Drugs, Poverty & Community Development

A Report of the Conference for Community Development Programme Projects on Community Responses to Drugs Issues held in February 1997

This conference was funded by the Combat Poverty Agency

1.1 State Responses to the Drug Problem - A History

Barry Cullen (Programme Director, The Children's Research Centre, TCD)

From the outset you might as well understand that for the most part, I consider state responses over the last twenty years to have been quite inadequate and in some instances they have compounded and exacerbated the problem being tackled. However, given the nature of the drug problem and its potential to draw out in us some of our most primitive and pathetic emotions, it is hardly any wonder that the state has found the problem so difficult to deal with.

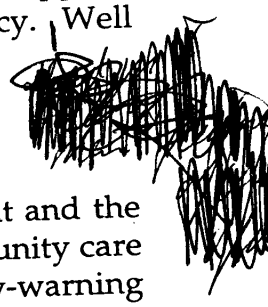
In the brief history of state responses to this problem I have categorised the different response phases under six separate headings which are outlined in the accompanying table which I will now discuss.

LATE 1960s	CALM	- COMMISSION OF INQUIRY ON MENTAL ILLNESS (1966) - GARDA DRUG SQUAD - WORKING PARTY ON DRUG ABUSE - NATIONAL DRUGS ADVISORY & TREATMENT CENTRE (NDATC)
1971-1979	STAGNANT	- INACTIVITY OF BOTH COMMUNITY CARE AND SPECIAL HOSPITALS CARE PROGRAMMES - INACTIVITY OF HEALTH EDUCATION BUREAU - PREDOMINANCE OF NDATC - EMERGENCE OF COOLEMINE THERAPEUTIC COMMUNITY
1979-1983	DISHONEST	- INITIAL DENIAL OF OPIATE EPIDEMIC - BRADSHAW RESEARCH - PREDOMINANCE OF PUNITIVE MODELS - MINISTERIAL TASK FORCE - CASTIGATION OF COMMUNITY RESPONSES
1984-1990	FRENZIED	- FEAR OF AIDS - MOUNTJOY SEPARATION UNIT - HARM REDUCTION THROUGH BACK DOOR
1991-1996	CONFUSED	- HARM REDUCTION UP FRONT - 1991 GOVERNMENT STRATEGY & DUAL MODEL
POST 1996	NAIVE	- DEVELOPMENT OF "MARGINAL" PROGRAMME - 1996 MINISTERIAL REPORT

Late 1960s - Calm

In 1966 the Commission of Inquiry on Mental Illness reported that we did not have a drug problem. At the time of course, drug problems were not seen as social problems and indeed many social problems as we now know them, simply did not exist. However, the Commission of Inquiry did sound a note of caution and warned that we should be careful. Undoubtedly, they were looking to the escalating situation in London and other European capitals. Of course, at the time, nobody bothered to speculate as to whether Irish drug-using emigrants going to London and elsewhere constituted an Irish drug problem or a foreign one. Drugs like most other social problems were preferably seen as foreign disorders.

During the years 1967-69 however, it became apparent that our island status was no longer capable of protecting us further from foreign influence. Garda drug seizures of amphetamines, barbiturates, cannabis, LSD and some pharmaceutically prepared opiates became commonplace and as a result in 1968 the Garda Drug Squad was set up. While this growing problem caused alarm in some media circles, generally the government, in line with the air of optimism and realism of the day, adopted a calm, reasoned approach. A Working Party on Drug Abuse, which interestingly included a community worker as a member, was assembled and for three years it deliberated on the problem and produced a fine, balanced report on the situation. While the report acknowledged the growing drug problem it emphasised the role of prevention and education and signaled the setting up of the Health Education Bureau. As regards illicit heroin the report commented that while there was no evidence of widespread supplies of this drug the situation should not be regarded with any complacency. Well complacency and stagnation perhaps best describe the next eight years.



1971-1979 - Stagnant

Essentially during this period the problem was ignored by government and the newly emerging health boards. Incredibly the new health board community care programmes which were set up in order that there would be early-warning systems for new social and health problems were completely inactive and uninterested in monitoring newly emerging drug problems. Psychiatric hospitals had no particular interest in becoming involved. Essentially, all the services deferred to The National Drugs Advisory & Treatment Centre which was set up in 1969 and located in a prefabricated building on the grounds of Jervis Street hospital, Dublin . It became the main focus for responding to drug problems. This centre operated detoxification and psychotherapeutic counselling from its own clinical base. It had no outreach or community facilities. The centre developed very close collaborative relationships with the Coolemine Therapeutic Community which was set up in 1973 and between both

services a centralist, abstinence oriented service ethos developed. The underlying presumption between both services was that interventions with drug users should be geared towards total abstinence: drug users needed to be removed from their communities, detoxified, exposed to therapy, encouraged to make lifetime commitments to abstinence, and rehabilitated, back into new, preferably middle-class lifestyles. The approach suited many drug users of the time, many of whom were middle class. The services were somewhat unsuited to the smaller number of working class drug users.

The services presumption on abstinence only developed unchecked perhaps because at the time none of the other authorities showed an interest. If they had showed this interest they might have looked a bit beyond the narrow perspectives of both Coolemine and Jervis Street and discovered, at an international level, a movement in the direction of providing services to drug users through community models in much the same way as services are provided to other groups in community care. In such community models social workers, doctors and other public health professionals provide care and treatment when the problem is manageable within the community and involve specialist clinics when difficulties arise.

1979 - 1983 - Dishonest

However, vision was not the hallmark of emerging health boards and eventually in 1979 the inevitable happened. The growing marginalisation of Dublin's inner city communities following the scaling down of industry in the midst of the oils crisis recessions created ghetto conditions and a community tolerance for criminality and youth deviancy. In the scramble for criminal dominance the commodity heroin brought to the underworld what the personal computer brought to industry: a down-sizing of personnel and a scaling up of profits, power and influence. In the social rearrangements a new type of criminal was born, distinguished perhaps by their lack of concern for the havoc they wreaked among their own families and communities. The Dublin 8 area was the first to experience the epidemic, followed by north east inner city and eventually spreading to Ballymun, Ballyfermot, Crumlin and elsewhere.

Incredibly, despite the mounting, irrefutable evidence of this unfolding tragedy, official responses of the day were generally dishonest and characterised by a form of denial. In 1981, Department of Health Officials told a Council of Europe meeting in Strasbourg that Ireland did not have a heroin problem. In 1982 the then Minister for Health commissioned the Medico-Social Research Board to research the problem and the researcher justified the need for the research on the basis that the Minister, while convinced of the sincerity of those who reported to him that there was a problem, needed the information to persuade his own officials who reported to him that the problem was being grossly exaggerated.

Indeed, the researcher's first report was dismissed by a number of officials as a complete over-estimate yet when the full report was finally published in early 1982 it showed a higher heroin prevalence in parts of the north inner city than some of the worst ghettos in New York.

In 1983 a task force of junior ministers was convened and produced a report on the problem. The report was never published but it did highlight that certain geographic areas needed to be targeted as priority areas. The effect of implementing this recommendation would have been to shift responsibility for drug treatment away from the specialist, psychiatric-oriented services of Jervis Street and its narrow abstinence-only model and into the direction of providing community-based services with wider service options and a clearer social and community dimension. Of course as we now know, this recommendation was never acted on. Indeed, the ministerial report was never published and in the government statement issued in relation to the report at the time, no mention was made of targeting areas. Indeed, in the wake of the report it became clear that whatever progress individual communities had previously made towards developing community responses that the resolve of the health board and the Department of Health was to become even more entrenched in a centralised clinical model, a move that was facilitated by attempts by senior health board personnel to discredit the work and reputation of some of their own community-based projects and workers.

Another example of official dishonesty during this period was the way in which government responded to the Concerned Parents Against Drugs Movement, particularly in its early stages. By isolating this movement as a provisional IRA front the government of the day completely undermined its early promise and potential to develop leadership in the most affected communities. Bear in mind there were no community development projects at the time and there were only a few full-time community workers. The Concerned Parents provided an opportunity for government to focus resources and other supports towards developing independent leadership structures that were badly needed within different areas. By crying Provo at a stage when evidence of such involvement was scarce the government distracted from the more fundamental issue of why these problems were escalating only in working class communities. Ultimately, the same communities became even more isolated and marginalised as a result.

1984-1990 - Frenzied

This leads us to the period commencing 1984 when the full implications of having ignored and mismanaged the problem began to dawn. Out of that dawn the red glow of AIDS was deeply searing the psyche of officialdom. Panic ensued and there was a flurry of frenzied activities. Anybody who understands history knows that in accounts of plagues and disasters scapegoats were always found. During the Black Death in the Middle Ages witches were blamed and of course

cats - witches assistants - were slaughtered on sight. We now know that the plague was spread with the assistance of rats who grew in number because of the slaughter of the cats. Bring yourself to the mid 1980s when overnight drug-using prisoners in Mountjoy were tested for HIV, and those found positive were subsequently segregated in an approach that at one stage involved prison officers using the equivalent of boiler suits, gloves and decontamination procedures. For years the Irish prison system was the only one in Western Europe that operated such a segregation policy.

Drug users had become convenient scapegoats for what was a public health disaster and in the climate of the time the prospects of realistically improving the delivery of services were more severely limited. Thankfully, the situation was partly rescued by another group who throughout history have known what it is like to be scapegoated. Dublin's gay community, facing real health-risk problems spearheaded an information prevention campaign that became known as harm reduction. The message had a simple logic: you don't have to agree with people's sexual preferences and choices to accept that the provision of information to them on how some sexual practices were unsafe had real public health benefits. The logic of this approach gained momentum in responses to drug users - we didn't have to agree with drug-use to accept that if you didn't convince people to stop using it might be possible to get them to use in the least harmful way possible. The approach had already been developed - without the support of public funding - by the Ana Liffey Drug Project - and before long it seemed that some health administrators were claiming to have been advocating it for years.

In the Department of Health such was the enthusiasm for the approach that a position of National AIDS Co-ordinator was created and funding became available to set up a range of new harm-reduction and outreach services, involving needle exchange and methadone maintenance. Interestingly, however, clinical, centralist control of these services remained intact, no real effort was made to integrate services with health board community care teams, let alone involve them with community development models. At a political level however, the approach had inherent contradictions primarily because it was not underlined by policy statements that indicated clearly that a shift was being made. In an article written by Shane Butler, he highlighted the contradiction as follows:

> "I was searching for some simple illustration of this and the one I picked concerned the end of 1987 when the new centralised drug service in Trinity Court was opened officially by the Minister. In that week at the end of 1987, the *Irish Times* noted that within the space of three or four days, the Minister for Health had indicated very emphatically that he had no time for methadone maintenance, needle exchange, condoms, any of these forms of

harm reduction. I can't remember whether it was the day before or the day after the National AIDS Co-ordinator, Dr. Jimmy Walsh said that the way forward was through methadone maintenance, needle exchange and condoms. I'm glad I'm not working in one of those services! This is technically known as an Irish solution to an Irish problem - this ability to look in two directions at one time. It must be extremely uncomfortable for people working in these services because you're not quite sure what will happen if the media picks up on these changes. It's quite controversial and the worker on the ground using new approaches is not sure who gave the mandate for these approaches or whether there is in fact a mandate."

1991-1996 Confused

Eventually, a new policy document was issued in 1991 (first in 20 years) and in its presentation it appeared that this document would sort out the confusion. It didn't. The document was quite good at rhetoric. It made it clear that neither harm reduction nor total abstinence were absolutes and that it was possible and acceptable, from a policy perspective, for both to be pursued. It advocated the setting up of new Community Drug Teams that would involve in a whole new generic approach with local GPs, local social workers, counsellors, community psychiatric nurses linking in with local community groups in developing local responses. Alas the report's rhetoric completely eschewed issues concerning structures and administrative and professional boundaries that would need to be sorted out for effective implementation. To use an example, the report advocated that responsibility for drug treatment services should rest with both the health board and the National Drug Treatment Centre, now at Trinity Court. Clearly, this dual model approach was a recipe for even further confusion - a confusion that has now turned into a battle between two institutions for control of medical consultancies. There are other examples, following the report a working group to devise a protocol whereby local GPS could become directly involved in prescribing opiates to persons who had stabilised lay on the shelf for over three years after being agreed in 1993 and to date nothing like the level of GP participation that would make the approach feasible exists. Using another example only two community drug teams were piloted and in their piloting little attempt was made by the health board to integrate them with overall service plans - they were excluded from contributing to the health board's evaluation of service. Another example is the complete failure to explore an effective link between expanding drug services and existing community care programme and services.

POST 1996 - Naive

This failure leads me to outline the current period which I feel could best be described as naive. Rather than take on fundamental issues concerning policy, structure, professional and administrative responsibilities and the creation of links for integrating different service components, the health board has decided

to fragment the system even further. It has created a new programme and appointed a new programme manager and management team and into this programme it has lumped, along with drug problems, a whole range of activities which its current structures has failed to manage. To support its decision on this new structure an evaluation report was commissioned from two researchers from outside the jurisdiction, a report that amazingly gave no consideration as to why, in Dublin, there is a dual system of service management or of the work of community drug teams.

Meanwhile, the government, in order to provide a soft edge to the package of hard, election-friendly law and order measures that culminated in the referendum on bail last year, set up a Ministerial Task Force on Measures to Reduce the Demand for Drugs, the first report of which was issued last October. It is an extremely interesting report. It is a very brave report. In many respects the report I am sure provides a context for this meeting. Without the report we probably would not be here discussing these problems. The most important outcome of this report is the recommendation that a small number of areas in the Dublin area be specifically targeted and that local task forces be instituted to support the process. It should have happened fifteen years ago and the authors of the report, unlike their predecessors in 1983, are to be congratulated for not only arriving at this conclusion, but for acting on it.

However, the report still does not address the issue of how existing statutory services sort out their territorial and responsibility disputes. Although the report allocates an additional £10m to new developments in task force areas it does not spell out how this allocation translates into actual spending according to the task force priorities and what measures are in place to ensure it doesn't disappear in the continued confusion of state agency structures. The Task Forces are being set up under an overall co-ordinating structure that is dressed up as containing community sector representation and as having executive functions. The reality is much different and the structure risks abolition if there is to be a change of government.

Perhaps most worrying about the current situation is that in the absence of coherent policy, planning and service delivery structures within existing institutional services, the new focus on community will become an attempt to shift all of the responsibility onto the same communities: with professionals and administrators remaining aloof but retaining overall power and control.

In describing the current response as naive I would like to emphasise that I choose the word deliberately and that I don't see it a offensive term. Indeed, there has been too much cleverness over the years in relation to drug problems - too many opportunities for people to set themselves up as experts and proceed to tell the rest of us how we should go about our business. A more naive approach

leads open the prospect that new ideas, new faces and new talents will emerge. I think it is great that the Community Development Programme and, more generally, the community sector, is getting around to talking about the problem.

Community development has a lot to offer, particularly in terms of its knowledge base and the skill that has emerged in developing groups, supporting local leadership, tackling local problems and challenging male dominated professions and structures. Community development groups should seek new ways of applying this talent and knowledge to the area of drug problems. In my view, the single best way to apply this knowledge is through the expansion of the programme, and through increasing the number of community development projects. For example, I believe more could be achieved in the geographical area I am most familiar with - south inner city - by setting up and supporting separate, independent community development projects in individual flat complexes. This would be a good use of community development programme money - if the money is not there it would be a good use of monies under local task forces.

However, and in conclusion I would like to emphasise that community development is only a part of the solution to this problem and further efforts need to be focused on getting the mainstream health and social services to devise comprehensive prevention, treatment and rehabilitative policies and plans and to develop structures whereby these can be more effectively integrated with existing community care services (nursing, social work, counselling and general medical care) and emerging community development programmes and activities. Above all dynamic leadership at a health and social care level is badly needed.