Community Drug Projects:

Responding to drug-related harms from a community development approach

Community Drug Projects:

Responding to drug-related harms
from a community development approach

November 2020

Aileen O'Gorman

CityWide
CityWide Drugs Crisis Campaign

About the author:

Dr Aileen O'Gorman has worked in drugs, community and policy research for over twenty years in Ireland and the UK. Currently, she is Senior Lecturer and Programme Leader of the Contemporary Drug and Alcohol Studies programme at the University of the West of Scotland. Previously, she was the Co-ordinator of the Community Drug Education and Research Partnership at University College Dublin, and lead researcher for the National Advisory Committee on Drugs (NACD). She has held research posts at Fatima Mansions, Dublin; the Health Research Board, Dublin, the Centre for Urban and Community Research, London; and at Middlesex and Birkbeck universities in the UK. She is a Board member of the European Society for Social Drugs Research; the Scottish Drugs Forum; and the Drugs Research Network Scotland. Previously, she was a Board member of the Rialto Community Drug Team, and the Rialto Development Association.

Contact:

Dr Aileen O'Gorman, School of Education and Social Sciences, University of the West of Scotland. PA1 2BE. Email address: aileen.ogorman@uws.ac.uk

TABLE OF CONTENTS

PREFACE AND SUMMARY

This report, documenting Community Drug Projects' community development approach to drug-related harms was due to be published in March 2020. But then the World Health Organisation (WHO) declared COVID-19 a global pandemic and Ireland went into 'lockdown' to halt the transmission of the virus. Now, months later, though the coronavirus has altered our way of life dramatically some similar patterns remain.

Evidence now highlights the disproportionate affect COVID-19 has on the more vulnerable and the more disadvantaged in society (see Stafford & Deeny, 2020). Similar to drug-related harms, the virus has exacerbated existing social, health and spatial inequalities. As the EMCDDA[1] has noted, people in addiction are often more common in marginalised communities and are vulnerable to COIVD-19 at multiple levels including underlying health issues, mental health, social marginalisation, higher economic and social vulnerabilities, criminalisation and stigma.

As noted in this report, Community Drug Projects, supported through Drug and Alcohol Task Forces (DATFs), have maintained a long and impressive tradition of responding to the needs of people experiencing drug-related harms in their communities. On a daily basis, they work with people with multiple interdependent needs through a 'whole person' and 'whole community' approach. They do so in the knowledge that the drug-related harms they witness are largely social and inseparable from broader structural and systemic inequalities.

Community Drug Projects working in, and with, communities of disadvantage have been to the forefront in identifying and addressing COVID-19-related issues locally. This "whole person" and "whole community" approach has been crucial to the effectiveness of the res-

---

[1] European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] (2020). Update on the implications of COVID-19 for people who use drugs and drug service providers. Lisbon: EMCDDA, March 2020

ponse to the impact of Covid, as outlined by Citywide in a report submitted to the Dept. of Health.[2]

As outlined in this report, Projects' responses are informed by community development principles and based on the analysis that people's drug and alcohol related problems cannot be addressed in isolation from their context. As a result, five key characteristics of their work practice exemplify their unique contribution to their communities, these are that they:

1. Provide accessible, inclusive, and safe community spaces.

2. Deliver trauma informed care.

3. Facilitate participation and integration.

4. Respond to unmet and emerging needs.

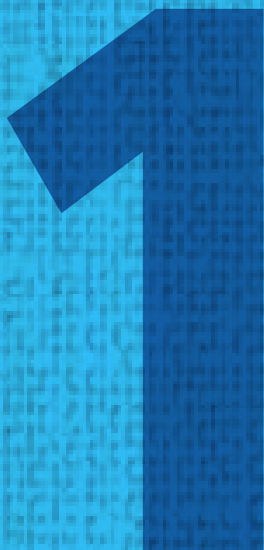5. Act collectively: through interagency and partnership work.

Key to this approach is their capacity to:

✓ reach and support people in crisis and adversity,

✓ work with people 'where they are at',

✓ provide wraparound services to individuals, families, and communities,

✓ engage in anti-discriminatory, and anti-oppressive practice,

✓ mediate fractured family and community relations,

✓ promote participative peer-led support,

✓ identify and respond rapidly to emerging needs,

✓ adapt to changing drug trends and drug-related harms,

✓ work in an inter-agency partnership approach to co-produce services, and

✓ develop innovative community development initiatives to address the broader needs of people and the community.

✓ reach and support people in crisis and adversity,

✓ work with people 'where they are at',

✓ provide wraparound services to individuals, families, and communities,

✓ engage in anti-discriminatory, and anti-oppressive practice,

✓ mediate fractured family and community relations,

✓ promote participative peer-led support,

✓ identify and respond rapidly to emerging needs,

✓ adapt to changing drug trends and drug-related harms,

✓ work in an inter-agency partnership approach to co-produce services, and

✓ develop innovative community development initiatives to address the broader needs of people and the community.

As this report documents, Community Drug Projects play a vital role in supporting the delivery of an integrated approach at a local level. They do so in an increasingly hostile policy environment that often refutes the value of their approach and work. COVID-19 has highlighted, yet again, the harsh impact of inequality on people's lives. Most likely, for time to come the coronavirus will continue to affect our health and economic well-being. Undoubtedly, those with the least resources and power will suffer most. The risk environment for community drug problems has just got a lot riskier.

SECTION ONE:

INTRODUCTION

1

Community drug problems describe situations where a significant number of people in a particular area experience drug-related harms, and the community does not have the resources to deal with the problems that arise (see Citywide, 2013). For people who use drugs, these problems can include drug and alcohol dependence; physical and mental ill-health; drug-related infectious diseases (such as Hepatitis C and HIV); and fatal and non-fatal overdoses. For the affected residents in the community, problems can include visible drug use; drug debris (such as discarded syringes, foil, pipes and other paraphernalia); open drug markets and associated intimidation and violence; an increase of fear in the community; and a disintegration of community networks (see Loughran & McCann, 2006; O'Gorman, 2004 and 2014).

Community drug problems do not occur in isolation from broader socio-economic contexts: they are shaped by social and public policies that create 'risk environments' for drug-related harms (see Rhodes, 2002; O'Gorman, 2004), such as, the policies that result in high concentrations of low-paid, insecure jobs and unemployment; educational disadvantage; health, housing and income inequalities; and inadequate state and community services. These policy-related harms constitute a form of structural violence by the state, which is defined as the avoidable impairment of fundamental human needs (see Galtung, 1990; Farmer, 2006).

Since community drug problems first emerged in Dublin in the late 1970s, community action (inspired by community development practice) has played a vital role in supporting people, families and communities affected; and in providing services locally when none were available. Many of the Community Drug Projects currently in operation originated from this self-help ethos in the communities devastated by the combination of drug-related and policy-related harms.

In 1997 the work of these projects, and their community development approach, was

acknowledged and formalised in drugs policy. At that time, they were recognised as key stakeholders in the work of the Local Drug Task Forces[3] (LDTFs) which had been established to address the dual concentrations of community drug problems and socio-economic deprivation. The value of LDTFs as an innovative model of interagency partnership between the statutory, voluntary and community sectors has been recognised and restated in successive national drugs strategies. And, community drug projects have played an essential role in the delivery of these strategies by providing integrated and holistic services in their communities within the context of a partnership framework.

In 2017, at the launch of the most recent drug and alcohol strategy *Reducing Harm Supporting Recovery*, the government acknowledged again the value of this framework, by stating that:

> partnership between the statutory, community and voluntary sectors was a major factor in the success of previous strategies and will continue to be the cornerstone of the new strategy.

This commitment was reinforced further by the then Taoiseach, Leo Varadkar, who noted in his foreword to the Strategy:

> the importance of supporting the participation of communities in key decision-making structures, so that their experience and knowledge informs the development of solutions to solve problems related to substance misuse in their areas.

However, despite government reaffirmations of the importance of the interagency partnership approach, this has not been the lived experience of Drug and Alcohol Task Forces and the Community Drug Projects on the ground (O'Gorman et al., 2016). The policy environment has changed considerably since 1997 and a combination of ideological shift, and the 'great recession' of 2007-2017, has led to reduced state support and resources for the community and voluntary sector, and for the health, education and social welfare programmes which had mitigated the impact of poverty and inequality in communities.

Patterns in drug use have changed also reflecting shifts in global drug production and local supply, and in the fluctuating levels of demand for different substances over time. Heroin, crack cocaine, benzodiazepines and alcohol are the substance most associated with dependent and problematic drug use. Polydrug use in the form of an assortment of licit and illicit substances (currently, mainly alcohol, cannabis and cocaine along with various pills, powders and 'tablets') has become a regular feature of youth and adult lives. Now, drug use is a widespread social phenomenon not confined just to marginalised groups and neighbourhoods: community drug problems, however, continue to reflect and exacerbate existing policy-related social and spatial inequalities in Ireland, as they do elsewhere.

The origins of this research study

This research report was inspired initially by a series of Citywide meetings and seminars where Community Drug Projects expressed their concerns about the demise of the partnership and interagency approach; the ongoing cuts to their resources; and the increased levels of governance imposed by their funders. As a result, in December 2018 this study was commissioned by Citywide to document and analyse the work of the Community Drug Projects and identify best practice in responding to drug problems through a community development approach.

The initial focus of the research was to assess three elements that were seen to characterise the projects' community development approach to delivering relevant and effective drug services (Citywide, 2018). These three elements were:

---

[3] Local Drug Task Forces are now known as Drug and Alcohol Task Forces (DATFs).

1. their work can range across all areas of statutory function so they are ideally placed to deliver an interagency partnership approach;

2. they can adapt and respond to the changing needs of service users, their families and the wider community in addressing the drugs problem; and

3. they can support and promote the reintegration of people back into the community and support a positive community response to the drugs issue.

In addition, the research sought to identify the key supports and barriers to implementing a community development approach. However, as the research progressed it became clear that the work of the Community Drug Projects was broader and more holistic than these three elements suggested. Consequently, this research study set out to capture the full complexity of their work and its evidence base.

Research process

Primary data for the research study was collected through a series of semi-structured in-depth interviews and focus groups with people working and attending Community Drug Projects. Participants were purposively recruited from projects who were passionate advocates about community development work. The aim was to capture the voices, views and lived experience of people who have worked and participated in this sector over time and who have a critical insight into the nature of their practice and the community drug problems they witness.

Interviews and focus groups followed a semi-structured schedule that facilitated an in-depth dialogue and provided space for new issues to emerge. Sessions were audio recorded and transcribed. Transcripts were coded and analysed thematically and inductively to identify emerging themes. Additional documentation (i.e. annual reports, research reports etc.) were analysed, and the findings of the study situated within the broader context of community development literature.

Overall, six in-depth interviews were conducted with either one or two participants – a total of ten participants in all. In addition, four focus groups were conducted with a range of between five and ten participants. Overall, twenty-seven people (management, staff and participants) from Community Drug Projects took part in the research – sixteen females and eleven males. The research fieldwork was conducted between February 2019 and June 2019. The findings reflect the local drugs situation and policy environment at that time.

Ethics

Ethical approval for this study was obtained from the Research Ethics Committee of the School of Media, Culture and Society at the University of the West of Scotland, where the author works. The ethos underpinning the research study is one of a non-judgmental approach which seeks to maximise our understanding from the perspective of the affected communities; and to ensure that dignity and respect underpin the social relations of the research process. This ethical approach is informed by the following values and actions:

• **Informed Consent:** people are provided with sufficient appropriate information about the nature of the research being undertaken so that they can make an informed judgement about whether they wish to participate or not. Permission is sought to record interviews where this is being done.

• **Confidentiality and anonymity:** the details of the people participating in this research are confidential. Care is taken to ensure participants and their input is anonymised. Interview and other data are stored in a safe and secure location, and codes used to anonymise data. Care is taken to avoid (further) stigmatising vulnerable groups or places.

These are difficult times for community projects and speaking truth to power can have repercussions. To facilitate the research participants' ease in speaking openly their names

nor the names of the Community Drug Projects have not been disclosed. Care has been taken so that projects and individual participants are not identified. Quotes from the interviews and focus groups are used to enrich the discussion in this report. Unless otherwise stated, the quotes are the voices of the people working and participating in the projects.

Layout of the Report

Section Two of this report outlines the basis for a community development approach to drug-related harms. Section Three, takes five central elements of community development practice to explore the unique contribution these projects make to individuals, families and communities. To conclude, Section Four explore the barriers to their practice and outlines recommendations for an enabling environment to support their work into the future.

SECTION TWO:

UNDERSTANDING THE COMMUNITY DEVELOPMENT APPROACH

Influence of the community development tradition

Motherway (2006) describes community development as being essentially about people working collectively together for social change which will improve the quality of their lives, the communities in which they live and/or the society they are a part. In Ireland, there has been a long tradition of community development work by co-operatives, credit unions, women's groups, Traveller groups, anti-poverty campaigns, and Community Drug Projects. Their work covers a multitude of different approaches and activities from radical community activism, social justice campaigns, rights-based advocacy, and the provision of services to communities of place and/or identity. Their activities are guided by anti-oppressive and anti-discriminatory practices, and informed by social analysis. And, their approach emphasises empowerment, capacity building, participation, and collective action with a focus on process (how things are done) as well as outcomes (what is achieved) (see AIEB 2016; CPA 2000, Kelleher & O'Neill 2018).

In the drugs field, community development work is linked to the new public health and harm reduction movements of the 1980s, which inspired a shift from the framing of drug problems as a bio-medical issue to an analysis of the risk environments that shape the unequal distribution of drug-related harms in society. As a result, as Citywide (2019) note, community responses are not just about the front-line services that provide innovative and wide-ranging services to drug users, they also work to strengthen community resources and cohesion. Their responses are holistic, integrated, partnership based, and crucially, involve the people most affected — people who use drugs, their families and their communities — in finding solutions that work for their communities.

The changing policy environment

In the 1990s, community development work flourished in Ireland under a national social

and economic recovery programme committed to social partnership and area-based strategies as a means to address social and spatial inequalities. The inclusion of the community and voluntary sector as a social partner in government aimed to bring local knowledge and experience into the policy-making process, and, in particular, to inform how poverty and the growing drugs crisis could be addressed through local community development (see Local Drug Task Forces Handbook, 2011).

As one Community Drug Project's worker, interviewed for this study, described:

> *In '97 the big buzz word was community development … there was a huge energy and fight at the time, and partnership. And the community had a huge voice 'cause we had the experience, we had the analysis we had the awareness.*

Since then, the policy environment has changed significantly and no longer enables community development approaches (see Kelleher & O'Neill, 2018). This change can be traced to the influence of neo-liberal thinking on policymaking (see O'Gorman et al., 2016), which is characterised by:

- the centralisation of power and decision making (to the exclusion of social partners and the community sector in particular);

- the contraction of state activities (e.g. the contracting out of public and social services);

- the individualisation of social problems; and,

- the adherence to new public sector management principles focused on measuring outputs, effectiveness and value for money.

In this neoliberal policy environment, two particular policy reforms have impacted on the work of Community Drug Projects: the cuts in supports and resources for vulnerable individuals, communities and the community services that support them; and the retreat from the partnership model of responding to the cross-cutting issues underpinning drug-related harms. In addition, there has been a noticeable shift in how drug use and drug problems are framed with more emphasis placed on individual responsibility for risk behaviours – as if these risks are context free. Political and public discourses pay little attention to how risk environments for community drug problems, and associated issues of poverty and inequality, are outcomes of policy not just individual behaviour. As a result, Community Drug Projects work in an increasingly hostile policy environment that refutes the value of their approach and work while simultaneously creating the social and structural conditions that produce drug-related harms, as a Project worker described:

> *In the mid to late 90s community was a very fashionable word. Now you almost feel dirty when you say you're from the community sector – it's how you're made feel by some of the statutory services.*

The work of Community Drug Projects

Despite the changed policy environment, Community Drug Projects have maintained a long and impressive tradition of responding to the needs of people experiencing drug-related harms in their communities. On a daily basis, they work with people with multiple interdependent needs – a legacy of unmet needs over the generations. The drug-related harms they witness are largely social and are inseparable from broader structural and systemic inequalities embedded in risk environments. In this context, people's problems with drugs and alcohol cannot be reduced to a disease of the individual to be treated with medical intervention alone: nor, can they be addressed in isolation. Community drug services unique contribution to the public good is their capacity to address drug-related harms through a broader 'whole person' and 'whole community' approach.

Many of the Projects were established as a result of local communities mobilising in

response to the drugs crisis in their communities, often establishing a service response in partnership with the state. Many of those involved in founding the Projects now work in the field, or continue to support the projects on management committees; this brings a unique sense of community owner-ship to the Projects' work, as a Project manager noted:

All our experience has shown us that if it doesn't come from the community, if it isn't owned by the community, isn't trusted by the community, then a lot of Projects won't work they become like a clinical service – that's where people respect you – having a sense of being in the community and of the community.

The Projects' analysis and understanding of their local context informs the services they deliver and the ethos guiding their work. Working from a grassroots approach, they witness first-hand the lived experience of people in the community:

we live here and know what's going on in the area, and even if they [the staff] don't live here, they're connected.

From this perspective, the concentration of drug-related harms in a community is more than the sum of individual people who use drugs: it is about communities with less resources and less power who have borne the brunt of neoliberal policies and experience the fallout at a community level. As a result, the Projects work from a social model of addiction, in contrast to the medical model that domin-ates current policy and statutory practice:

If you look at drug issues, and the mental health and physical health of certain populations, how can anybody say that's individualised and it's not structural or not related to poverty and the conditions people are living in.

In this context, Community Drug Projects work holistically to reduce drug-related harms by providing a range of services and supports,

either solely or in partnership with other agencies, to people, their families and the wider community. A process described by a Project manager as follows:

You may come into the drop-in, you may be homeless and at that point you will meet other workers that can help you deal with housing, food, provide emotional support. You can link in with key workers, and we can do referrals once we identify what the issues are. Addiction is not in one straight line from you've a problem you go straight into addiction services, it's always causes and some of them can be deeper long-term pieces and some of them incredibly poor situations … So if you're working with people around all those pieces, working with people in a wraparound service, it's hugely beneficial for people. We are not just a clinical service; we are more community focused which means we are open to all the issues people are facing and working with them and looking at ways of connecting with people formally or informally.

At the time of the research fieldwork, the main issues identified as affecting communities were: poverty, financial insecurity and debts; difficulties with accessing sufficient social welfare and health supports; housing prob-lems (which included multi-generational living, precarious accommodation, homelessness, and rough sleeping); mental ill-health, stress and anxiety; general ill-health; drug-related overdoses and deaths; violence and intimi-dation related to drug debts and the drugs economy; stigma and discrimination. These issues were seen to have worsened since the great recession, and the austerity policies that followed, and had not improved with the recent upturn in national economic growth:

The life of the people using the services is the same and I see it on the street all the time. Things are worse now than they ever were – and I know there are different drugs and polydrug use, not just heroin, but I think the increased marginalisation

and total isolation and being on the streets and sleeping in parks and hotels it just seems to be getting worse and it doesn't seem to be improving.

To address these interdependent and unmet needs in the communities, the Projects provided a range of services from: one to one crisis interventions and counselling; medication assisted programmes; harm reduction; 12 step programmes; education and training programmes; treatment and rehabilitation programmes (including stabilisation, rehabilitation and aftercare); family support programmes for affected parents, partners and siblings; pro-

grammes for those in prison and their families; street, home and hospital outreach; awareness raising and capacity building; and community development programmes.

The range of engagement provided by Projects reflects the diverse needs of affected individuals and communities. Their work is influenced by Maslow's (1945) 'hierarchy of needs' – a key concept in community development work – whereby people's basic, psychological, and self-fulfilment needs must be addressed in order to successfully address issues relating to addiction (as demonstrated in Figure 1 below).

Figure 1: Responding to communities' hierarchy of needs.

In the section that follows, the work and ethos of the Community Drug Projects is explored through a community development lens to demonstrate the unique benefits they bring to their communities.

SECTION THREE:

COMMUNITY DEVELOPMENT PRACTICE IN RESPONSE TO DRUG-RELATED HARMS

An analysis of the work of Community Drug Projects led to the identification of five key elements of community development practice that inform their work and exemplify the unique benefits that the Projects bring to the communities they serve; these are that they:

1. Provide accessible, inclusive, and safe spaces.

2. Deliver trauma informed care.

3. Facilitate participation and integration.

4. Respond to unmet and emerging needs.

5. Act collectively: through interagency and partnership work.

1. Provide accessible, inclusive, and safe spaces

Key elements of Community Drug Projects' inclusive approach is their capacity to:

✓ Reach and support people in crisis and adversity.

✓ Provide accessible and inclusive spaces to deliver care.

✓ Provide wraparound services to individuals, families, and communities.

✓ Outreach and support people in crisis and adversity.

✓ Offer dignity, respect, and a non-judgemental approach.

✓ Provide a safe space to discuss drug debts, intimidation and violence.

✓ Provide an analysis and understanding of addiction for the community.

A key feature of community development work is its social justice ethos that challenges inequality and champions inclusivity and anti-discriminatory practices. In this respect, Community Drug Projects provide caring spaces that are accessible and inclusive to all. People who experience drug-related harms are among the most marginalised and stigmatised

in society. There are few places in society where they are welcomed or treated with dignity and respect. In response to this, a core value of the Projects' work is their non-judgmental approach whereby, 'everyone is listened to and respected' – an approach appreciated by the project participants:

> *One of the lads said, 'when you walk in here, you're made to feel like a human being', whereas that's not how he was used to being treated.*

Projects emphasise their accessibility to all: 'the door is never closed to anybody' and 'we don't refuse anyone'. In an era when many services are driven by eligibility criteria and assessments, this level of accessibility provides a welcome respite to those that attend. Central to this approach is the chat and the cup of tea, as described by workers across the Projects:

> *So it's, 'Come on in, let's drink a cup of tea. What's going on for you?'. Because for most people they just need a chat and a cup of tea – the cup of tea is very important.*

> *We don't refuse anyone … straight away you are being heard, you're being listened to and treated with dignity and respect.*

> *My thing is being aware of where people are at, asking if they're okay, have a cup of tea, small things.*

From the project participants' perspective, this inclusive and non-judgemental approach reassures that, **'**they're just not giving up on you'. As one participant described:

> *I've been in most of the organisations over the years, all the others you had to sign in and sign out, you're just a number on a piece of paper you have to give urine samples, you have to be supervised and there was no aftercare checking in on you, they never got to know you me as a person. I was a drug addict and this is all they needed to know. But, coming in here … they trust you and that's a big thing for me. In the other place you have to give*

> *urines it's like you have to prove something with the urine sample in a bottle whereas here I come in and say I had a relapse; in other places I'd be … trying to get away with stuff.*

As part of the community development approach, inclusivity extends to the needs of the broader community who experience drug-related harms within their families and their neighbourhood and where everyday life is affected by the structural violence of policy-related harms and the systemic violence of the drugs economy. The provision of information, support, referrals, and holistic therapies to those affected helps ease the stress and strains of living in these environments. This approach also brings people together in a way that destigmatises the people and families who have been affected by drug-related harms, and helps broaden the collective understanding of community drug problems and heal fractured family and community relations. The broader community can witness progress of people 'in treatment' and interact with them and this waylays fears, as a project worker described:

> *We're having an impact in the community in a way that's hopefully reframing or challenging the conception of people who use drugs.*

Safety is a crucial issue now for Community Drug Projects. The increased level of systemic violence and intimidation associated with the drugs economy and its impact on marginalised communities has been well documented (Bowden, 2019; Connolly & Buckley, 2016; O'Gorman 2014). This affects people in many different ways: from witnessing drug sales on the streets and by the shops; to being threatened and intimidated over drug debts; or they, their family members and neighbours being attacked and shot. The Project's staff note that people are fearful, anxious for their own safety and that of their friends and families, and reluctant to ring the Gardaí for assistance for fear of being identified as an informant:

With the feuds and the gang violence that's going on in this town, like people are living in fear and intimidation, they're living on an edge, never mind the addiction and the mental health and the homeless and the poverty. We try to make it a safe place to come and share their fears and their stories.

The Projects are concerned too about the consistent portrayal of young people (particularly those caught up in the drugs economy) as violent, anti-social, and undeserving of support. They feel the longer they are viewed with such negativity while their needs (for work, housing, and a future) go unmet, the more isolated they will become:

It's scary – the dealing, the hard core stuff going on at the moment, the young ones, they're grooming them, some are holding gear [drugs] – it's scary stuff. The level of intimidation that comes with that, if you walk around … they look at you, they glare at you, the younger people are now intimidating the people walking around this community.

2. Deliver trauma informed care

Key elements of Projects' trauma informed approach include:

✓ Social analysis and connectedness with the community, which provides an insight into the trauma people experience.

✓ Working with people 'where they are at' and taking account of their lived experience.

✓ Recognition that trauma affects different people and social groups, such as men and women, differently.

✓ Provision of symbolic supports at anniversaries and memorial events.

Community Drug Projects' social analysis provides them with an insight and understanding of the trauma and policy-related harms people have experienced in their lives,

either directly or indirectly by witnessing trauma within their families or their community. Adverse childhood and adult experiences surface in mental and physical suffering, in problem alcohol and drug use, and in domestic and community violence (see Dube et al., 2003). As one project worker described the problem:

It's not just about drugs, it's about loss and bereavement and poverty and Hepatitis C and trauma. I'm not surprised people use drugs it's incredible the sort of things they experience.

Community Drug Projects have a strong tradition of providing trauma informed care, even before the approach was adopted into mainstream health and social care practice. Their social analysis and inclusive non-judgmental approach brings an awareness of the trauma underpinning many drug problems and a recognition that risk behaviours are often ways of coping with both past and present trauma. As a result, Projects seek to address the underlying cause of problems as well as the presenting issues. Workers in different Projects described this aspect of their work as follows:

We're trying to come from a very trauma informed perspective and our number one rule is that this building is a safe place for the people who come here. You need to be listening to what the people who come here are saying … you create a space where those who come in with all of their worries can sit down with us and say this is what they need.

Some people have more or less ceased their drug use and a lot of the issues they were hiding away from in their deep subconscious are now coming to the fore and suddenly after thirty years of drug or alcohol misuse, of running away from whatever, trauma and attachment issues are suddenly coming back to the fore.

It's more problematic today like a young person coming in involved in addiction, there's serious trauma there – addiction

is no longer the issue, it is everything around that.

The type of strengths-based and holistic 'whole person' approach that Projects use to address trauma is time and resource intensive, and Projects find that this is not always appreciated by their funders:

If you're working with vulnerable individuals, who have experienced isolation and separation, so much of that takes a while like it's not one session, like, now we have that worked out. And, unfortunately that is not always understood well enough.

The inclusive, non-judgemental approach facilitates Projects to build a connection and relationship with people and work with them 'where they are at' – a key feature of community development work – rather than imposing unrealistic demands from the offset.

We can be more patient; we can give people that bit of space. We'll find something they can fit into rather than say, 'well you didn't turn up with your appointment so you're going to have to wait for the next appointment and go back to the back of the list'.

There's a warmth in the place and when they have a major relapse or small slip they're welcomed in and there's not, 'Oh you should have done this'. You come back in and it's, 'where do we start again'.

The Projects' community development approach takes a gendered analysis to its work and recognises that trauma affects both men and women differently. Many Projects choose to work with men and women separately. For women, in particular, the loss of children to care or premature death are causes of intense trauma throughout their lives:

the number of women who do not have children in their own care – across their life cycle the number of children lost … the women are losing large parts of their families, their families of origin and their own families, so they are quite isolated.

Children's anniversaries are such sad times – anniversaries are a big thing for them. We know within 30 seconds of meeting someone if they've had a bad night…. you'll only get that in a community setting, it is the safe space.

The critical mass of trauma within a community is most evident in the many symbolic memorial services organised by the Projects each November and Christmas to provide a space for people to grieve and remember friends, neighbours and family those who have died from drug-related deaths over the years.

3. Facilitate participation and integration

Key elements of Projects' participative and integrative approach include:

✓ Involving participants in developing their own care plans.

✓ Promoting peer-led support.

✓ Empowering people to participate in society.

✓ Supporting the reintegration of people into the community.

✓ Mediating fractured family and community relations.

Working from a community development practice, Community Drug Projects are not just service providers, they encourage and support people in contact with their service to be active participants in identifying their needs and developing their own care plan. This empowerment approach is central to the community development process, and has been a longstanding practice of Projects before this approach became recommended best practice in health care. This participative approach was described by workers as follows:

We encourage people to participate. They are involved in their own care plans so they're actively empowered to participate in their own kind of recovery.

18

Others want to fix the problem for them and give them the solution and hope they'll come out the other end, instead of going on the journey with them and enabling them to work through the problem and come up with the solution of what they want ... so we're empowering young people to make change in their lives and work through their addiction.

If you go to an OTC [opiate treatment centre] they write your care plan. In the community the individual writes their care plan, they create their goals ... We would sit with them, communicating with them, finding out what they want ... In a community setting that's where you're blossoming, that's where you grow.

I think in some way it is about valuing the voice of the participant, ultimately, you're not a client or customer you're a participant and there is that sense that the participant has to be heard.

A common feature of many Community Drug Projects is their focus on community and peer education with peer work an important outcome of this approach. In many community projects, peers are involved in running support groups, and education and training sessions for people in prison, hospital, returning to education and work, and accessing drug and/or HCV treatment. As one of the participants described:

You get the educational side of it so when you're taking away the addiction, you're not leaving that empty space there. But, it's more than just getting education and getting certs. You're also doing assertiveness programmes so you're learning about yourself you're doing peer training programmes so you're learning how to build your self-confidence and learning to use your past to help others.

This type of participative approach is seen to benefit everyone. It addresses participants' higher-level needs of esteem and self-actualisation identified by Maslow, which can

be addressed once people's basic needs have been met. This approach also reinforces Projects' non-judgemental support, working with people where they are at, and giving voice to participants' expertise by lived experience. For example, one project worker described the unique peer support provided to people undergoing treatment for Hepatitis C:

It is a really beautiful model that works particularly well with hard to reach populations who can't cope with the restraints of the medical set up. But, the medical set up can't cope with them either. So having somebody like a peer worker just cushions all that ... with that real empathetic understanding and not judging ... and it's not simply by holding their hand sitting through the meeting translating it afterwards, having a cup of coffee with them afterwards, but actually it's the eight phone calls it takes to get them to go to the appointment and the six or seven sessions it takes to build their confidence to apply for the assessment or the blood test.

In many Projects, community education in the form of social analysis, drama, music, and art are key tools for addressing people's higher-level needs and combatting the stigma they experience from society, and often in their own community, where they are defined by their addiction. Valuing participants' capacities outside of their addiction and recovery stories is both empowering and helpful in reintegrating people back into their family, community and society. As project workers described:

If you don't empower people, if you don't give them a reason to come in and support them and keep them alive, in some cases honestly some people would be dead. If you're not linking all that in and working with people to meet their goals or to have dreams to be able to work for something long term, you're only going to be able to be successful with a few.

They're seen as contributing to the community, as opposed to being a burden on

the community or something that shouldn't be talked about. Cause they're not talking about how many mls a day or how many tablets they're taking, it's we've done this and we've done a show and we've made this and written this. We're good at the integration part back into the community and even back into life … they tell us, 'people aren't talking about my addiction, they're talking about me doing something good in the community'.

4. Respond to unmet and emerging needs

Key elements of Projects' responses to emerging /unmet needs include their capacity to:

✓ Adapt to changing drug trends and drug-related harms.
✓ Identify and respond rapidly to emerging needs and crises, such as housing and mental health support.
✓ Provide family support to cope with addiction within multi-generational living.
✓ Develop innovative community development initiatives to address the broader needs of people and the community.

The Community Drug Projects' social analysis of the needs of their communities and their close connection with their community means that they are often the first to observe new trends and raise concerns about emerging needs, as project workers remarked:

The big thing about community development is that this is where you see things first off, it's the coal face, it always has been.

Unmet needs is a huge issue in this community for young people and adults – a lot of slipping through the net.

Over the past thirty years, Projects have acted as an early warning system for new drug trends and harms as they emerged (such as, cocaine use, polydrug use, legal highs, head shops, 'tablets', 'chem sex', crack cocaine, and drug-related overdoses and deaths). They have also provided rapid responses and emergency interventions in times of crisis:

We're like an A & E in the community, you never know what is going to happen and what's going to present at the door … the community would be lost without this project – in an emergency you can come in the door and there is always someone to talk to, to reassure, to set up an appointment.

Projects have been at the forefront of developing innovative responses to these needs often before they have come to the attention of, or are responded to, by mainstream services. For example, one Project related how they had addressed 'legal highs' in the neighbourhood:

Like there was no knowledge about them and we responded quickly when a head shop opened up locally and it was coming in the door. We didn't know what was happening but we educated ourselves pretty quickly and provided interventions around that. The HSE came along a year later and publicised education material but we had been dealing with it for nearly a year at least.

Over the years, many of the emerging needs identified by the Community Drug Projects reflect changing trends in drug use and in the drugs economy. Increasingly, however, Projects find they are dealing with the social context of addiction and the policy-related harms that have exacerbated poverty and inequality. Projects work with people in poverty, in precarious housing, with poor mental and physical health, who experience stigma and discrimination, and often drug debts and drug-related intimidation and violence. At the time of the fieldwork for this

research study, two areas of need that were of particular concern for the Projects and their participants were housing and poor mental health.

Housing

The housing and homeless crisis in Ireland has impacted severely on the lives of project participants and, in turn, on the Projects themselves. Many participants are living in either insecure housing, in multi-generational family households, in hostels or rough sleeping. In addition, they often have mental health difficulties. The impact of this on the needs of people who seek help from the service, was described as follows:

> *We're seeing the impact of homelessness on the mental health, and the drug use, and the alcohol use, and the polydrug use, and general health — feet, teeth, people coming in with massive injuries, bruises, broken bones, always on crutches, always limping, assaults, attacks, so much risk in that space out there when they have no safe home to go to, and then people saying some of the hostels are as appalling as being on the street.*

The housing crisis affects young people particularly and many have remained living, or have returned to, their family home. When drug-related problems develop, relationships between family members deteriorate leaving both the young peoples and the affected family in need of support.

Mental Health

The lack of mental health services for the population in general filters down to the community projects. In the absence of access to mental health teams, psychiatrists, sometimes even a GP, Projects become a primary source of mental health support and intervention because people have nowhere else to go. Projects report an increase in people presenting with mental health difficulties such as anxiety, stress, depression, as well as in psychiatric crisis. They experience

great difficulty in referring people onwards to appropriate specialist services, not only because of the lack of services but also because of the long-standing reluctance of psychiatric and mental health services to work with people with a dual diagnosis of mental ill-health and addiction. Recommendations to solve this issue were outlined in a 2004 study commissioned by the National Advisory Committee on Drugs (MacGabhann et al., 2004), yet little has improved since. The barriers to accessing appropriate services affects all concerned:

> *It's really difficult, be the person 16 or 56, to involve them in the mental health service if they're in addiction. They [the mental health services] will say, 'No, it's the addiction, get them off drugs and then we will see them', but an awful lot of time the mental illness issue preceded the addiction.*

> *We have people here with schizophrenia, bio-polar, depression, anxiety, and people might think they're out of their head but they're on medication. So that can be hard in a community setting to work with 'cause the HSE doesn't recognise the need to work with mental health and addiction together.*

Projects identified young people as being in particular need of support. They reported long waiting lists to access mental health services for them and, if successful, long distances for young people to travel to services when they are wary of traveling too far outside the safety of their own neighbourhoods. For project workers, the length of time it took for people's mental health needs to be addressed was a key concern:

> *It's a year on the waiting list for young people — young people come in in dire straits self-harming and suicidal thoughts and chaos was going to kick off — this young fella was trying to kill himself and all they wanted him to do was sit in A&E because they won't have an assessment place for another week.*

The acute need for community-based mental health and dual diagnosis services to counteract the rise in distress, self-harm and suicide was stressed by all Projects.

5. Act collectively: through interagency and partnership work

Key elements of Projects' interagency and partnership approach include:

✓ Working with a range of voluntary, community, and statutory agencies to meet the diverse needs of people affected by drug-related harms.

✓ Making referrals to other services such as: primary care, drug and alcohol treatment, detoxification, residential rehabilitation, mental health etc.

✓ Advocacy work to negotiate access to social welfare, housing etc.

✓ Liaison work with social work, police, probation and prison services etc.

✓ Networking to build knowledge of other services, for example attending local drug task force meetings, forums, participating on committees.

✓ Co-production of services.

Since the 1990s, community drug problems have been identified as a cross cutting issue that require coordinated responses – an interdepartmental response at government level, and an interagency response at local level (Department of Tourism Sport and Recreation, 2001).

At the local level, Community Drug Projects, and Drug and Alcohol Task Forces, have been key to this interagency approach with many of the Projects originating as partnerships between community activists and Health Boards [the forerunner of the HSE]. This interagency partnership approach of community, voluntary and statutory sectors matches the community development ethos of working collectively towards common goals, as well as the prag-

matic appreciation that no one organisation can address the structural issues underpinning drug-related harms. As project workers remarked: 'not one agency can do everything'; you definitely can't do it on your own.'

The interagency approach continues to be a keystone of the work of Community Drug Projects and Drug and Alcohol Task Forces who seek to support a diverse range of groups differentially affected by drug-related harms (such as young people, women, men, the Traveller community, older people, families etc.), and address their broader needs relating to health, justice, education, housing, social welfare etc. which impact on people's drug and alcohol use.

Community Drug Projects are ideally placed to deliver holistic services to meet these diverse needs as they are not limited to a specific statutory function and have the flexibility to work across all departmental briefs. This type of collective approach needs time to establish good working relationships with other agencies and requires ongoing engagement work by the Projects: networking, building alliances, collaborating, and sharing knowledge and experiences in order to build the foundation for interagency work. The strength of this approach was described by one project manager as follows:

We can link into all other services, we can identify them, we know them, we've got strong links. All the other services know us and know the type of service we offer and we know them so we can have that conversation. If you don't have that really strong sense of working with other agencies, and a strong sense of community around that, you don't get the right referrals ... networking is huge, it's a massive thing for us.

Interagency work takes many forms, from making referrals to other services, advocating for a participant's access or entitlement to a service, to developing formal Memorandums of Understanding (MOUs) to co-produce services. As services and resources become

more constricted, and access and entitlement to services becomes more bureaucratic and more confusing for people, advocacy with other agencies has become a core part of Projects' work:

So that's part of our thinking anyway, that no one agency can do everything. However, we also understand that most of our participants are not skilled at managing all of these other agencies and all of the stresses that go with that. So, as part of our community development we do lots of advocacy, lots of working with the participants and going out and engaging with all these other agencies that they are connected with.

Throughout the Projects interviewed, there were innovative examples of interagency work with homeless services, family therapy, criminal justice etc. These services played to the strengths of each agency, neither of whom could have provided it on their own, and produced a synergy greater than the individual inputs of each agency:

We couldn't have funded it ourselves but Probation couldn't have provided this kind of service 'cause there was a wrap-around support system that was needed.

However, as discussed in the introduction to this report, for some time now government policy no longer provides an enabling environment for this type of interagency and partnership work, which pushes each agency to work in silos:

What we're trying to do is integrate people into drug projects, integrate them into clinics, get them into GPs, social care, public health services. There many, many barriers to that. We need mental health and homeless services working together, at times it works and others it doesn't work, it's very, very difficult.

It's the homeless services here, and the drug services here, and the psychiatric services here, and it's never the twain shall meet.

The overall sense is that though partnership lives on in government rhetoric, it is no longer a priority in practice:

They talk about partnership but they're not really partners in it, they're really masters in it.

The following section of this report will examine the lived experience of this disabling policy environment and its impact on the work of Community Drug Projects, and in turn on the communities they serve. The report then concludes with recommendations for the future.

SECTION FOUR:

CONCERNS AND RECOMMENDATIONS FOR THE FUTURE

The future of Community Drug Projects' work and their unique community development approach is uncertain now. Despite the valuable contribution they have made to their communities, the sector faces increasing challenges in the current policy environment. A key aspect of this environment is the centralisation and hierarchical approach to decision-making, which undermines the original community-based partnership approach to delivering the National Drugs Strategy. This is evident in two main ways: first, there are fewer spaces for communities and community-based services to input into the decision-making process; and secondly, there are extreme levels of monitoring, reporting requirements, and evaluations of effectiveness and value-for-money (see O'Gorman, et al. 2016). As a result, the Projects find their ethos is not understood, their work devalued and treated with suspicion, and its governance questioned. As project staff related:

> *The context of community development is being eroded in general — justifying actions, interventions, everything has to be outcome focused and numbers focused. How many go through your door and what was the outcome? We understand that, but there is no recognition for the nuances within community work in supporting people to reach a point where they enter a service or programme or support.*

> *They're not interested in social analysis they're just interested in value for money, bums on seats, get them out the door, that's the attitude.*

> *We're asked to look at the case management model and to move away from harm reduction and community development approach, we're told what we do is 'fuzzy'.*

Projects respond to the growing level of unmet needs in their communities, but are reprimanded by their statutory funders for doing so:

I'm hearing, 'why are we doing homeless when there's homeless agencies?' Why are we feeding the homeless when there's other agencies doing that?' So, they are looking at all the elements our service has built up around the needs of people and now they're questioning why are we doing all that. So, we are having to work much harder to justify all that and you just feel you are on a losing battle.

The experience of the Projects demonstrates how the ethos and practice of community development responses is at odds with public management governance focused on logic models, progression pathways, short-term throughput and quantifiable outcomes. Projects noted extra conditionality being applied to their service level agreements, and extra productivity demanded for less funding:

It has got very punitive – the attitude of HSE towards the Community Drug Projects is —— are we getting value for money? And they're [HSE] expecting you to do more and more and more and more for the same or considerably less funding. Unbelievable kind of stuff. Nothing we did was right at the community and voluntary sector level.

All the money they took away from services and still they want us to increase our outcomes with less and less resources all the time – it's demoralising for staff.

It's all about numbers. It's about outcomes … sometimes people need a lot of work before they can even enter key work. But, how do you show that? That takes years. How do you show that on an Excel sheet?

Projects struggle to measure the human and community impact of their work, and to quantify the level of their interventions using public management metrics that were not intended for this purpose. The administrative burden on Projects to do this work is vast. Despite this, most Projects do not receive funding to cover staff time and resources spent on management, financial accounting,

GDPR compliance, and governance, even though these demands have grown exponentially over the years:

Like we have the same level of governance as a project that is funded 20million — it is crippling small community projects because we don't have the resources … it's absolutely nuts that we have the same level of compliance with huge entities that get millions — we all agree we need to be accountable and we need good governance but the level! So when we sign our annual Service Level Agreement (SLA) we have to comply with everything that someone who gets 10m or 20m does and if you get 20m you got a lot of resources to deal with the stuff. So you're really under pressure.

I genuinely don't have an issue with being asked to account for what we are doing but what I do have an issue with is that lots of extra work is expected and the resources are not made available to us and they do seem to be made available to HSE staff. All the SLAs on a yearly basis and then going through this performance dance with the HSE every year reporting quarter after quarter after quarter when the only thing that counts is the audited accounts at the end of the year. And people coming back with bureaucratic nonsense that takes time away and resources from the community.

Increased bureaucracy not only diverts staff from their work with the community but it impacts on people attending the Projects who are faced with increased levels of assessment to measure their progression:

There's pressure for everybody to be assessed and now they want them every month instead of every year. Assessment itself can be traumatising and upsetting and distressing and somebody will say 'I've done this 100s of times' … It's tough enough to come into the system to be faced with these massive assessments every time and we've always taken our

25

time with them, but now the emphasis is get it done, get it done fast.

We get asked, 'What's your success rate?' 'How many do you save?' 'What are the outcomes?' Everything is geared towards this aim of getting the Methadone down. Everyone is looking for this halleluiah moment where everyone walks out drug free and you're trying to explain that it's not for everybody.

The public management approach creates tension between the Projects and their funders. There are different expectations as to what community sector projects can achieve. The problems and unmet needs of the project participants are structural and social. The community sector cannot solve these alone, the solution requires a partnership approach and structural reforms to address the complex interdependent needs of the participants. Without a change in policy direction, the future for the Projects and their communities looks bleak:

I wish I could be more hopeful about the community development approach … Where we go now is really crucial. Do we stay more broadly community focused or do we jump to a much more clinical focus and tick all the boxes for the HSE and guarantee our future? But that would mean the organisation denying its roots, denying where it gets its connection with the community. Half the people that come into us would be lost, they would not be seen anywhere, they would be dead.

Recommendations for the future (adapted post COVID-19)

Over time, drug policy in Ireland has come to focus more on addressing individual drug using behaviour, as if these issues are context free. Policy discourses pay little attention to the underlying issues of poverty and inequality, and even less consideration is given to the harmful outcomes of policies. The social and structural determinants of risk environments, for drug-related harms and community drug problems, requires that these issues are dealt with as public health problems, rather than problems of the individual. However, to do so in practice requires a shift in ideology and policy, and an acknowledgement that these issues cannot be addressed in isolation from broader social and economic inequalities (of income, health, education, housing etc.); nor can they be addressed by one agency. A well-resourced collective approach is required.

By holding firm to their community development principles and practice, Community Drug Projects can help resist the individualisation of drug use problems and solutions, and help reframe the discourse of risk behaviour and risk groups to one focussed on risk environments.

We have seen over time, and now in the era of COVID-19, that Community Drug Projects have the flexibility to respond to emerging needs, often in ways that statutory bodies are not able. In addition, they have a unique capacity to deliver holistic integrated services directly to the people most in need. We know from experience, that partnership works when there is both a shared vision of what needs to be addressed and an effective co-ordination of sectors and agencies locally.

To continue all this valuable work, the following six actions are recommended:

1. Reprioritisation of the interagency partnership approach via DATFs to address the cross-cutting issue of drug-related harms.

2. Meaningful consultation with DATFs and the Community Drug Projects to enable their participation in policy development and delivery.

3. Acknowledgement of the value of the community development approach by Community Drug Projects.

4. Development of a valid and equitable system for evaluating Projects' work.

5. Provision of sustainable funding and resources for Projects.

6. Recognition that structural changes are required to address community drug problems.

REFERENCES

AIEB [All Ireland Endorsement Body for Community Work Education & Training]. (2016). *All Ireland Standards for Community Work.* Galway: Community Work Ireland

Bacchi. C. (2012). 'Why study problematizations? Making Politics Visible' in *Open Journal of Political Science,* 2, 1, 1-8.

Bowden, M. (2019) *The Drug Economy and Youth Interventions: An Exploratory Research Project on Working with Young People Involved in the Illegal Drugs Trade.* Dublin: CityWide Drugs Crisis Campaign,

Connolly, J., & Buckley, L. (2016). *Demanding Money with Menace: Drug Related Intimidation and Community Violence in Ireland.* Dublin: Citywide Drugs Crisis Campaign.

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

Department of Health (2016) *Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017—2025.* Dublin: Department of Health.

Kelleher, P. & O'Neill, C. (2018) The Systematic Destruction of the Community Development, Anti-Poverty and Equality Movement (2002-2015).

Loughran, H., & McCann, M. E. (2006). *A Community Drugs Study: Developing Community Indicators for Problem Drug Use.* Dublin: National Advisory Committee on Drugs.

MacGabhann., L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G & Philbin, M. (2004) Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland. Dublin NACD.

MacGregor & O'Gorman (2019) 'Drink, drugs and the 'dangerous poor': fear and loathing in contemporary cities.' In: MacGregor, S. & Thom, B. (Eds.) *Risk and Substance Use: Framing Dangerous People and Dangerous Places.* London: Routledge.

Maslow, A. H. (1943). 'A theory of human motivation'. *Psychological Review*, 50, 4:370-96.

Motherway, B. (2006). *The Role of Community Development in Tackling Poverty in Ireland.*

O'Gorman, A., Driscoll, A., Moore, K., and Roantree, D. (2016) 'Drug harms, policy harms and the needs of community in the Clondalkin Drug and Alcohol Task Force Area'. Dublin: Clondalkin Drugs Task Force.

O'Gorman, A. (2014). Social (Dis)Order and Community Safety. In M. Norris (Ed.), Social Housing and Liveability: Ten Years of Change in Social Housing Neighbourhoods. Routledge: New York.

O'Gorman, A., Moore, K., Piggott, K., Napier, K., Emerson, D., Driscoll, A., Mooney, R., Fennely, C., Gately, P., and Foley, M. (2013) 'An analysis of current licit and illicit drug use patterns in the Finglas and Cabra areas of Dublin'. Dublin: Finglas-Cabra Drug Task Force.

O'Leary, M. (2009). Intimidation of Families. Dublin: Family Support Network.

National Advisory Committee on Drugs. (2014). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: National Advisory Committee on Drugs and Alcohol.

National Advisory Committee on Drugs and Alcohol (2016). *Prevalence of Drug Use and Gambling in Ireland and Drug Use in Northern Ireland.* Dublin: National Advisory Committee on Drugs and Alcohol.

Rhodes, T. (2002). 'The 'risk environment': a framework for understanding and reducing drug-related harm.' *International Journal of Drug Policy,* 13, 85-94.

Stafford, M. & Deeny, S. (2020) 'Inequalities and deaths involving COVID-19: What the links between inequalities tell us'. The Health Foundation: www.health.org.uk