bray 3	15.8%	11.1%	8.1%	7.1%	11.9%	9.4%	2.8%	3%
Rathmichael	30.1%	18.3%	15.1%	12.9%	8.8%	9.6%	0.86%	0.91%
Kilmacanogue	14.3%	7.8%	9.7%	6.1%	12.8%	11%	2.9%	3.6%

** Age Education ceased for persons aged 15+ as a percentage of all those aged 15+ in each respective ED*

Source of data: Small Area Population Statistics, Census, 1996, 2002.

Further, Table 4.7 highlights the fact that the majority of those who sought treatment for drug use in Bray between 1996 and 2002 had left school at 15 years-of-age or younger, thus supporting concerns that early school leaving adds to disadvantage for these young people.

Table 4.7 Age at which those who sought treatment in Bray left school - % for the years 1996-2002

Year	Age Left School Grouped		Total
	< 15 yrs	> or = 15	
1996	5 (22.7%)	17 (77.3%)	22 (100%)
1997	7 (18.9%)	30 (81.1%)	37 (100%)
1998	3 (18.75%)	13 (81.25%)	16 (100%)
1999	6 (37.5%)	10 (62.5%)	16 (100%)
2000	12 (27.3%)	32 (72.7%)	44 (100%)
2001	25 (24.7%)	76 (75.3%)	101 (100%)
2002	35 (33.3%)	70 (66.7%)	105 (100%)
Total	93 (27.3%)	248 (72.7%)	341 (100%)

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

Statistics for leaving school at 15 and under have improved in each of the profiles, as the following tables show:

Table 4.8 Level education ceased for Crumlin EDs 1996 and 2002*

ED	Ceased Under 15 yrs		Ceased at 15 yrs (Lower Secondary)		Ceased at 17 yrs (Leaving Certificate)		Ceased at 20 yrs (Primary Degree)	
	1996	2002	1996	2002	1996	2002	1996	2002
Crumlin A	38.2%	25.8%	14.1%	10.7%	11.2%	10.2%	0.78%	1.3%
Crumlin B	40.3%	24.7%	13.6%	10.1%	8.8%	8.2%	0.89%	1.5%
Crumlin C	41.2%	16.4%	11.8%	7.1%	7.9%	6.5%	0.88%	1.8%
Crumlin D	37.5%	19.2%	13.1%	10.2%	10.7%	8.2%	0.85%	1.6%
Crumlin E	43.4%	23.7%	12.9%	9.8%	8.3%	8.6%	0.89%	0.93%
Crumlin F	26.7%	12.3%	11.8%	8.1%	13.1%	11.8%	2%	2.5%

** Age Education ceased for persons aged 15+ as a percentage of all those aged 15+ in each respective ED.*

Source of data: Small Area Population Statistics, Census 1996, 2002.

Official statistics reflect a significant improvement in the numbers staying in school between 1996 and 2002. These figures represent the whole population and not specifically drug users. It is evident from the table above that the ED of Crumlin F has a much lower rate of people leaving school under 15 years-of-age and a higher rate staying in school until 20 years-of-age.

For Ballymun, the picture is similar:

Table 4.9 Level education ceased for Ballymun EDs 1996 and 2002*

ED	Ceased Under 15 yrs		Ceased at 15 yrs (Lower Secondary)		Ceased at 17 yrs (Leaving Certificate)		Ceased at 20 yrs (Primary Degree)	
	1996	2002	1996	2002	1996	2002	1996	2002
Ballymun A	37.5%	15.6%	12.7%	7.8%	8.6%	6.7%	0.7%	0.71%
Ballymun B	37.1%	15.7%	13.9%	8.4%	7.7%	6.4%	0.5%	0.60%
Ballymun C	28.9%	14.9%	16.6%	9.7%	8.5%	8.8%	0.6%	0.93%
Ballymun D	32.1%	18.3%	20.9%	11.1%	9.6%	7.4%	0.4%	0.62%
Ballymun E	10.5%	7%	7.1%	5.3%	17%	11.6%	3%	3%
Ballymun F	18%	11.1%	9.7%	7.3%	13.4%	11.1%	1.6%	2.2%

** Age Education ceased for persons aged 15+ as a percentage of all those aged 15+ in each respective ED.*

Source of data: Small Area Population Statistics, Census 1996, 2002.

The table above illustrates that, with the exception of one ED, Ballymun E, the percentage of those leaving school under the age of 15 years-of-age in 1996 was consistently higher than the percentage of those who ceased education at 17 years-of-age, or Leaving Certificate level. The statistics are similar for 2002. Local research in 1996 estimated that less than 25% of children attending schools in Ballymun complete the senior cycle (http://www.cap.ie/cap/ballymun.htm).

However, between the years 1996 and 2002, a marked decrease in the numbers leaving school under 15 years-of-age, and at 15 and 17 years-of-age (with the exception of Ballymun C for 17 years) is evident. Furthermore, there is a very slight increase in the percentage of those ceasing education at 20 years between these two years. While it is encouraging that the numbers leaving under the age of 15 show such a decrease, levels of educational disadvantage are still a major issue of concern. The retention is still lower than in areas not characterised by disadvantage.

Statistics from the NEWB show that for 2004 over 80,000 children nationally missed over 20 days of school in 2004 (NEWB, 2005 Launch of Strategic Plan, 2005 to 2007). Low attendance is a particular problem in schools with high levels of disadvantage at both primary and post-primary levels (Weir, 2004). Weir's analysis of attendance in school concluded that a true understanding of attendance problems will only be achieved by a close examination of patterns of absences within schools and over time.

The issue of early school leaving was seen as potentially related to drug use at two levels. Firstly, early school-leavers may be more vulnerable to being exposed to drugs and secondly, pupils leave early because they are already engaged with problem drug use. Drug use in the family, in particular a parent, was also identified by participants as an issue (Bray Feedback).

Participants commented on the limitations of focusing on early school leaving as they reported that in their experience poor attendance is the precursor for drop out. They felt more attention should be paid to this in terms of developing community indicators (Bray Feedback). One participant reported that from the time children begin attending school a pattern of attendance becomes established. Early identification and intervention with children who have poor attendance was seen as important. This has been recognised by the NEWB chairperson, Dr. Anne Louise Gilligan. She talks about being able to intervene before negative patterns emerge through "people who can develop a meaningful relationship with a young person and their family" (NEWB, 2003). However, it was noted by participants in this research that the Educational Welfare Act covers children 6 years and over. There was agreement that this was already too late for many children. One participant working with families with drug problems suggested that even by 3 years-of-age problems could be observed, and so, immediate action should be taken if these children start school at 4 years-of-age.

The connection between poor attendance and drug use in the family was seen as an issue for children as young as 3 years-of-age (pre school). Task Force support for school liaison personnel underscores this fact. In all three communities profiled for this research there are breakfast clubs and homework clubs run by volunteers and part-time paid staff. These services would be in a position to offer some insight into the needs of young people with drug-using parents.

A participant recognised some of the efforts being made to improve school retention, saying that the situation in schools is:

> *Much better than two years ago. They're actually doing their junior cert, and the schools are patting themselves on the back. So I think they are doing a good job. This participant suggests that the reason for this is just changing attitudes, getting the community and statutory agencies to come around. And the community not to lose its head and expect something done tomorrow. It's about being realistic, and having small steps to reach a goal. Instead of everyone coming in – I want this and I want it now* (31:58/59).

However, the issue of educational disadvantage is deep rooted in these communities. Suggestions for improvements in this area were made by one participant who stated:

> *80-90 percent of people in this area left school before sitting a state exam. So there's a lot of literacy problems in the area. I'm not saying that they're ignorant people – they're very smart people. I think literacy skills, more adult education* [are needed] (31:144).

This is evidenced in Ballymun, as an example. The educational levels of adults in Ballymun are substantially lower than the national population: 49.8% of persons in Ballymun left school before completion of the junior cycle of second level compared to a national figure of 27.8% (1997, Labour Force Figures). Given the level of educational disadvantage prevalent in Ballymun it is not surprising to find that educational levels among the unemployed also compare unfavourably with national figures (http://www.ballymun.org). However, these levels of participation in education should not be interpreted as a lack of interest on the part of parents in the area. In Ballymun Partnership's survey (2003), nearly all parents (99.6%) said they would like their children to go on to third-level education (Ballymun Partnership 3:9). There is ample evidence of the blocks and difficulties faced by families in reaching this aspiration. Also interesting to note is the fact that the levels of education have not improved among treated drug misusers.

It is evident from official statistics that the majority of those who seek treatment for drug misuse in Crumlin leave school at, or younger than, 15 years-of-age. The figures presented below for the years 1996 to 2002 fluctuate, with no significant improvement between these years apparent.

Table 4.10 Age at which those who sought treatment in Crumlin left school - % for the years 1996-2002

Year	Age Left School Grouped	
	< 15 yrs	> or = 15
1996	30 (28.3%)	76 (71.7%)
1997	23 (26.1%)	65 (73.9%)
1998	43 (33.1%)	87 (66.9%)
1999	19 (19%)	81 (81%)
2000	40 (24.8%)	121 (75.2%)
2001	42 (27.4%)	111 (72.6%)
2002	40 (26.6%)	110 (73.4%)

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

Table 4.11 highlights the fact that the majority of those who sought treatment for drug use in Ballymun between 1996 and 2002 had left school at 15 years-of-age or younger.

Table 4.11 Age at which those who sought treatment in Ballymun left school - % for the years 1996-2002

Year	Age Left School Grouped		Total
	< 15 yrs	> or = 15	
1996	106 (38.8%)	167 (61.2%)	273 (100%)
1997	52 (26.5%)	144 (73.5%)	196 (100%)
1998	111 (33.5%)	220 (66.5%)	331 (100%)
1999	88 (32.1%)	186 (67.9%)	274 (100%)
2000	137 (38.3%)	221 (61.7%)	358 (100%)
2001	126 (34.3%)	241 (65.7%)	367 (100%)
2002	96 (34.3%)	184 (65.7%)	280 (100%)

Source: NDTRS Data 1996-2000, e-mailed 19/03/03 and 2001-2002, e-mailed 28/07/04.

Increase In Services/Interventions

Positive change was reported with the increase of services for drug users. The methadone programmes, combined with better security measures in some public places like shopping centres, were credited with reducing the levels of crimes like handbag snatching, house burglaries and pilfering in local shops. The improvement in the economic state of the country was seen to have made it more possible to open up services, and fund services. Services had "improved immensely". However, there was also concerns about the appropriateness of some services, about the choice available to people, the possibility to move forward, and the satisfaction with services. While greater services are appreciated, the actual numbers of services are not the only issue for communities. They are concerned with effectiveness, choice, accessibility, and with gaps in service provision.

There were different views about the services available.

> *… Cleaning themselves up. With safe needles going around. You were able to change your needles. There was a lot more drug awareness there then, around hepatitis, the way it was going around, the interferon and the virus. And people were aware of that, and that's why they done an exchange into the local centre here too. From 6 – 8 in the evening, they had an exchange, on Tuesday night and a Thursday night. And people could go there with their old syringes and get an exchange. Like, it was a lot better. It's a lot better since the clinic came along* (3:98).

And the clinic was a lifesaver in Ballymun (3:197).

> *(woman) What … from the physeptone service was a lot of fat young people, as opposed to skinny ones who were on drugs. Suddenly we saw these young people and they had blown out to that size. And I was kinda saying, God, maybe if it gets them on the road – maybe it's worth it for them. I don't know. But I'd say-* (2:188).

> *Now the whole methadone programme, of course, has made a difference. I'm not sure when that came in, was it? Around that. But that certainly has made a difference, because young people now can obviously access methadone, maybe not too easily, but they can access it. But what they're doing now is taking tablets along with the methadone, to get the buzz that they used to get from heroin, and that they don't get from methadone on its own* (9:4).

> *I'll tell you, just looking around me in this room, at who's here. We all look a helluva lot healthier than we did back then. Mentally, as well.* (3:104)

In Bray, the data overall suggests that while people acknowledge the major advancement due to the provision of services they remain disillusioned and frustrated that the drugs situation in Bray has not improved. It has changed and continues to change. In relation to drug use, the main presenting problems are heroin and benzodiazepine dependence. This may be reflective of the services currently being provided rather than the needs of the community. Part of the changing face of drugs problems in Bray is the emergence of cocaine as an easily available and popular drug of choice. The concern regarding the structure of methadone programmes and the lack of facilities for young people, in particular around alcohol, were evident.

Participants had noted the development of other services, not only drug services:

> *There are now the Stay in School, the School Completion, the youth services in Dublin 12 youth service, none of those existed [in 1996]. So there's a lot of positives going on* (24:99).

Despite the positive remarks about the introduction of the school programmes and the potential of them, it has been commented that this has happened too late (18:127). Another participant stated,

> *Crumlin is a designated area, for Rapid. And that's covering this funding for the schools completion, and the Stay in School project. And they're two very good projects. But again, they're understaffed. Now I don't know if this is to do with the funding or the management or whatever, but again, they're only targeting a very, very minor amount of the young people. They're not targeting the big numbers* (24:82).

In Bray, other participants suggested that there was an improvement in other facilities for younger people. They identified playgrounds and limited sports facilities. Across the three communities, attitudes to the success in providing such amenities differed; some participants felt that things on this front had not improved at all. Again in Ballymun, there was great frustration at the lack of basic services for the general population. For example, the new Health Centre was built, as part of the Civic Centre. People could see it, yet it lay empty for a long time while a wrangle went on between agencies and departments about who would fund the fitting out of it. In the meantime, the people and the staff were using a building which had major flaws. Delays like this add to the loss of trust in agencies, and to a feeling of insignificance for the population.

Communities themselves have contributed greatly to the establishment and development of services. In all three areas, statutory services were preceded by community services. In Ballymun, the *YAP* has been developing services since it was founded in 1981. In Crumlin, *ARC* campaigned tirelessly to raise awareness locally of the need for services, and has developed a comprehensive range of services for drug users and their families, in spite of major local conflict. In Bray, community activists, sympathetic to the plight of users, were working to provide some response to their needs. They described the complete lack of services and facilities in the area throughout the '90s. A group of local people who were concerned for the users initiated the first community-based response service. This was not an attempt at treatment, but an effort to provide support and contact for users. It is clear that these locals were worried about both the users and their communities.

> *The end of '94, into '95, going up to September '95. Probably the first meeting (local volunteers who ran the 'Getalong Gang drop-in) with the Eastern Health Board would have been somewhere around June/July 1995, and then a large meeting was called in the local hall here for awareness to drugs, and that would have involved ……..*
>
> *But that was open to everybody in the area, parents of drug addicts and anybody that wanted to know about it.*
>
> *And then the clinic got started in early '96, and … got the Eastern Health Board to come on board with us and that was run in the portacabin, which is still there in the grounds of the church, which was at the time Franciscans — it's not now — but in our time, Franciscans. And we ran there for two or three years maybe …*
>
> *In '96, when it started, we would have had 30 drug users, and that was as much as we probably could handle. And we would have gone to 35 in a push, but then we would lose one or two, so we'd still be back to 30* (12:127-129).

Interestingly, there was a lot of community commitment to helping users. Volunteers got organised and petitioned for help. The local parish priest was very supportive and agreed to provide a premises to start a drop-in service. In 1996, without designated funding, Bray as a community attempted to organise itself. It did so quite successfully and continued the campaign for recognition and funding, until eventually it was successful in getting a LDTF in 2000.

There was a consensus that the establishment of treatment services in communities was a huge step forward. However, many voiced the concern that these treatment-based facilities were not having any impact on preventing the problems. Across the three communities there also appeared to be disillusionment about methadone use. People talked about the fight to get services. For example,

in Crumlin, they described marches and protests attempting to influence the government. In the early days they did not even think about methadone; then they fought to have methadone clinics locally. But it seems that drug users get stuck on maintenance and so the pressure is off. Community activists, and some service providers, talked about their dissatisfaction with this as an outcome of treatment. There was some debate among participants about maintenance. A number were aware of people who had been stabilised and then got back into work and a stable lifestyle. However, others were aware of long-term methadone users who seemed to be stuck.

The Role Of Community Volunteers And Professionals

This role was generally perceived to have changed since 1996, when there were very few resources available. With the increase in services, more activity on the part of statutory service providers, and the establishment of a layer of local bureaucracy, a question was raised about where local people fit in relation to the changing nature of community responses to concerns about the drug scene. With the growth of the economy since 1996, many jobs have been created in local social services, including the drugs services. Structures have changed. Where people worked voluntarily before, those jobs are now the domain of paid workers. Some of the paid workers are local people. However, some evidence points to local people being in the more low-paid, vulnerable positions in agencies (King, McCann and Adams, 2001). While many of these services are welcomed, there is a sense that local people are no longer important, no longer needed, and that their role has become one of assisting the paid professionals. There were some quotes which show a growing cynicism that the structures and workers can actually make any difference in the long run. There is some evidence of a loss of trust in the institutions of the state.

It was evident that a number of dedicated volunteers were to the forefront of drawing attention to the needs of drug users in all three communities, at different times from 1981 onwards. This has resulted in a range of services being developed in all LDTF areas, which participants valued. However, there was discussion that the professionalisation of the response had in some way undermined or devalued the bottom-up community effort. Some participants commented that it was difficult to engage people in a voluntary capacity because it all fell to the same few people in the community.

It is interesting that people in Bray and Crumlin responded to the drug problem, in the absence of any community development infrastructure. Crumlin still has no Community Development Project (CDP). It is part of the Kimmage Walkinstown Crumlin Drimnagh Area Partnership (KWCD) area. Bray has no CDP either. It has had a partnership since 1995. Responding to such a serious issue is not, it seems, dependent on existing community infrastructure. However, such infrastructure can assist in improving life in the community, essential for positive change in drugs problems. The community responses to drugs in all three areas have played a vital role in the ongoing development of their communities, leading to more community advocacy and support.

Different Perceptions

It was evident in the data that there were different perceptions among community members as to the prevalence of drug use in their areas, and the consequences of different patterns of drug use. This is further evidence of the diversity of communities, and the difficulty in gathering community perceptions of drug problems. However, it is something which should be measured, as these perceptions can affect the responses which are made, and how early interventions can happen.

Chapter Five
Developing Community Indicators

Introduction

In this study, we are interested in change in community drug problems, as perceived by the communities themselves. As per tender brief, an attempt is being made to capture the experiences of communities in relation to drugs. In particular, the study is interested in how those have changed since 1996 when the Ministerial Task Force on Measures to Reduce the Demand for Drugs produced its first report (Government of Ireland, 1996), and significant changes in structure and resource allocation were made. The perceptions of the three communities involved in the study will then help to inform the development of more informative indicators of community drugs problems than we have at present. As has been seen in the preceding chapters of this research, using current units of measurement (EDs), while yielding some information, is not accurate enough for capturing the complex nature of community drug problems.

In particular, there are problems of; 1) time lag between collection of data and availability for planning responses; 2) accuracy of recording; 3) differing methods of collection among agencies, and different boundaries; and 4) disaggregating data. From this study, it is apparent that 'community' can be as small a unit as one or two streets, or a particular small housing area within a larger area.

Indicators Of Drug Misuse In Ireland

The core information systems used to monitor the drugs problem in Ireland and to inform policy making are in the health and law enforcement areas.

The sources below provide information about particular drug-using populations in Ireland:

- **Drug abuse treatment data:** The NDTRS can provide data on treatment given by statutory and voluntary agencies on a nationwide and local area basis.
- **Health data**

  A. National Psychiatric In-patient Reporting System:

  This is a monitoring system which collects data on admissions to, and discharges from, public and private psychiatric hospitals and units in Ireland.

  B. The Hospital In-Patient Enquiry (HIPE) Scheme:

  This is a computer-based health information system designed to collect medical and administrative data regarding discharges from acute hospitals.

  C. The Department of Health & Children:

  Infectious diseases are required to be notified to this department and statistics are published annually. AIDS data are collected by regional AIDS co-ordinators and returned to this department. HIV data are collected by the VIRUS Reference Laboratory and submitted to this department.

- **Mortality data:** The Registrar General's Office: Registrars of Births and Deaths are collected from a number of sources (medical practitioners, police, coroners) and returned centrally to this office. These data are reported upon (Report on Vital Statistics) by the CSO.
- **Law enforcement data:** Data on the number of charges (arrests) for drug offences. The data are event-based, individuals cannot be identified so the number of individual persons involved is not known. Collection of drug seizure data is carried out by the Gardaí and the Customs Service.

Limitations Of Current Indicators

While data collected from these sources gives some information, limitations mean that establishing accurate pictures is difficult. The information presented often bears little or no resemblance to the reality of community drug problems. The focus of drug treatment on heroin, a central aspect of *The First Report of the Ministerial Task Force on Measures to Reduce Demand for Drugs* in 1996, means that the extent of polydrug use, so important in 2004 to all three areas in this study, is not adequately captured. In particular, lack of information on local alcohol-use patterns, with their consequences, levels of benzodiazepine use, and the emergence of cocaine use, have been identified here as major concerns of local people. Information on these drugs is missing from current data.

Similar limitations are to be found in the health data. Data from the psychiatric hospitals captures only those who present to these institutions. The HIPE system gives minimal data, especially since data from A & E departments is not included.

As discussed in the previous chapter, it has long been recognised by local communities that the mortality data does not accurately reflect their experience of the deaths of local young people. *Action 67* of the National Drugs Strategy calls for the development of an accurate mechanism for recording the number of drug-related deaths in Ireland (Government of Ireland, 2005). A National Drug-Related Death Index has now been established.

While a picture of reduced crime levels can be drawn from the annual reports of An Garda Síochána, a number of concerns have been raised in relation to their reliability (Expert Group on Crime Statistics, 2004, *Minority Report*). Statistics give a more accurate picture of Garda activity, than levels of drug use. It is difficult to obtain an accurate picture of the crime situation in communities because of the lack of standardisation of reporting, the different administrative boundaries used by An Garda Síochána and the local authorities, and lack of clarity regarding the collation of information relating to crimes reported to and recorded by, An Garda Síochána (Expert Group on Crime Statistics, 2004, *Minority Report*). The *Annual Report* of An Garda Síochána breaks crime up into two categories – headline crime, and non-headline crime. These statistics are not disaggregated to local areas. Therefore it is difficult to get a local picture. In addition, the non-headline category contains many of the types of crime that communities are concerned about – for example, criminal damage, possession of offensive weapons, public order offences, drunkenness offences, trespassing, breach of bail. Generally speaking details are only published relating to cases where proceedings are taken. Over-riding all the systems, is the difficulty imposed by the administrative regions for each sector. Health regions, for example, do not correspond to Garda regions. Both can differ substantially from EDs. Collating data from different sources, so necessary to understand local trends, is made impossible.

Indicators can be seen as tools that measure, simplify and communicate important issues. The temptation is always to measure what is measurable, rather than what is important. Not measured are issues like those raised here. For example, the range of drugs being used, the impact on families, the sense of community safety, or the use of public spaces. Yet these are the things which really matter from a community perspective. Improving people's quality of life has to be an important concern. People will lose faith if they feel that their areas are not improving. Unless people feel that they benefit, there is also a danger in that they will not support current and future initiatives (Groundwork, 2000:1).

The findings point to an increase in drug use on a more widespread basis. Social and economic disadvantage is still recognised as being closely linked to community drug problems. In particular, the use of cocaine does not appear to be influenced by social or economic disadvantage in the same way that heroin was in the 1990s. Cocaine users were described quite differently in the three communities. Cocaine use was widespread among all income groups. It had become relatively cheap in comparison to its cost in the 1990s and a number of occasions where heroin became scarce offered the opening for cocaine to gain a foothold in these communities. But the experience of the participants of this research points to significant impact of local drugs markets, particularly the rise in violence associated with the cocaine trade, and its use with alcohol. So while the drug use is widespread, its consequences can be more severe in areas with cumulative disadvantage.

This issue raised another valuable point in relation to the task of developing indicators. As participants described the growing acceptability of hash and cocaine use in their communities it became apparent that such levels of acceptability may result in an under-reporting of problems. Consideration should be given to a number of factors:

- Users who do not see their use as a problem are unlikely to seek help and be recorded in the treated drug misuse statistics.
- The more prevalent use of cocaine, in particular as a social/recreational drug appears to create a level of acceptability of the drug, not just at a personal, but at a social level. Participants expressed the view that drug use was being normalised. This may result in increased ambivalence about drug use and again under-reporting.
- The participants recalled the multi-generational nature of the drug problem. We are now in a time when some parents themselves are drug users and may not have the same perspective on the dangers of drug use. This arose in particular in relation to hash.

The issues outlined in the findings of this report have been selected as those which matter to the communities who took part, and those which should be measured. This chapter details the elements of a set of community indicators which would more accurately capture what is important to communities.

Recommendations For A Set Of Community Indicators

Indicator 1: The Range Of Drugs Being Used

The statistics for treated drug misuse do not reflect the experiences of the communities in the study. The data clearly indicates that while heroin use continues to be a problem, it may have been superseded by the widespread use of other drugs. At best then, while accurate they must represent a major under-reporting of drug use and drug problems for drugs other than heroin.

Methadone use can be more easily monitored because of control over most outlets for the drug. A case for similar monitoring of benzodiazepines emerged from the data in this study. Community participants indicated that use of benzodiazepines was a concern but that little attempt was being made to check this. Taking the reporting from all three communities would suggest that there is a problem to be addressed.

Given that the data points to hash, e, and cocaine users as perceiving their use as recreational and therefore more socially acceptable, it is unlikely that the traditional drug service will be attractive to these 'new users'. To continue to base indicators on treated drug misuse will demand that services which are acceptable to users are offered. A paradoxical benefit of the changing attitude to use of drugs such as hash and cocaine may be that self-reporting surveys will provide some useful data. Where participants see no problem with such use they may be more inclined to offer accurate information.

Data Collection Instrument – a) National Drug Treatment Reporting System

The data suggests that for communities heroin and methadone are no longer the biggest problems. Established indicators of treated drug misuse provide an accurate and useful basis for measuring use of these drugs but are currently inadequate in terms of the more widespread use of a range of other drugs.

> ***Expansion of the capacity of the treated drug use data is essential but must be supported and elaborated with more community sensitive indicators.***

The expansion of treatment to other drugs would provide a more accurate picture of the current patterns of use. Data on drugs being used should be collected from people on waiting lists, and from people who are not accepted into treatment. Of course, the data from the NDTRS will not more accurately reflect the range of drugs being used until there are more treatment options available. Problems in making treatment options attractive to users of other drugs have already been highlighted. Low-threshold information and advice services may at least enable some level of contact with users of a wide range of drugs. In terms of accurate raw data, such figures would be invaluable.

Data Collection Instrument – b) A Community Drug Trends Monitoring System (DTMS)

A local population survey could be seen to yield important data about drug use generally in the community, which perhaps is not presenting to treatment services. However, for this to be of value, work needs to be done in designing a local questionnaire which would be comparable to the national one, to be able to draw any conclusions. Consideration would need to be given to intervals of data gathering for this to be of value. In addition, it is likely that a local population survey, like a national one, would miss clusters of drug use in smaller areas of the community. A community monitoring system, which could be collected twice yearly, would be of more value.

Approximations as to the levels of use might be assessed by regular surveys of those working in the field; in particular, outreach workers, community and youth workers and drugs workers/counsellors. This data would be indicative and unsubstantiated but it appears from the current research that such data might be more flexible in recording the micro changes in drug-use patterns.

> ***The pilot study on developing a DTMS, which has been carried out by the NACD, shows some promise for meeting the need for more comprehensive, current data relating to drug use in communities.***

The proposal in the NACD pilot study that Drug Trend Monitors be recruited in different areas, with a standardised questionnaire, and a clear reporting system to a centralised location, would yield important data about drug use in a community. The questionnaire should be comprehensive enough

to include alcohol, and benzodiazepines in the responses. When considered with focus groups, and media monitoring, a more accurate picture would emerge. Suggestions similar to this were made by the participants in this study, for more relevant gathering of local drug use patterns.

Indicator 2: Alcohol Use

There was a common response in all three communities that alcohol use is a fundamental problem. The accompanying belief was that high levels of at-risk drinking among the under-aged, and young drinkers were making them more vulnerable to drug use. The problems regarding under-age drinking are further complicated by the lack of data. We have access to statistics on general levels of alcohol consumption. What we do not have are the figures which identify the extent of the sale of alcohol to under-age drinkers, nor do we know officially where the drinking takes place. Since it is illegal to serve under-age in a pub, participants felt it was fair to say that these young people are, in general, using in unsupervised settings. Participants reported that this leads to many areas in their communities becoming no-go areas at night when drinking gangs take over local parks and open spaces. The general perception was that under-aged and young drinkers developed this pattern of alcohol use. If we are to make any progress on developing effective indicators of drug problems the challenge of obtaining more accurate information about the extent of the drinking among these young people must be tackled. The attempts to gain such data are hampered by the key factors already discussed in relation to drugs. Selling to under-aged is an illegal activity and the drinkers themselves do not perceive it as a problem. High levels of at-risk drinking have become a cultural norm it appears. Self-reporting as evidenced in the schools' survey (Health Promotion Unit, 2003) and the European survey (Hibell et al., 2004) support the community concerns that drinking is a substantial problem. It is as yet unclear if drinking among young people who may be beyond the reach of such general surveys is even more problematic.

Added to these not insignificant difficulties is the fact that from a treatment perspective there are no dedicated alcohol services for young people. No such service existed in any of the three communities and where some level of service had been initiated it was as an adjunct to another service. Inclusion of alcohol as the primary problem drug, or only problem drug, on the NDTRS (since 2004) is welcome, and will give some information on those who are experiencing problems.

Data Collection Instrument: Disaggregating National Data

Data about at risk drinking is being gathered at many sources, for example crime statistics, accident and emergency information, and national and European data on consumption levels. As already stated the inconsistent application of specified geographical area demarcation in this data gathering diminishes its usefulness to local communities. It would be a significant advance in terms of the development of community sensitive indicators if data from A & E and local Garda stations could be disaggregated to show local area profiles.

Information about incidents in local communities even where they do not result in arrests or criminal proceedings may be useful indicators of levels of drug/alcohol-related problems.

Regarding sales, there would appear to be no obvious barrier to harnessing the data regarding sales of alcohol to provide profiles on a community basis. Holder (1998) did a similar exercise in the USA. They were able to map the sales from off-licences in a geographical area. They then used this information to facilitate the analysis of alcohol-related trouble. This helped the police to identify problems and initiate appropriate responses.

All alcohol-related data which is gathered at national level should be able to be disaggregated locally, for use by local communities. This would include sales of alcohol, with local consumption levels. It would also include harm to individuals, families and the community, data on health issues such as babies born affected by alcohol, and alcohol-related mortality.

The *Mid-term Review of the National Drugs Strategy* (Government of Ireland 2005) recognised the concerns expressed about alcohol use, and that "*treatment that is client-centred should address all the issues personal to the client, including alcohol treatment*" (2005:54). However, the necessary collaboration between the national drugs strategy, and national alcohol policy, remains to be worked out.

Indicator 3: Profile Of Local Housing Development

The concentration of community drug problems still seems to be in local authority housing estates. However, not all such estates experience high levels of community drug and/or alcohol problems, or other social issues (Fahey, 1999). The relationship between local authority tenure and community drug problems needs to be further investigated. It seems that tenure alone is not the sole indicator. In the areas worst affected, it has been shown that of the families with children, the majority are lone-parent families. Housing alone will not be enough to ensure that these children grow up healthy and safe in their environment. Attention needs to be given to where they play (Government of Ireland, 2000), how their environment is maintained, how exposed they are to explicit drugs/alcohol paraphernalia, how their parents get support with their responsibilities, how they are cared for when things are difficult, etc. Therefore in proposing indicators for the profile of local housing development, elements are included to do with maintenance, tenant involvement and satisfaction with housing.

Much of this information is already gathered by City Councils. However, there doesn't seem to be a centralised system for retrieval of such data. The difficulties caused by the delays in receiving data have already been outlined (Connolly, 2002:44). While there was no great reluctance to give information, delays affected the usefulness of the data.

Use of public spaces

Public spaces such as parks, village squares, and other areas – cultivating places where people can spontaneously meet – are considered important for the creation and development of social capital (NESF, 2003:108). Yet these are the very places which the study found are affected by community drugs activity. Therefore, indicators should pay close attention to the state of public spaces, the levels of use by local people, and changes over time. For the purposes of developing indicators of a community drugs problem, questions need to be asked about the relationship between changing levels of use of public spaces and local drugs activity. For example, use of the local shopping centre – how often do you shop there? If people don't shop there, why not?

Data Collection Instrument: City/County Councils Administrative Data Systems

A centralised data storage system needs to be developed by City/County Councils, so that relevant information can be retrieved for the purposes of compiling a comprehensive picture of community drug problems.

Indicator 4: Drug-related Deaths

As previously mentioned, this area of concern to local communities has been recognised as one requiring more accurate recording.

Data Collection Instrument: National Drug-related Death Index

This instrument has the involvement of the Departments of Justice, Equality & Law Reform, Health & Children and Community, Rural & Gaeltacht Affairs, the National Drugs Strategy Team and the HRB, in conjunction with the CSO. The mechanism will include both drug-related deaths and deaths among drug users.

The development of the Index has already benefited from the involvement of CityWide Family Support Network. Ongoing involvement of the community sector would greatly enhance the implementation, and the quality of the data obtained. Such involvement ensures that issues of importance to local communities are included in the instrument.

Indicator 5: Crime

Drugs and Crime are key priority areas for the NACD in its renewed mandate. It is reasonable to assume that the greatly extended use of methadone maintenance since 1996 has contributed to an overall reduction in crime (O'Mahony, 2004). Many of those involved in this study agreed with this conclusion. Yet crime is still an issue. There was a sense in the study that much of the crime experienced locally is unreported. As discussed in the previous chapter, this was found to be the case in the Quarterly National Household Survey *Crime and Victimisation* (CSO July 2004), which reported that in general, levels of reporting tended to be down in 2003, when compared with 1998. Reporting depended on the seriousness of the crime, that there was no financial loss, and the perception of whether or not the Gardaí could do anything. Vandalism had the lowest rates of reporting. However, Connolly (2002), in a local survey, found a different reason for not reporting a crime to An Garda Síochána. By far the most common reason in that survey for not reporting a crime was the fear of reprisal from those locally involved in criminal activity. In this study, people were concerned with public order type offences. People felt that groups were being allowed to control local areas, with no effective response being made to them.

Data Collection Instrument: Garda Statistics

> ***The most important element to highlight is the need to disaggregate local data from the collected Garda statistics and to provide this information regularly. A small CSO unit has been established to commence work on crime statistics. Contact should be made with this group to discuss the need for drugs and crime statistics.***

Community safety

Perception of crime is often as important as experience of crime (Ballymun Partnership, 2003:7). In all areas in this study, people expressed fears about their safety in certain places. In Ballymun, it was found that the vast majority of people felt safe in their homes at night. However, more felt unsafe walking in the neighbourhood after dark. This household survey could offer a template for other local surveys, with such key measures included. When compared with national Datasets, like CSO and the *Quarterly Household Survey* they could provide important data for indicators of community drug problems.

An example of how local surveys can be used is given by the DMRD (Drugnet 2004b), using the survey referred to earlier (Connolly 2002). It was pointed out in this report to the EMCDDA on the drug situation in Ireland, that 30 percent of respondents in a national survey felt unsafe or very unsafe walking in their neighbourhood after dark. However, the Community Policing Forum (CPF) survey in one part of Dublin, found that 63 percent of respondents stated that they felt unsafe or very unsafe walking in their area after dark. These feelings of insecurity were related to what respondents believed was drug-related activity (Drugnet 2004b:48).

It is important to take findings from small local areas, e.g. a couple of streets, or one group of houses, to capture clusters of problems. As noted earlier, if the area being measured is too large, it is likely to miss out on important experiences of local drug problems.

Data Collection Instrument: Quarterly National Household Survey (QNHS)

Surveys, national and local, need to be complemented by regular, qualitative gathering of data. With the central involvement of local people, this could yield data not readily available through any other source.

The evidence from this study is that local groups would welcome the opportunity to be involved in this, and would feel empowered by being able to monitor change in a planned, systematic way.

> ***The QNHS is collected on a regular basis. It also includes modules at particular intervals of time, e.g. on crime victimisation. It has been recommended elsewhere (Connolly, 2002) that this module should be collected annually, and we support that view. In addition, a local module which would be applicable across communities should be designed and conducted locally. This module should be standardised enough to enable comparisons to be made with national survey data, but should also have some flexibility to capture particular local conditions of relevance to the communities themselves.***

Indicator 6: Social Capital – Informal Social Support Networks/Informal Sociability

A number of participants drew attention to the ways in which families cope with drug use in their community. A theme emerged which appeared to support the view that families in some areas were becoming introspective as a strategy for protecting their family from the drug scene. It was noted that this is not a new strategy. In searching out participants who would not normally be involved in drug-related services this research made contact with a number of people, living in the middle of 'drug-ravaged' communities who did not appear to know what was going on. The notion of 'keeping your head down' was used to identify this theme. Examples of families who keep their children in or restrict their engagement with the community and restrict their own involvement with the community, supported this notion. The family is most important and seeing the family as part of a community may not be necessary or desirable.

Data Collection Instrument: Quarterly National Household Survey

While such a phenomenon cannot be solely accounted for by the prevalence of drug problems in a community it may be an indirect indicator that drug use is a factor in making the community an undesirable context for family life. Questions about family perception of the importance of community in terms of family life may begin to access this type of information.

A module about family engagement with community and or neighbourhood and the measurement of views on the importance of neighbours may be helpful. Such a module could be included, for example, in the QNHS; a local module which would be applicable across communities could be designed and conducted locally.

Examples of what could be measured is taken from NESF, 2003

- Informal social support networks including their structure, density and size and composition by age, class, gender, ethnicity, etc. (e.g. who knows who),
- Informal sociability – regularity of social contacts with others (speaking, visiting, writing, emailing).

Other variables could focus on the use of local services – e.g. sending children to local schools, participating in local activities, etc. It would be important to investigate what is accountable for the family's position either for, or not for, community involvement.

Community participation/volunteering

Since the analysis of community drug problems led to a conclusion in Irish national drugs policy that community involvement was crucial to effectiveness (Government of Ireland, 1996), it is important to measure how people are involved in their community, and how this changes over time. This is particularly true given the findings from the research that people withdraw from social interaction, and mind their own families when they perceive drugs to be an issue in their area. Also, there is evidence in the data that people feel they are no longer being listened to, and that community involvement has changed since 1996. Professionalisation of the response has to some extent excluded them. This was reported around drugs issues, but also around other issues, for example, regeneration.

Involvement in the response to drugs in the area is an important indicator. Community involvement was seen in the evaluations of the LDTFs to have given a critical edge to the work of the group, and have brought to the table organic local knowledge of the situation which otherwise would have been missing from the deliberations. If this is allowed to dwindle away, the danger is that effectiveness will be reduced.

Examples of what could be measured is adapted from the interrelated and overlapping dimensions associated with Social Capital (NESF, 2003:31):

- Community engagement – various types of social networks and volunteering efforts; in general but also **particularly in this instance in efforts to reduce the demand for drugs**
- Community efficacy – a shared sense of empowerment and capacity to effect change at local level; in general, but also particularly in improving the situation re drugs
- Trust in institutions – public, corporate, voluntary; particularly around their effectiveness in improving the situation re drugs
- Political participation – patterns of active citizen engagement, voting, etc
- Norms of trust and reciprocity – mutual credits, expectations and obligations, as well as sanctions on opportunistic or anti-social behaviour (also understood as formal or informal social "rules" which guide how network members behave towards each other).

Data Collection Instrument: Quarterly National Household Survey

NESF has urged the National Statistics Board and the Senior Officials Group on Social Inclusion to support the inclusion of social capital as an important dimension in the development of social statistics at national level. The Report of the National Committee on Volunteering has recommended the inclusion of ongoing data collection on volunteering in the *Census of Population* and *Quarterly National Household Survey*.

> ***We conclude that data collected from such national sources would be valuable information for policy makers in the drugs field, at the macro/societal level. However, specific questions related to drugs issues should also be included in such modules. This calls for collaboration between national statistical sources, and drug groups.***

This national data needs to be complemented by collection at local level, to learn about the other two levels, the micro/individual, and the intermediate/community. The *Census of Population*, for example, is only collected every five years. While the evidence produced is valuable for monitoring national trends over time, this interval is too long for issues such as community drugs issues.

Local information could be collected, with agreed frameworks, but with room for issues of local interest to be included. Utilising community participation in the design, collection and analysis of this data could provide valuable information for policy makers. Local modules need to be designed, which would complement national modules, and make comparisons possible. Local modules could be collected twice yearly, as is suggested for the DTMS.

Indicator 7: School Attendance

The data links early school leaving with areas of disadvantage, and indirectly, with high risk of drug use. Exploration of this in the focus groups and interviews illustrated that early school leaving in itself is only one part of the picture. Participants in all areas discussed their view that poor attendance at school was a precursor for ongoing problems, among them, drug use. The NEWB Annual Report 2003 reflected on the significance of absenteeism as an early warning. They undertake the task of standardising reporting mechanisms with regard to absenteeism (2003:15). The need for standardisation of measures has been commented on in this research.

Data Collection Instrument: National Education Welfare Board Reporting Systems

Given the increase of staff within the Education Welfare service from 37 to 63 (2003: 10) and the commitment to looking at absenteeism as an early warning, this research suggests that a community drug-indicator mechanism could be integrated into Education Welfare data gathering. This would provide valuable information which would offer specific data on the role of drug problems in the context of school attendance. It could provide a backdrop for developing a more comprehensive and targeted response to drug issues as they present in the school context.

Contact should be established with the NEWB, at this stage in their work of standardising reporting systems on attendance and absenteeism.

A Set Of Reporting Systems

What is being recommended here, rather than one instrument which can gather all the information needed to measure change in community drug issues, is a set of reporting systems which, when presented together, can "communicate the pervasiveness of alcohol and other drug abuse across all sectors of the community" (Gabriel, 1997:336). Some of the systems are already in place, but require development so that community drug issues can be captured in a timely and meaningful way. The major sources of data for social statistics are censuses, household surveys and information obtained as a by-product of administrative systems. In Ireland, administrative sources are less developed than some other countries, therefore a much greater reliance is placed on censuses and surveys to meet social data needs (National Statistics Board, 2003). While this can make the cost much more expensive, the statistical information value can be greater, as censuses and surveys can be designed to meet the needs more precisely.

These indicators are gathered together in Table 5.1. The table shows the sector the indicators are taken from, with the illustrative indicator which can be measured, existing instruments where they exist, with those that remain to be developed as a first step in obtaining more accurate community information.

Table 5.1 Illustrative indicators

Sector	Illustrative Indicators	Existing instrument	To be developed
1. Treatment	1.1 Enrolment in treatment programmes	NDTRS	Broadening of treatment availability
	1.2 Waiting lists for treatment		Records of drugs being used by people on waiting lists
	1.3 Prevalence of alcohol and other drug use while in treatment	NDTRS	Broadening of treatment availability;
	1.4 Nos. of services; Types of services	LDTFs and RDTFs	Collaboration between alcohol and drug strategies
	1.5 Community involvement in service development		Local module adapted from Social Capital dimensions
	1.6 Satisfaction with services		New qualitative instrument for local use

Sector	Illustrative Indicators	Existing instrument	To be developed
2. Health	2.1 Drug use locally	Drug Trend Monitoring System pilot	Implemented nationally; disaggregated locally.
	2.2 Drug/alcohol affected births	HIPE Maternity Hospital Statistics	Recorded and able to be disaggregated for local use
	2.3 Alcohol and drug-related A & E visits	HIPE	Recorded and able to be disaggregated for local use
	2.4 Alcohol and/or drug-related deaths	Report on Vital Statistics, CSO	National Drug-Related Death Index. Results able to be disaggregated for local use. To include alcohol
	2.5 Incidence of drug-related sexually transmitted diseases, including HIV/AIDS	Department of Health and Children Statistics published annually	Statistics to be disaggregated for local use
3. Housing	3.1 Housing tenure; numbers of children; nos. of private dwellings being privately rented	City Councils	Centralised system for retrieval of data
	3.2 Maintenance – nos. of complaints received; how soon complaints were dealt with; vandalism to play equipment, damage to public property; requests for transfer	Various departments of City Councils, e.g parks department	
	3.3 Tenant sense of participating; satisfaction with housing; use of public spaces		New qualitative instrument for local use
	3.4 Drug/alcohol specific – incidents of paraphernalia being found; nos. of beer cans picked up; nos. of alcohol bottles picked up; drug/alcohol-related graffiti	Various departments of City Councils	
	3.5 Levels of homelessness	Homeless Agency	Disaggregated for local use

Sector	Illustrative Indicators	Existing instrument	To be developed
4. Education	4.1 Prevalence of alcohol and other drug use from school surveys	ESPAD studies HBSC	Local module to capture clusters of drug use
	4.2 Suspensions and expulsions from school related to alcohol and other drug use	School records	Standardised and made anonymous to be available for local use
	4.3 Attendance records	NEWB Annual Report	General standardisation and inclusion of drug-related variables; Disaggregation for local use
	4.4 Literacy levels	International Adult Literacy Surveys	Disaggregated for local use
5. Justice and Law Enforcement	5.1 Headline and non-headline crimes	An Garda Síochána Annual Report	Disaggregation for local use; Reported quarterly.
	5.2 Perceptions of safety	National Crime & Victimisation Survey, QNHS, every five years	Carried out annually; Local module for administration twice annually
	5.3 Reporting of Crime	NCVS	"
	5.4 Experience of Crime	NCVS	"
	5.5 Local drugs markets	An Garda Síochána Annual Report Drug Seizures	DTMS Disaggregation of Garda statistics.
6. Social Capital	6.1 Informal social support networks		Module for inclusion in national data collection, e.g. Census of Population and QNHS; Inclusion of drug-related variables; Local module which can also contain flexibility for local circumstances
	6.2 Informal sociability		
	6.3 Community participation/ volunteering		
	6.4 Community efficacy		
	6.5 Political Participation – voting, etc.		
	6.6 Trust in institutions		
	6.7 Use of public spaces		

Operationalising The Indicators

This study points to the issues which need to be measured, as identified by the three communities who took part in the research. People spoke about what matters to them, when considering what changes have taken place. Indicators have been drawn from these issues. These should be able to be measured. Some of the issues are already part of our data gathering, but require development to capture more comprehensive data. Some, like the Garda statistics, could be more helpful if they were disaggregated to local level, and made available regularly. Others, like the social capital modules, require new instruments to be worked out. The most productive way to do this would be to continue the involvement of the communities themselves, working in collaboration with national agencies.

It is accepted that caution needs to be exercised when considering what data can be made publicly available. National statistics can be published, because single areas do not need to be identified. However, some of the data would be extremely sensitive when disaggregated locally. For example, data on infectious diseases, on newborn babies affected by drugs/alcohol, etc. It could further stigmatise areas, and individuals and families within an area. This data is, however, necessary for fuller understanding of community drugs issues, which can lead to increased effectiveness for planning and monitoring of actions. The ethical issues of what can be published would need to be carefully considered.

Local focal points

Ongoing work in this area needs the identification of local focal points for gathering information, and collating it. The design of local surveys, and qualitative modules, the collection and collaboration of data, needs to be named as an important function for the local response to drugs. It seems obvious that there should be involvement of LDTFs and RDTFs. However, some geographical areas could be too large, as has been apparent in this study. There is a need for a few local groups from smaller areas to be identified. The information then needs to be fed to a central point for collaboration. There could be a regional central point, perhaps the RDTF or the LDTF, and a national central point.

National and local collaboration

The second important infrastructure to be developed concerns collaboration between drug data-gathering agencies and other bodies, e.g The National Statistics Board, the Senior Officials Group on Social Inclusion, the CSO, the NEWB, HSE, An Garda Síochána, and the HRB.

Conclusion

Recognition of drug problems as community problems, rather than individual issues, has formed the basis of Irish drugs policy since 1996. Many developments have taken place since then. A whole new infrastructure was put in place, with the National Drugs Strategy Team, LDTFs, and more recently RDTFs. Treatment services have increased dramatically, and investment has been made in young people's services locally. Close collaboration with social inclusion measures, such as the RAPID programme, has taken place.

However, community drug problems still persist. Neither communities themselves, nor patterns of drug use, stand still. They are living, moving phenomena. There is a need for more developed instruments to measure change. Current indicators do not adequately portray the lived reality for local communities. This study has identified the areas which need to be measured in order to more

accurately monitor the benefits to the community of action around drugs. Recommendations are made for action which needs to be taken to develop these indicators. The next step is that of collaboration with the various data collection agencies, and local community groups. The establishment of an infrastructure for data gathering, with national, regional and local focal points, is central to obtaining a clearer picture of the reality of community drug problems over time.

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