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Community and Drugs

A case study in community conflict in the inner city of Dublin

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A case study in community conflict in the inner city of Dublin

A thesis for the Masters in Letters degree submitted by

Kieran Cullen
Department of Social Studies

December 1992

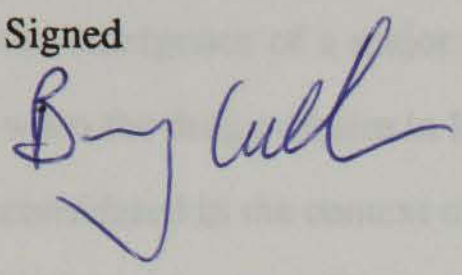
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This study is dedicated to the memory of Tony, Eddie, Maria, John, Patrick, Robert, Mark, Jimmy, Patricia, Jacqueline and Thomas, who all lived in St. Teresas Gardens during the early 1980s and, who died prematurely as a consequence of their involvement in problem drug use

Declaration

I declare that this thesis has not been submitted for a degree in any other University, and that it is entirely my own work. I agree that the library may lend or copy this thesis if so requested.

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Abstract

This thesis is a case study of community conflict in St. Teresas Gardens a south inner city flat complex (pop. 1,250 approx.) during the years 1978/85. The study describes the emergence of a major drug problem in this community in the late 1970s, a time when the drug problem in Ireland as a whole, was relatively small. The drug problem is considered in the context of general deprivation and social and economic disadvantage in the community. The study considers the response of the Eastern Health Board to the drug problem and examines this response in the context of the health board's Community Care Programme and its policies and structures. The study also examines the emergence, and decline of a local community action group, the Concerned Parents Against Drugs (CPAD) in terms of the perceived failure of statutory efforts. The thesis is a retrospective, participant observation study by the author who worked in St. Teresas Gardens, as a social worker/community worker during the years 1980/85. The primary conclusion to the study is that if statutory social services are to have an effective impact on drug problems in communities like St. Teresas Gardens, then greater efforts in relation to understanding local problems and consulting with local people will be required.

Acknowledgement

Paul Humphrey kept comprehensive records and files of his experiences with the St. Teresas Gardens Development Committee and its involvement with the Eastern Health Board. Without these records it would not have been possible to attempt this study. Michael King supplied me with his set of minutes, correspondence and reports of the Youth Development Project committee, together with handwritten notes. Fergus O' Kelly also provided valuable records and notes. In addition to these three people. I would like to thank the following who either interviewed for this thesis or provided vital background information: Matthew Bowden, Francis Chance, Frank Deasy, Mary Doheny, Aine Flanagan, Cecilia Forrestal, Moira Higgins, Terrie Kearney, Catherine Lillis, Sean McArdle, Ray McGrath, Paddy Malone, Willie Martin, Mick Rafferty, Pat Smyth, Noelle Spring, and Helen Walker. Others, who would not wish to be mentioned in this acknowledgement, have also provided important background information and clarification. The study would have no meaning if it were not for the imagination of people in St. Teresas Gardens and I thank them for the opportunity to experience this. I wish to thank the staff of the Library, Trinity College for their help and courtesy and also the staff of the National Library of Ireland, for their assistance. My supervisor, Shane Butler was a great encourager and somehow he managed to believe in this study at times when I had given up. Finally, I wish to thank Pat Tobin and Bonnie.

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Chapter 1 - Introduction

Community case study

This thesis is a study of one community's experience of drug problems during the period 1978-85. The community under study, St. Teresas Gardens, is a local authority flat-dwelling estate (Pop.: 1,250 approx[1].) in the south inner city of Dublin. During this period of study, 1978-85, St. Teresas Gardens experienced a problem of widespread intravenous opiate-use among young people. One study (O'Kelly *et al,* 1988) estimated that at the height of this problem in 1981, almost 30% of the male 15-24 age cohort were using heroin intravenously. The involvement of this group of young people in drug problems commenced at a time when there was no prior history of serious opiate-use in Ireland[2]. It was also a time when those concerned persons - families, friends, doctors, social workers, youth workers, community workers and nurses - who first became aware of the developing serious situation, while willing to respond to this problem in a meaningful way, were quite unsure as to how to practically go about this response[3]. Where they did go to seek help and assistance in developing an appropriate response was to the Community Care Programme of the local Eastern Health Board.

The Community Care Programmes of eight regional health boards were set up in the early 1970s following a period of radical restructuring of health services administration

---

[1]This population figure is taken from a local, household survey conducted in 1982 in which the author was involved and which produced this estimate of the local population (STGDC, 1983a)

[2]The report of the *Government Working Party on Drug Abuse* (1971, 9) observed that there was "no evidence of any significant use of heroin *(in Ireland)* but having regard to the fact that illicit supplies are at present difficult to obtain..., the position should not be viewed with complacency lest such supplies become available."

[3]At the height of the heroin problem during 1981, none of the locally based doctors, social workers or nurses had any formal training in drug problems, principally because no such training was provided in University courses. This situation has been rectified considerably through the provision at Trinity College, since 1983, of a one-year Addiction Studies diploma course for personnel who work in or who are involved with both statutory and voluntary drugs services. The course is integrated to the college's Department of Social Studies.

in Ireland (McKinsey, 1970). The remaining health services were organised under two other programmes - the Special Hospital (Psychiatric and Handicap) Programme and the General Hospital Programme. The Community Care Programme was charged with identifying the health needs of the population on a localised, community basis and responding to these with structures which were open, flexible and coordinated. The Community Care Programme was as Lavan (1981, 12 and 15), in a study of voluntary and statutory responses to social need in a new Dublin suburb - Tallaght -, argued "based on a belief in the importance of local knowledge", and in the "superior capacity of local provision to respond to the whole person or family". This thesis explores the efficacy of the Community Care Programme's structures and policies in responding to the local problem of drug use in St. Teresa's Gardens; it is a review of Community Care practice which compares this practice to the rhetoric of Community Care.

Initially, in the late 1970s, the efforts of those persons who sought assistance from the health board Community Care Programme in responding to drug problems, were directed at representing local needs arising from these problems and at seeking statutory resources for drug prevention and education in the community. Later, between 1981 and 1985, these efforts were focused on developing the Eastern Health Board's Youth Development Project (YDP) which was seen as the principal statutory response to problem drug use within the community. This Project scaled down its operations in 1985.

In 1983, the general population in St. Teresas Gardens became involved in taking direct, collective action against suspected drug dealers for the purpose of persuading them to stop, or otherwise prevent them, from selling drugs in the community. This action represented the expression of an even deeper and more active interest by the local community in drug problems. It also resulted in the formation of the Concerned Parents Against Drugs (CPAD), a movement which later spread to many other Dublin communities which experienced similar drug problems. The combination of these

events and the various local efforts to initiate and support a Community Care response, provide the main local background to this thesis, the basic aims of which are the following:

(i) to describe the emergence of a major drug problem in St. Teresas Gardens in the context of new needs resulting from social and economic changes;

(ii) to examine the response of the Eastern Health Board to this problem in the context of its Community Care Programme policies and structures;

(iii) to explain the emergence and decline of the local Concerned Parents Against Drugs group in terms of the perceived failure of Community Care and other statutory efforts.

Along with other community studies[4], the idiosyncrasies of this thesis make it difficult to draw conclusions which make sense to a broader analysis of the drug problem. However, the study is concerned with trying to understand problem drug use within a particular social, environmental and cultural context. In this regard, the study provides an opportunity to understand both the community setting being studied and its interaction with the statutory system with responsibility for the delivery of services to problem drug users. It also provides an opportunity to gain some insight into the issue of problem drug use itself. These issues will be considered in later chapters. Before proceeding with this discussion however, an outline of the research method and approach of this thesis is now provided.

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[4]For a critical overview of community studies see Worsley (1987, 238-272), Gilligan and Harris (1989), Stacey (1969),Clark (1983), Willmott and Thomas (1984) and Bell and Newby (1971).

Positivism

There are, essentially, two basic approaches to the study of drug use as a social problem. The first, based on positivist[5] research, is derived from the view that the methods and techniques which had been successfully used in the study of the physical and animal worlds are of equal validity in the study of society and human behaviour. Durkheim (1982, 50-59), argued, in his *Rules of Sociological Method,* that social facts should be regarded as things, by which he meant that society's beliefs, customs, social institutions and problems - for research purposes - should be treated in the same way as things in the natural world. Positivist research relies on the collection of information about phenomena which can be observed and classified, arranged as statistical data, correlated with other data, and analysed in the search for causal relationships. Within the study of social problems, this approach relies heavily on the quantification of attributes and characteristics of individuals, and of groups of individuals, who are perceived as having problems, and on the correlation and analysis of this information.

For analytical purposes much positivist research on problems of deviancy, such as illicit drug-use and criminality, is based on comparisons between those who are "deviant" and those who are not - "conformists".[6] By discovering the differences between both, the factors which predispose some individuals to commit crimes or to use drugs are thereby deduced[7]. The correlation of poverty and drug problems, could in a positivist model, allow a researcher to speculate that one causes the other, thus

---

[5]The nineteenth century writer, Auguste Comte, coined the term 'positive philosophy' in his search for a rational science of human behaviour. See Swingewood (1984, 40-6) for a discussion of his contribution to sociological thought.

[6]This particular approach was used in one study of heroin users and non-heroin users in Dublin's North inner city (Dean *et al.*, 1984). See also Nurco and Shaffer (1982) for consideration of an addict typology based on antecedent behaviours and characteristics.

[7]The crudeness of such approaches is highlighted by Box (1981, 2-3) in his short historical review of conceptions of deviance and their progress from: demonology - deviants "perceived as persons possessed by evil forces"; physiology - deviants "characterised as having deviations in their head shapes, peculiarities in their eyes, receding foreheads, weak chins, compressed faces, flared nostrils, long ape-like arms and agile and muscular bodies"; and, psychology - "deviants were individuals" whose "pesonalities were not amenable to the 'normal' process of social learning" or whose"weak super-ego had abdicated control to a riotous id" or who were simply "insane".

POVERTY----leads to----DRUG PROBLEMS. There are, however, other interpretations of correlation analysis. Problem drug users - rich or poor - may be required to spend whatever wealth they have available on purchasing drugs to such extent that they all either are, or become, poor. Thus, it can be postulated, DRUG PROBLEMS----lead to-----POVERTY. The approach becomes somewhat more complicated when other variables are taken into account - such as age, sex, education, employment experience and so forth in the above example - and in such situations the approach of positivists is to hold one or more variables constant, and through a process of multivariate analysis (usually now with the assistance of computer programmes) deductions can be made to show the relationship between a number of variables. While the positivist approach to drugs research is important for establishing basic data in relation to people who use drugs - particularly prevalence and incidence figures, social profile information, records of treatment and so forth - it provides an incomplete picture of drug problems.

One fundamental difficulty with the positivist approach in the study of social problems is that problems are accepted as given, without any real attempt to interpret their subjective value or meaning. For example, Cohen (1966,1) defines deviant behaviour as that which violates "expectations which are shared and recognised as legitimate within a social system" and Merton and Nisbet (1966, 805) refer to deviance as "conduct that departs significantly from the norms set for people in their social statuses". In this functionalist approach[8], there is an inherent acceptance of a consensus of values and this commitment to common values is seen as providing a basis for social order. Positivist research on drug users, therefore, shifts the focus away from society as having structural problems, and, frequently concludes that the "problem" lies in the

[8]This approach is derived from functionalist sociology which perceives societies as wholes, made up of interrelated and interdependent parts which contribute to the integration of the whole. Deviance derives from dysfunctional elements within the system. See Swingewood (1984, 225-52) for a discussion of functionalism.

defects in the individual, his/her family or locality[9]. The response to deviance which is implied within this particular research and analysis is to correct the defect, either through punishment or treatment. As pointed out by Box (1981, 3) in his critique of this approach:

> The deviant was a defect person, and since that defect was internal, and hence inseparable, it was the deviant who had to be subjected to various correctional technologies. Until these were successfully applied, it remained unsafe to allow a 'defective' - dangerous - deviant either to stay in or return to the community.

Qualitative research approaches

The second basic approach to the study of social problems - interpretive, qualitative research - draws heavily on the interactionist's school of theory and research[10]. Researchers who adopt this approach are concerned to interpret the meanings and motives upon which human behaviour is based. In undertaking this investigation they rely heavily on qualitative data. This approach to research questions the assumptions which are made about what is "normal" and "deviant" in society. If a set of conditions are defined by one group as being a problem, it is also appropriate to ascertain what values - which *they* hold - are threatened or offended by these conditions, and whether the group which is perceived as being involved with this problem, experiences the same value-conflict.

---

[9]Using this drug-user-as-defective individual approach, Rasor (quoted in Worsley, 1987, 417) describes drug users as follows: "Most individuals addicted to drugs are considered self-centred and narcissistic and are interested only in satisfaction of their own primitive needs. This is a very infantile form of behaviour; it is acceptable in infancy but not in adults. These individuals have not matured in a healthy way and so do not accept mature roles. They make poor husbands and wives, fathers and mothers; they are poor sexual partners because their social development has been retarded. They experiment with many types of sexuality but usually they cannot accept a mature heterosexual role. They are not interested in giving to anyone; they are interested only in receiving."

[10]For insight into the type of research studies conducted by interactionists, see Goffman(1961), Becker (1963), Becker (ed, 1964) and Lemert (1972).

Qualitative research rejects the approach of applying the research techniques of natural sciences to the study of humans. The natural sciences are concerned with the study of matter, which has no consciousness. The response of matter to external stimuli is - within the scope and methods of natural sciences - easily observed and explained. Not so with humans whose response to every situation is derived from the conscious meaning they attach to it. The situation of researcher observing the observed is in fact a dynamic situation. It is the interaction, not the mere summation of observations, which determines research outcomes. Thus, methods of research - qualitative and participant observation techniques in particular - need to be developed which are capable of understanding and taking account of the meanings attached to the human behaviours of those who are observed and studied. This understanding necessitates the researcher getting inside the subjective world of those being studied in order to make objective sense of that world. Insight into this world only becomes possible when the researcher has had an opportunity to actively engage subjects rather than to adopt a position of neutral, uncommitted observer. In outlining the methods of qualitative research, Walker (1985, 13) comments:

> Insight into human behaviour is only possible because the researcher and subject share a common humanity. However, because such insight or knowledge is acquired subjectively, the objectivity demanded by a positivist model of social science is impossible to attain. What the researcher learns from his research depends on the quality of his interaction with his subjects, his ability to interpret what he observes and is told, and his own ethical and social values.

The major intellectual roots of qualitative research is in the philosophical school of phenomenology, so called because in its sociological application it is the study of things

as they appear to us - of phenomena[11]. In a phenomenological approach to social enquiry there is a greater emphasis on studying the various processes which interact with the phenomena being studied than with direct observation of the phenomena as accepted. The qualitative research school of interactionists, in their studies of deviance, direct attention away from the acts and behaviours of those who are supposedly deviant and focus instead on their interaction with those who have defined them as deviant - a research approach which led Becker (1963, 8) to conclude that a deviant is "one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label".

Within this research approach, a label defines an individual as a particular kind of person, it is not neutral, and it makes a value judgement about that person. If an individual becomes labelled as drug user (or heroin addict, junkie, dope-fiend) the likelihood is that this label overrides their position as parent, friend, neighbour and worker. Others - including the researcher - are likely to perceive and respond to the labelled person more in terms of the label and will also assume that the labelled person has the characteristics which are assumed to be commonly associated with the label. In turn the labelled person's self-concept is determined by the perceptions and responses of others. So, they see themselves in terms of their own label, thus producing a self-fulfilling prophecy. According to interactionists it is the complete process - including varying meanings and values within it - which contributes to the labelling outcome and therefore it is the totality of this process which needs researching.

A developmental approach

Gabe and Bury (1991) and Manning (1985) outline the merits of the developmental approach which is an attempt to combine the strengths of the interactionists with a

---

[11]The connections between phenomenology and social science are provided by Schutz (1954).

wider analysis of the social conditions surrounding particular problems. Rather than focusing on identifying and describing social problems, the developmental perspective advocates looking at the way in which groups set about changing conditions which are perceived as problematic. Spector and Kitsuse (quoted in Manning, 1977, 10) have argued that research should be more concerned with how problems are responded to than with how and why they exist:

> Social Problems are the activities of groups making assertions of grievances and claims to organisations, agencies and institutions about some putative conditions.

Gabe and Bury (1991, 28-9) also argue the necessity of providing an outline of the objective conditions which exist at the point at which the problem begins to emerge. They point out that some attention needs to be focused on why claims in relation to one set of conditions will generate the kind of public response which facilitates the legitimation of a problem, while similar claims in relation to another set of conditions will not. In the midst of this interaction between claim-makers, the public and the state, there is a variety of responses and behaviours which provide insight into social problems.

Manning (1991,13) has highlighted the key role of "modern state as the most important agency to which people turn for a solution to their problems". The increasing role of the state in the affairs of the public has meant that it is to it that the public most frequently turns for solutions to social problems. The state in formulating a policy response does not do so without taking other interests and policy areas into account. The greater the perceived consensus about the nature, extent, causes and possible solutions to the problem, the greater the likelihood that the state will develop a policy response. In the absence of this consensus, the response of the state, while slower to develop, is likely to reflect the demands and views of those groups which are better organised and whose

models of response more closely fit the structures, procedures and methods of work already available within state machinery.

Research Method in St. Teresas Gardens

This developmental perspective is utilised in setting out the objectives of the study of problem drug use in St. Teresas Gardens, during the period 1978-85. It is within this period that claims in relation to the existence of the drug problem were made and gathered momentum, and that the first statutory and non-statutory responses were developed. Both the claims and the responses involved an interaction which often resulted in conflict. In the midst of this conflict there were divergent views of what the problem was, what were its manifestations, causes and possible solutions. It was variously referred to as a youth problem, an unemployment problem, a police problem, a crime problem, a class problem, a drug abuse problem and a problem of parents passing on their drug consumptions (alcohol) habits to their children.

This case study is, to a large extent, a retrospective account by the author who worked in St. Teresas Gardens first as a social worker 1980-81, then as a community worker 1981-83 and finally as project leader of the health board's drug project[12] 1983-85. The account is based on the author's observations of the community, of its activities during this period and of the interaction of key members with outside agencies and institutions, and afterwards, an analysis of various documents which have either been stored by the author or since given to him, and a number of focused interviews which the author conducted with persons who were centrally involved in the events which are described[13].

---

[12]This project was known as the Youth Development Project (YDP).

[13]The author has also drawn from notes and recollections of informal discussions with a number of people from St. Teresas Gardens who had a direct involvement in the events which are described. He

Participant observation is a particularly effective way to study small units of social organisation such as primitive societies, deviant subcultures, communities and informal groups. As a method of survey it does not lend itself to the collection of statistical data. The researcher assumes a role within the community or group being studied and in addition to observing community events, behaviours and interactions s/he also documents the effect of his/her own presence. Participant observation research, in comparison to social surveys, is relatively unstructured. The fact that it is unstructured means that the researcher spends a considerable amount of time collecting superfluous data, which is not necessarily usable in the final research report. However, there is the benefit that the community is being observed firsthand and community members and their behaviours are witnesed in a variety of different situations thus providing a good opportunity to understand the underlying meanings and subtleties of community life. The task of the researcher is, according to Powdermaker (1966, 9), to become immersed into the group being studied: "learning, as far as possible, to think, see, feel and sometimes act as a member of its culture and at the same time as a trained (researcher) from another culture". The researcher strikes a balance between being involved and being detached.

Of particular benefit is the opportunity for the researcher to have direct observation of unanticipated, dramatic events. As Poplin (1972, 278) points out, it is unrealistic to expect that participants in such events can always, in their aftermath, put "their deep feelings into objective words". There are obvious dangers in relation to the role of the researcher in undertaking a study of events in which s/he can have a direct or indirect involvement. The researcher can become so "devoted to group purposes that" s/he loses "scientific objectivity and detachment" (*Ibid.*, 279). However, supporters of the participant observation method point out that these risks need to be taken and by taking

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also had informal discussions with various personnel who worked with the Eastern Health Board during the period of study.

them there is greater opportunity to understand the meaning of community behaviours and activities, than there is with other research methods[14].

Gold (1958, 217-23) has identified four roles for participant observation researcher, along a continuum as follows:

> *complete participant* - fully integrates into group being observed and conceals the research purpose;
>
> *participant-as-observer* - researcher announces his intentions to study and then, as far as is practicable, blends into community life.
>
> *observer-as-participant* - researcher explains his intentions to conduct a study but then remains aloof from direct participation in community life.
>
> *complete observer* - has no direct interaction with the group apart from observing it.

There are practical problems associated with the complete participant role whereby the researcher can become over-involved with the community being studied and lose objectivity. There are also ethical problems in relation to concealing one's identity as a researcher. In relation to the role of complete observer, it is unlikely that a researcher with this approach will gain insight into or understanding of the underlying meanings and subtleties of community life and behaviours. From both an ethical and practical point of view, the favoured approach by this author is participant-as-observer whereby the researcher reveals identity and intentions to community members being studied.

---

[14]For a discussion of the techniques involved in developing a participant observation role see Whyte's classic study Street Corner Society A relevant extract from this study on participant observation is published in Worsley (1970). See also McCall and Simmons (1969) and Hargreaves (1967, 193-205) for a further elaboration of participant observation methods.

While this announcement may cause modifications of the behaviours of community members it is also likely to improve the researcher's access to key events, activities and persons. Janes (1961, 448) has noted that "the manner in which community members define the investigator's place in the community also affects his ability to collect meaningful, accurate data".

The author of this study was a participant in many of the events and activities concerning drug problems which took place in St. Teresas Gardens during the period 1980-5. The author was not always participant as researcher in these events. Clearly, his role was as a social worker, community worker and project leader. The role of researcher was not fully declared primarily because, at the outset, the author was not observing events as a researcher. His access to events for observation derived from other roles within the field of research. I say not fully declared because in the context of observing community action events in St.Teresas Gardens, the researcher did in 1984 decide to record many of these events and to announce this intention to community members.[15] The research therefore relies heavily on the author's recollections as participant-as-worker in the community and not as participant-as-researcher. The thesis however, does not rely solely on the author's recollections and notes. Quite a lot of documentation in relation to the field of study has been kept both by the author and by other key people. Other documentation has also been sought. Furthermore, many of the key people who were central to the events agreed to undertake focused interviews with the author for the purposes of adding further clarity to the thesis. Not everybody, however, from whom an interview was requested, agreed to participate. Other persons who lived and worked in St. Teresas Gardens or, who were otherwise familiar with the field of study, provided clarifications on points of detail as requested.

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[15]This included an announcement at a large community meeting in St. Teresas Gardens in early 1984, that the author was interested in the writing up of these events.

This is a retrospective and not a pre-planned study. A pre-planned study would have had the opportunity to anticipate and deal effectively with some of the methodological problems outlined above, which unfortunately cannot be avoided in a retrospective account. As pointed out above, the decision by the author to note his observations of the field of study was taken in 1984. However, the decision to pursue this further as a thesis was not taken until 1986. There are a number of reasons why this study was, in these circumstances, undertaken:

(1) The events which unfolded in St. Teresas Gardens during the period of study had importance for those interested in the study of problem drug use, its emergence, its effects on local communities and the wider society, the lessons they teach in relation to future developments in this field and, their potential contribution to social policy, social work and community work literature.

(2) The author did have a unique access to informants, documentation, personal records and recollections, which made this retrospective study more possible.

For the above reasons, and despite its methodological limitations, this thesis was a worthwhile undertaking. In other chapters in this thesis, the community case study of St. Teresas Gardens is explored using the above developmental research method. The following is a brief outline of the focus of each of these remaining chapters:

Chapter 2 sets out the main drugs policy issues for discussion in this thesis. Chapter 3 considers the emergence of the heroin problem in St. Teresas Gardens in the context of the effects on the community of recent social and economic changes. Chapter 4 provides an outline of the objectives, structures and operations of the Eastern Health Board Community Care Programme, with particular reference to the role of community social work. Chapter 5 considers the attempts of community social work personnel

alongside other local health workers and community activists to identify St. Teresas Gardens' problems and to seek appropriate statutory responses. Chapter 6 outlines the achievements of localised community social work in St. Teresas Gardens and details the progress of the health board's primary local response to the drug problem - the Youth Development Project (YDP). This chapter also describes the emergence and development of local community action against drug dealers. Chapter 7 considers the various interactions between local activists, locally based health board personnel, statutory agencies and the media which, in the wake of local community action and perceived institutional inertia, contributed to community conflict in St. Teresas Gardens. Chapter 8 summarises the main conclusions to this study.

Chapter 2 - Drugs & drugs policies

Introduction

In this study we are concerned with psychoactive drugs which when used create social problems for either/both the user and/or others. Definitions as to what constitutes a social problem will vary according to differences in values and attitudes between and within different societies. There are drugs which are approved and accepted in some societies, as alcohol is in western societies, but yet prohibited in others, as alcohol is in Islamic societies. There are drugs which are considered beneficial in relation to certain uses, as when morphine is used to relieve pain, but considered unacceptable in other circumstances, as when morphine is used to create euphoria. In these examples the pharmacological properties of the drug remains the same. The variations will normally result from other factors not least of which is any society's political and economic priorities. At times it is not possible for society to adequately meet its own demands and requirements for drugs - psychoactive or otherwise - and *this* could constitute a social problem; a problem which Barber (1967, 117) has referred to as "the avoidable unavailability of drugs". The social consequences of this "unavailability" are that persons who *need* certain drugs for medical purposes will, usually as a result of poverty or remoteness, not always get them. However, in most modern societies when we refer to the "drug problem" we invariably mean the unavoidable availability of psychoactive drugs to people who are not perceived as *needing* them. Predominant in this group in the public eye are those who use illegal street drugs. They are predominant not because they constitute the greatest number of problem drug users, but because they are engaged in illegal and/or socially disapproved activity and, consequently, their problem is more visible. This chapter is an overview of problems and policies associated with and arising from the illegal use of opiate drugs.

The changing context of drug problems and policies

Many of the drugs which today are illegal were not always illegal. It is not so long since opiates were available easily and in large quantities across the counter. The non-medical use of opium for much of the nineteenth century was as Berridge (1989, 25) pointed out, "more normal" and "more acceptable" than "heroin is ever likely to be in Britain in the 1980s and 1990s". Throughout the nineteenth century United States, people from all classes and walks of life took opiates which were freely available in across the counter medicines and Brecher (1972,3) has noted that the country could "quite properly be described as a 'dope fiend's paradise'". As a result of the easy availability of opiates, the numbers who habitually used was high, but the wider social consequences were minimal and the dominant social attitude towards those who used opiates was one of tolerance.

The terms used in relation to describing drug problems therefore, have not, in an historical sense, remained static. Rather they shift from time to time through notions of morality, bad habit, criminality, disease, social problems and public health. The terms used and the reasons why they are used reflect wider political, cultural and economic considerations. One of the most important steps that needs to be taken to improve our understanding of drug problems is to clarify the terms that we do use. In this context, it is also important to distinguish clearly between scientific and value-laden terms.

Drugs are not inherently "good" or "bad[1]". They are inanimate. It is human behaviour in relation to the use or non-use of drugs and the social-value context in which this behaviour takes place that lead to the application of the labels - "good" or "bad" or

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[1]Neither are they necessarily "hard" or "soft" as outlined by Kaplan (1983) in his investigation into the social problems caused by heroin. Kaplan points out that in "all probability, the hardness of heroin, in the public view, stems from a combination of factors - the condition of those users who come to our attention; the public attitude towards the kinds of people who use the drug; the serious criminal penalties for its sale or use; the strong social disapproval it evokes; and, the enormous social cost to the nation attributed to its use" (*Ibid*, 1).

indeed any other value label. Yet, from a pharmacological perspective no drug is safe. Depending on the dosage, frequency and method of intake, all drugs have the capacity to cause toxic effects. It is equally true that all drugs, at certain dosages, and frequency and level of intake, are safe. It is important therefore, to see drug problems not in terms of the pharmacological properties and physical effects of drugs. Drug problems exist and have meaning in a particular context - a social, economic, cultural and historical context - and they need to be understood within the totality of this context.

Drug problems do not attract a consensus of opinion and understanding even within homogeneous societies and communities, which share broadly similar values. Nowhere is the confusion of terms in relation to drug problems more apparent than in the widely different and often conflicting approaches of US legislators and their UK counterparts following the signing of the first International Treaty on the Control of Opiates in The Hague in 1912[2].

The US Punitive approach

The US Harrison Narcotics Act 1914, which was introduced to fulfil obligations under the Hague Convention, effectively removed a doctor's right to prescribe opiates for the purposes of the treatment of addiction. Under this Act and succeeding legislation, many doctors were arrested, convicted and imprisoned. Opiate users for the first time found themselves relying totally on illegal supplies. Morphine maintenance clinics set up by public health officials in 1920 were publicly denounced and shortlived[3]. The

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[2]A detailed comparison of the contrasting effects and consequences is provided by Trebach (1978).

[3]The shortlived attempts by public health officials to make medical facilities available to drug users are described by King (1972, 33-9). One official - D. S. Hubbard - in reviewing the experiences of the clinics, commented: "The clinic is not the solution - but it aids the secretive addict out of his lair. He becomes friendlily *(sic)* disposed and, deprived of his supply, he is willing to be cured....No doubt, with suitable organisation and funds to institutionalise and adequately and properly care for them, not only to effect withdrawal of drugs, but to rehabilitate by several months aftercare in the open country, together with efforts to get the individuals away from bad and demoralising associates, into new and more useful environments, many will revert to useful and normal lives (*Ibid.*, 37).

predominant political-moral attitude of the time was one of "prohibition"[4]. The prevailing attitude towards drug treatment, up until the 1960s, was punitive and based on the premise that "addicts must be deterred from using drugs by incarceration and helped to give up drugs by receiving therapy while incarcerated"(Brecher, 1972, 69). In the late 1930s, two public health hospitals for drug users were set up in Lexington and Fort Worth. Their underlying philosophy, as reported by Lewis and Sessler (1980, 98) was "complete detoxification in prolonged isolation from the environment where the addiction occurred". In a review of the evaluation literature of such programmes Brecher (1972,77) commented they "firmly demonstrated that neither incarceration alone, nor incarceration plus treatment nor incarceration followed by intensive parole supervision accomplishes much of value for more than a handful of addicts, and that costs per addict are very high"[5].

The British reformist system

In contrast, the UK, which introduced similar legislation to the US in 1922, i.e. the Dangerous Drugs Act, convened a committee - known as the Rolleston Committee - to consider the role of doctors in prescribing opiates to addicts. The committee, in its report in 1922, defined addiction as "a manifestation of a disease" and recommended that doctors should continue to be involved in the provision of prescriptions for both the purposes of gradual withdrawal and maintenance (Departmental Committee on Morphine and Heroin Addiction, 1926, 11). Underlying the approach of the Rolleston Committee was their belief that "the number of addicts had decreased and would continue to decrease as a result of their Report" (Bean, 1974,68). There is some

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[4]See Musto (1973) for a full consideration of the social, political and moral issues concerning alcohol and opiate prohibition.

[5]Brecher's (1972) report for the Consumers' Union is a balanced, authoritative and comprehensive overview of drug control laws and drug treatment policies. The report concludes that the drug problem is "the result of mistaken laws and policies, of mistaken attitudes toward drugs, and of futile, however well-intentioned, efforts to 'stamp out the drug menace'" (*Ibid.*, 521). It coins a phrase the *drug problem* problem which it describes as "the damage that results from the ways in which society has approached the drug problem"*(Ibid.)*.

evidence that this was achieved. In 1935 the UK authorities reported that there were only 700 opiate addicts in the entire country (Brecher, 1972,121). In 1951 a similar report estimated 301 addicts *(Ibid.,122)*. Right up until the 1960s, the British system managed to avoid a serious criminal problem with respect to the supply of opiates[6].

In the 1960s in Britain, however, a rise in the incidence of opiate use by young people was attributed in part to excessive prescribing by doctors, and the Second Brain Committee, convened to consider this matter, recommended that the rights to prescription of heroin be taken out of the hands of the medical profession as a whole and be restricted to a limited number of licensed doctors[7]. The Committee referred to the drug problem as a "socially infectious condition" and its recommendations were consistent with public health procedures (Interdepartmental Committee on Drug Addiction, 1965). Licensing was restricted to doctors attached to new Drug Dependency Clinics (DDUs) which were developed almost solely as a result of absorbing those "misusers who had previously been maintained by general practitioners" (ACMD[8], 1982, 26). The DDUs consisted of clinical teams with consultant psychiatrist, other medical staff, social workers, nurses, psychologists and clerical staff. Methadone prescribing, either for the purposes of detoxification or maintenance, was provided and it tended to be related to patient attendance for counselling and urine monitoring.

During the late 1960s, heroin users were concentrated in the Greater London area with the result that most specialist services developed in this area with little or no provision elsewhere. By the early 1980s, many drug users living elsewhere self-referred to general medical and social services where they would receive either minimal treatment,

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[6]Schur (1964, 80-1) in his examination of British drug policies up until 1959 commented: "This writer knows of no evidence, or comon-sense argument, refuting the assertion that low-cost and legal provision of drugs (as in Britain) inevitably curtails illicit traffic. Conversely, it is clear that current American policy cannot achieve its stated aims."

[7]The implementation of the new changes are discussed in Phillipson (1970).

[8]Advisory Council on the Misuse of Drugs.

counselling or advice, or, be referred on to a specialist service (not always locally available). Furthermore, because the specialist services were set up essentially to deal with the heroin (or opiate) problem they did not develop a comprehensive brief in relation to problem drug use in general with the result that many drug users, who did not use opiates, received but a minimal service, if indeed, such a service was available.

In considering these problems and difficulties, the report of the ACMD (1982) recommended two major shifts in the area of treatment and rehabilitation of drug users. Firstly, the report suggested a shift away from focusing on a "substance or diagnosis" approach towards a problem-focused approach. The report introduced the term problem drug-taker, by which it meant "any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)" (ACMD, 1982, 81). Strang (1989, 144) comments that this shift "resulted in a more appropriate approach to the task of responding to an individual drug-taker's problems". The second important shift recommended by the report was to increase the involvement of the non-specialist services in the drug problem, especially the "statutory services concerned with social support, including social work and youth services, housing and employment agencies." (ACMD, 1982, 82)

The new approach reflected, to some extent, the perspective of the labelling theorists that drug users were not all that different from non-users and that their problems did not necessitate separate services. Thus, as Strang (1989, 148) points out:

> Psychological problems may require intervention from a psychologist or social worker or may be best helped by the sympathetic ear of a relative or friend. Social problems may well be similar to those already being tackled by housing departments or citizens advice bureaux. Legal problems may be

related to drug-use but here again the provision of help to the individual need not necessarily be separated from the provision of this service to the general population. In all these areas, some extra knowledge of the drug field may be required by the pre-existing generic services but it need not involve a major change in their daily work.

At the time this report was published in 1982, the new wave of heroin use in the UK had not become apparent, nor indeed had the more serious, from a public health perspective, problem of HIV. The new shifts and emphases in the ACMD (1982) Report were later teased out at a time when the magnitude of the presenting problem was by far greater than that anticipated at the time the Report was being drawn up[9]. In time these changes were to place even greater public health demands on drugs services. The Advisory Council's report on drug use and HIV[10] (ACMD, 1988,17) emphatically concluded that "the spread of HIV is a greater danger to individual and public health than drug misuse." In some respects, new developments - assisted perhaps by what Stimson (1990, 124) refers to as a "rare" consensus among government, administrators and practitioners as a result of HIV - accelerated the process of change which was required. At the centre of what was to be changed was the dominance - through the 1960s and 1970s - of a medical/specialist model of drug treatment and rehabilitation. Within the operation of this model, the role of the non-specialist was one of referring-on to the specialist, if one existed, a process which in fact reinforced a view among non-specialists that drug work was indeed, a job for the specialists. The introduction of a more generalist approach required that the Drug Dependency Clinics discard many of their specialist procedures and adopt a more integrative model of work with non-

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[9]Indications of the increase in the UK's opiate problems are provided from a study by Glanz and Taylor (1986) on the involvement of GPs in the treatment of opiate using problems. This study highlights an increase in first-time notifications of drug users - as a proportion of overall number - from 29% in 1975 to 49% in 1980 and 55% in 1984. On the basis of the survey, "an estimate of 44,000 new cases of opiate drug misusers consulting GPs in 1985-86 has been produced" (MacGregor and Ettorre, 1987,128).

[10]Human Immunodeficiency Virus which is responsible for Acquired Immuno Deficiency Syndrome (AIDS).

specialists. As Strang (1989, 151) has pointed out "The avenue of referral has become a two way street". In his review of the changes that were brought about in the North Western Regional Health Authority area of England, Strang points out that these were achieved through a "re-negotiation of priorities of service provision(and funding)" and a "trusting collaboration" between a wide range of statutory and non-statutory services - both specialist and non-specialist, even though some of these agencies embraced "clashing ideologies"(*Ibid.*, 146,168/9).

Whatever about making the adjustments to an increased involvement of non-specialist services, the changes in the nature and context of the drug problem which occurred in the UK throughout the 1980s, required that the specialist services develop some *modus operandi* to enable them integrate their efforts with localised, community interests. Whereas, previously, communities had little direct interest in the drug problem, the scale of the heroin epidemic among youth within disadvantaged communities throughout the UK in the 1980s[11], demanded a localised response. While these responses have taken a number of forms they share the common outcome that the community now has a greater interest in drug treatment policies and practices. In holding that the drug problem is a community problem, community groups have requested a wide range of local agencies to respond to it. The choice for specialists is whether they become part of these new arrangements or isolate themselves from what are inevitable developments. As Burr (1989, 96) commented:

> ...the involvement of other institutions in the drug field has begun to erode medical authority and domination of the drug problem, even though local DDU consultants are so powerful.

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[11]See Pearson (1987).

Irish Experience

The Irish experience of problem drug use is relatively new. Prior to the late 1970s, the heroin-use problem was negligible. In the 1960s there were drug problems involving the use of amphetamines, barbiturates, cannabis, LSD and some pharmaceutically prepared opiates and while in 1971 it was reported that the Gardaí knew of almost 1,000 drug users there was no concern in relation to the "illicit supply of heroin" (Government Working Party on Drug Abuse, 1971, 9). However this situation changed dramatically within a decade and in the period 1979-83 Dublin experienced what is now known and referred to as "The Opiate Epidemic" (Dean *et al,* 1985). It is generally accepted that the period 1977-9 showed significant increases in the availability of heroin in Dublin, increases that were the result of both changes in international market supplies and the involvement of criminal elements in its distribution in Dublin, as well as increased demand.[12] Demand for heroin has been concentrated in those areas of Dublin which are characterised by high levels of unemployment, low quality housing and general indicators of poverty (Department of Health, 1991; O'Hare and O'Brien, 1992)). In the early 1980s therefore, the nature and extent of Ireland's drug problem - itself a relatively new phenomenon - underwent major change. Whereas previously drug users were a separate subculture using mainly cannabis and LSD, the new cohort of opiate users - most of whom were using heroin intravenously - came in large numbers from the mainly disadvantaged, impoverished communities of Dublin city.

In October 1969, the National Drug Advisory and Treatment Centre (NDATC) was established at Jervis Street Hospital, Dublin, initially providing an outpatient psychiatric and social work service to drug users, while limited in-patient facilities,were later provided in the main hospital. The NDATC - a prefabricated outpatient building on the

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[12]For a full journalistic account of criminal involvement in drug dealing see Flynn and Yeates (1985).

site of a city centre general hospital and with nine inpatient beds on a separate psychiatric ward in the same hospital - was modelled on the Drug Dependency Clinics in London and emphasised detoxification programmes leading to psychotherapy. A small number of opiate addicts, of whom there were very few at the time the centre was set up, were maintained with methadone (Harty, 1975) but this practice was discontinued in the late 1970s, except in the case of pregnant women, who were maintained for the duration of their pregnancy and for a short period afterwards.

The NDATC became the specialist drug service for the whole country. In other psychiatric hospitals, no special arrangements for dealing with drug addict admissions were made (Department of Health, 1984). The general expectation was that drug users who became known to any of the statutory services -hospital, psychiatric, general practice, or community care - were referred on to the NDATC. Staff in the NDATC were not involved in providing services in community locations nor were they linked into the Eastern Health Board's Community Care Programme structure. On a practical level, NDATC social workers did not do home visits, but rather they operated on the basis of providing a centre-based counselling service (Law, 1972). Drugs abstinence was the primary drug treatment ethos of the NDATC and this approach was quite embedded in the centre by the time of the opiate epidemic in the early 1980s. A prior commitment to a drug-free lifestyle was expected of attenders and the use of methadone in the centre was solely for the purposes of controlling the symptoms of physical withdrawal[13]

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[13]According to a centre spokesperson in 1982, new referrals must:."....prove that they have some form of motivation and commitment to give up using heroin before we will take them on. We generally ask them to prove their sincerity by coming in and giving a series of urine tests.....Methadone is the drug used to control the symptoms of physical withdrawal.....A lot of people come in here hoping they'll get it, and a lot don't, because we don't consider them properly motivated.....we will offer methadone to a *small number*, who we consider well-motivated, on an outpatient basis. That means that they have to come in here every day, give a urine sample and drink their methadone here in front of us. So it's controlled and supervised, and the agreement with us is that they don't take drugs on the street while they're on this treatment. We will reduce them by five milligrams every second day until they are drug free. That renders them physically drug-free, but it does n't mean they're *cured*. The psychological addiction is so deep that it needs long term supportive counselling (Kilgallon quoted in Raftery, 1982,22) *(Italics added).*

The NDATC developed close working relations with the Coolemine Therapeutic Community (Coolemine) which was set up in 1973, and encouraged its own patients to go there for residential rehabilitation. Coolemine was set up mainly through the efforts of Lord Rossmore and two ex-addicts who had graduated from Phoenix House Therapeutic Community in London. Coolemine requires prospective residents to make a firm commitment to remain drug free before acceptance on its programme, a programme which emphasises a process of psychological restructuring whereby a resident's personality is reshaped from addiction-prone to one where a return to drug use is unlikely[14].

Residents completely immerse themselves into a community lifestyle which emphasises self-discipline and peer support. The structure of therapeutic communities is quite rigid. Daily routines are organised around work schedules, rotas and a system of punishments and rewards. Behaviour modification is the basic therapy. Desirable behaviour is rewarded with privileges - the main privilege being the opportunity to move up the status hierarchy. The new member starts off as a crew member in the hierarchical structure and progress upwards depends on commitment and performance. Promoted residents may become Heads of Departments - cooking, maintenance and administration - or expeditors and coordinators responsible for the "functional needs" of the community and the "emotional needs" of residents, respectively (Coolemine Therapeutic Community, 1983). If a resident is perceived as docile or uncommitted to the programme, previously awarded priviledges may be removed or they may be assigned to the least desirable work routines - the "Dishpan" (Delaney, no date). They may also be required to face their peers in an encounter group during which they may be shouted at, ridiculed and confronted with the reality of their former lifestyle - "negative values, acting out, hostility, distrust and drugs" (Coolemine Therapeutic

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[14] A pamphlet from Coolemine explains this approach as follows: "The primary psychological goal is to change the person's negative patterns of behaviour, thinking and feeling that predispose drug use; the main social goal is to develop a drug free lifestyle.....healthy behavioural alternatives to drug use are reinforced by commitment to the rejection of drugs, the creation of an anti-drug culture, to viewing drug-use as a cop-out" (Coolemine Lodge Therapeutic Community,1983).

Community, 1983). Residents may also be degraded following rule infractions, and this may include having their heads shaved or the wearing of self-deprecating signs. Many of these latter activities have in recent years ceased in Coolemine.

Therapeutic communities acknowledge the importance of the social context in which an individual uses drugs and the programme is concerned with changing the social context. This change however does not take place within the social system surrounding the drug user. Rather the drug user is removed from the social system - "resocialised" *(Ibid.)* or as Rosenthal (1980) puts it "reterritorialised[15]". In a sense, the emphasis of the programme is to remove the addict from the "slum-like" conditions. (McGarry quoted in Raftery, 1982). In the midst of this "slum", "vocational and educational problems are marked; middle class mainstream values are either missing or unachievable" whereas the therapeutic community provides addicts with the opportunity for the "development of a socially productive, conventional lifestyle for the first time in their lives" (DeLeon quoted in Peele, 1989)

Coolemine received support from the the Special Hospitals Programme (Psychiatric) of the Eastern Health Board which was mainly instrumental in securing a premises for the programme. It also provided part-funding and the remainder was raised through voluntary fund-raising. By 1975 there were nine residents in the programme and a staff consisting of three ex-addicts and a social worker. The Programme also had the back-up service of a consultant psychiatrist. In its early years the Coolemine ethos derived from a liberal reformist mould and reflected a philanthropic interest in drug problems which had originated in London in the 1960s. By 1979 the philosophy of Coolemine was increasingly deriving its influences not from therapeutic communities in Britain, or

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15 Rosenthal (1980,105) elaborates on this approach as follows: "In reterritorialising the addict the effort is directed towards locating him in a more drug free environment.Treatment programmes must compete successfully against the addictive social system of which its members were originally a part. This is accomplished through the construction of a new social landscape, and the reconnection of the addict with the community whose values and modes of operation are antithetical to the community within which he originally became addicted."

the general drug scene there - which as pointed out above was moving away from a substance focused approach to a problem focused one - but from the United States, where drug problems were still generally considered from punitive, drug control and medical control perspectives (Peele, 1989). Coolemine became closely associated with Daytop Village Inc - which manages a number of therapeutic communities in the US - and utilised the latter's facilities for staff training and programme development.[16]

In the media the Coolemine approach was given a high profile and an opportunity to make claims such as: "The therapeutic community is the only real means of curing addicts .....All the others have been tried, and they don't work" and "Coolemine has a ninety percent success rate among those who complete the treatment" (Raftery, 1982). In 1983, Coolemine undertook a major expansion of its facilities and established a large community home in St. Martha's, Navan, which could accommodate in excess of 100 residents. However, due mainly to a reduction in statutory funds which was related to a fall in demand for Coolemine's services, St. Martha's ceased functioning as a community home in 1988.

The Eastern Health Board was also involved in setting up a Special Care Unit at its Psychiatric/Custodial Hospital in Dundrum. A basic behaviour modification programme, utilising tokens, was operated but it was reported as having poor success (Harty, 1975). This Special Care Unit functioned from 1971 to 1977. An Eastern Health Board adolescent, psychiatric day-care centre located at Usher's Island quay in the south inner city, was also utilised during the mid 1970s for the purposes of providing drugs advice and counselling services to young people who had behavioural problems, including problems with drugs and alcohol. The centre however found it

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[16]The following from a quarterly journal published by Daytop indicates the extent to which Daytop was taking a direct interest in the development of Coolemine. "Sam Anglin along with his wife, Maggie, were *(sic)* dispatched to Dublin in February 1981 to assume the Clinical Directorship of Coolemine and the dividends surfaced swiftly. A Coolemine graduate, Thomas McGarry, came to Daytop for training and under Sam's guidance will blossom before long into the Director's spot at Coolemine" (Anonymous, 1981,2).

quite difficult to deal with young people with severe behavioural problems. For others, it reported a number of successes (Harty, 1975). At a later stage, this centre became directly involved in providing, with the assistance of AnCO - National Industrial Training Authority - vocational training programmes for young people with mild behavioural problems. In relation to young drug users, these training programmes were particularly suited to those people who had only recently experimented with drugs and who had not become absorbed in a drug subculture.

Conclusion

In this chapter we have reviewed contrasting approaches to drug problems and policies in the US and UK and the emergence of drug problems in Ireland since the late 1960s. Although, initially, Irish drug problems were relatively minor, an opiate epidemic escalated dramatically in the late 1970s and was particularly prevalent in the poorer, disadvantaged inner city communities. At the outset of this opiate epidemic the two services which were at the centre of service provision were the NDATC and Coolemine Therapeutic Community. Although, developments in drugs policies in the UK indicated a preference there for community-based, generalist models of care involving social workers, general practitioners, counsellors, nurses and voluntary street-agencies, both the NDATC and Coolemine Therapeutic Community more closely emulated developments in the US and adopted a clinical, specialist, institutional approach to drug treatment They also opposed harm-reduction and problem-focused models of service. An important consideration in this study is whether and to what extent these services were both disposed to and capable of recognising and responding to the emerging problems of heroin-use in inner city communities. These matters are considered in later chapters in this thesis.

Chapter 3 - St. Teresas Gardens and social change

Introduction

As pointed out in the previous chapter 2, the drug problem in Ireland prior to the late 1970s was minor, relative to other Western countries, and in relation to the use of opiates, it was virtually non-existent. By the early 1980s however, such was the escalation of intravenous heroin-use in disadvantaged, inner city areas, that the problem was later described as "The Opiate Epidemic" (Dean *et al*, 1985). This constituted a major change in the nature and extent of the Irish drug problem; whereas previously the problem was minor, in the matter of a few years it had escalated to one where in inner city areas, the numbers involved rivalled the worst affected areas of New York (Dean *et al*, 1983), a city with a sixty year history of drug problems at the time. To develop a knowledge and understanding of the drug problem therefore, it is important to gain insight into the context in which this change took place. This chapter focuses on the social and economic context of St. Teresas Gardens in the years leading up to and during the escalation of heroin-use in the late 1970s. The chapter also describes the manner in which young people became involved in heroin-use and other related activities, the growth of a drug using peer group and the impact of this on local community life.

Background and history

St Teresas Gardens, a local authority-owned and managed flat complex, is located in the parish of St. Teresa which is part of the "ancient Liberty of Thomas Court and Donore and also known as the Earl of Meath's Liberty" (Anonymous, 1971). The estate has 350 two and three bedroomed flats, arranged in twelve, three story blocks, separated by fenced grass patches with a single entrance from Donore Avenue. The road from the entrance divides the estate, and leads down a 300 yard cul-de-sac to a

statue of St. Teresa. The estate is surrounded by the Coombe Maternity Hospital, Player Wills cigarette factory, football playing fields, the church of St. Teresa, Donore Avenue, and a number of terraced houses on Eugene Street.

St. Teresas Gardens was built in 1951 as a direct response to the looming accommodation crisis in Dublin. Many of the tenants came from the nearby tenements in the south inner city which were lacking basic amenities, such as running water, bathrooms and flush toilets, and had become uninhabitable. The new flats were comparatively modern and convenient - they were bright and spacious, and within walking distance of the Liberties shopping markets of Meath Street, Francis Street and Thomas Street. Their new residents were closely knit with many extended family interrelations. One resident recalled that despite, as a young child, sharing his new two-bedroomed flat with his mother, three brothers, two uncles, aunt, grandad, and grandmother: "everything was so big and open" and compared to his previous cramped accommodation he could now "stretch out and touch the walls[1]".

The early years of St. Teresas Gardens are generally described as having been happy, with a good community spirit. Local people speak of "the good times" when "front doors were left open" so "neighbours could call freely as they pleased" (Bowden, 1983,4). Many residents in recalling earlier days describe the community's social and religious events. During the Catholic feast of Corpus Christi the "flats were festooned with coloured bunting" and for the procession "everyone dressed up in their Sunday best" for an event that was as much an "excuse for a bit of gaiety and a children's party as it was a religious occasion" (Geoghegan, 1983,14). The physical state of the flats was good and regular maintenance was provided by Dublin Corporation caretakers, whose pride in their work was regularly rewarded with on-the-job cups of tea and "home-baked cake from appreciative tenants"*(Ibid.)*.

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[1]These comments were made to the author by Willie Martin a community activist in St. Teresas Gardens, during an interview in 1984.

Inner city decline

Despite the estate's relatively agreeable beginnings, it was greatly affected by the economic difficulties of the time. The nineteen fifties in Ireland were characterised by economic protectionism and stagnation, low economic growth and and a net outflow of both labour and capital. Ireland was according to Brunt (1988, 14) "the most sluggish economy in Western Europe". Many of the 400,000 emigrants who left during this decade were from the economically declining inner city, where traditional industries, once prosperous, were beginning to disband and close in competition with cheaper, mass produced imports. A particularly significant example in the south inner city area is that of weaving firms, the last of which, Elliots, eventually closed in 1972 exactly one hundred years after it first went into production (Breathnach, 1977, 98). Throughout the nineteen fifties many men from St. Teresas Gardens emigrated to Birmingham, Manchester, Liverpool and London, from where they sent money to their families at home. Some of the younger emigrants stayed away to start their own new families and today, particularly in Birmingham, they provide an important contact point for visiting families or new emigrants[2].

During the nineteen sixties, as the first *Programme for Economic Expansion* (1958) began to take effect, there was an increase in locally available jobs, which offered optimistic prospects to youngsters entering the job market, and encouraged others who had earlier emigrated to return and live with their families again. Indeed, the nineteen sixties was a period of relative prosperity, and perhaps the "happiest decade St. Teresas Gardens would ever know" (Geoghegan, 1983,14). Encouraged by a new optimism, a local tenant's association was formed, and many of its side benefits such as social clubs, sporting events and dances were organised.

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[2]In the course of this study the author has had informal discussions with a number of Birmingham-based St. Teresas Gardens born persons, both in Dublin and in Birmingham, during which their early years in St. Teresas Gardens were described.

As Irish industrial expansion took root its technological advances forced a contraction of employment opportunities for unskilled workers, particularly in Dublin. Although the city experienced rapid commercial and industrial development and an increase in its workforce, the skill profile for jobs, especially in the city centre, was changing, and entrance to new positions increasingly depended on evidence of educational or technical qualification[3]. While the expansion of education provision following the *Investment in Education* report (Department of Education, 1966) and the introduction of free education in 1968 had a dramatic impact on participation rates in second level education, it did little to encourage social mobility particularly among those whose traditional communal and familial work practices had required little if any formal education (Breen *et al*, 1990, 139)[4].

As unskilled jobs became fewer, the prospects of those who previously occupied them getting alternative skilled or semi-skilled employment in the newly developed industrial or white collar sectors were limited, if not virtually impossible. The new city centre jobs especially were professional, white collar clerical, and service. The educational profile of inner city residents did not fit the job requirements. One survey of the educational qualifications of Dublin adults found that despite free second level education, 77% of those living in inner city areas had attended only first level (McGreil, 1974). A survey of the skills background of one group - parents of children attending a local secondary school - from a south inner city flat complex found that 90% were

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[3]In discussing trends in Irish class structure across the period 1951-1979 and using the distribution of class categories from successive Census of Population figures, 1951-1979, Rottman and O'Connell (1982, 72-3) have observed a "shift in the balance in the employed workforce from semi-skilled and unskilled labour toward white collar and skilled manual work". Using 1971 Census of Population figures and statistics from a Higher Education Authority report on new University entrants 1979/80, they also argue that the "educational accomplishment" required to obtain the new job opportunities in white collar and skilled industrial employment was achieved disproportionately by the middle classes, and achieved little social mobility.

[4]A 1981 report from the National Economic and Social Council (NESC) on problems of growth and decay in Dublin, commented on the seriousness of this situation, as follows: "While the low level of educational achievement in the Inner City has serious implications for employment opportunity, a more critical factor is that such levels tend to be self-perpetuating. A child is educationally disadvantaged from the beginning where there is a low level of parental education" (NESC, 1981,188).

unskilled and 46% were unemployed (SCARP[5] - cited in *Hibernia*, 26/4/79). With a decreasing inner city population[6] there was a fall-off in the numbers attending local schools. Statutory grants to schools are based on a capitation fee with the result that in the inner city there were a number of large schools now with fewer pupils, but which had the same maintenance and other fixed costs as when the pupil numbers were greater. This situation tended to undermine the local school's status and functioning and there was an inevitable weakening in standards which reinforced a picture of further educational deprivation[7]. In the secondary school survey referred to above, over half the children surveyed had been referred for psychological assessment and 78% were at least one year behind in their reading ability *(Ibid)*.

This situation of declining inner city employment and lack of local skill was further exacerbated by the relocation, through rationalisation, of existing industries from their traditional base in the inner city to new sites in the suburbs (Dublin Corporation 1975 land use survey, cited in Joyce and McCashin, 1982, 88). In the south city area Powers Distillers was lost to Midleton in Cork, Jacobs biscuits manufacturers went to Tallaght and Dockrells timber yard moved to Clondalkin. Guinnesses brewery reduced its workforce and other industries, including O' Keefes knackers yard, which at one stage employed over two hundred people, and Monegues clothing factory closed down altogether (*Hibernia,* April 26, 1979). In 1979, one of the gravest blows to local employment came with the closure of Donnelly's sausage factory, one of the factories close to St. Teresas Gardens, and which had a workforce of nearly 300. At the time,

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[5]South City Area Resources Project

[6]While the Irish population grew by 3% in the period 1966-71 the population of seven district electoral divisions in the north inner city declined by 15%. The population of Dublin County grew by 31% over the same period. In south inner city electoral wards surveyed by the Combat Poverty Project there was a 16% drop in population between 1971 and 1979 (SCARP, 1980).

[7] In 1978 the Chief School Attendance Officer for Dublin Corporation, quoted in the *Irish Times* described education in Dublin's inner city as a "fraud": "Its a fraud that's all. We're conning the kids. We tell them if they come to school we'll give them an education and that they'll be something. But they won't. Its hard to realise that when you ask a youngster down here what is he going to be he probably won't know what you mean. What is he going to be? He's not going to be anything. We don't educate them properly, and even if we did we can't offer them jobs. Yet we raise the school-leaving age and keep them - for what? Its a fraud. They know its a fraud and when people are defrauded can you really be surprised when they get vicious" (*Irish Times*, February 10 1978).

community workers commented that its closure wiped out "with one stroke" the IDA's overall programme for the Liberties, a reference to the government supported plan to set up a small manufacturing business estate in the area with an estimated 200 new jobs (*Hibernia,* June 21, 1979).

In the south inner city the unemployment rate for both sexes in 1971 was estimated at 9.7%[8]. The estimate for the same area in 1977 had increased to 15.5% and unemployment was considered to be heavily concentrated in the corporation flat complexes of St. Teresas Gardens, Dolphin House, Fatima Mansions, Bride Street, Iveagh Buildings and Oliver Bond House. Fifty nine per cent of those unemployed in these areas were unskilled.[9] Overall, the picture which emerges of the inner city during the post-Economic Expansion era is one of general decay and decline. A National Economic and Social Council Report summarised the situation as follows:

> Dublin's inner city can then be seen to have a declining population base with a contracting job market for the less skilled, and to have contracting sources of income from the 'formal' economy. The housing stock is relatively old, decaying and often overcrowded, located in a deteriorating environment, affected by dereliction, blight, threats of motorway expansion and the ever present conflict of commercial versus residential uses. With severe land use competition, threats of redevelopment, obsolete industrial capital, deteriorating schools and an ageing physical infrastructure, the area is poorly equipped to provide for the general needs of its long term and low income residents (NESC, 1981,198).

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[8]These figures are based on an analysis of Census of Population 1971 conducted by SCARP (1980).
[9]Figures compiled by SCARP(1980)

Effects on young people

The effects of growing unemployment in St. Teresas Gardens were, throughout the 1970s, most apparent among the youth. These were the children of the 1950s and 1960s, the first significant cohort of young residents to experience their teens in the relatively new flats complex. Unlike their parents, these young people had grown up with experiences of TV, widespread consumerism and their expectations, in terms of employment, life experiences and material possessions were, to say the least, different from their parents. The key experience of employment however was not available to many and in the early 1970s some of these became significantly involved in petty crime - car theft, house breakings and factory theft. Some grouped together in small gangs and engaged in anti-social activities[10].

In essence the youth problem did not belong solely to St. Teresas Gardens and reflected the traumas of a generation who were reaching school-leaving age with few prospects of work during a period which was deeply affected by economic recession and international oil crises, by a lower demand for what had become an increased labour supply, and by high unemployment. The problem had structural causes and in the absence of policy measures with the capacity to redress these, other measures whether inspired by local frustration or institutional concern, had little possibility of long term success.

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[10]These activities prompted the following statement from the St. Teresas Gardens Tenants Association, in the local *Donore Newsletter* in 1971: "The tenants in general are very dissatisfied at the way the youth hang around the launderette and the chemist's shop. They have broken steel grids on Mr. Moore's *(chemist)* window. This has got to stop. It has been decided that members of the Association will police the flats every night until the trouble is stamped out. People will have to be allowed to enter and leave the flats either walking or in cars without being molested in any way. The specific age group at the moment seem to be 11-14" (St. Teresas Gardens Tenants Association, 1971).In May 1973 the same newsletter reported that telegram boys making deliveries into the area were beaten up and had their motorbikes taken (Anonymous, 1973). After a succession of such robberies they refused to do deliveries. For a time some general practitioners feared visiting patients in the community, the problem of car theft was so rife. Members of the tenants association engaged in further patrolling but these only ever had a short term impact on both the activities of the youth concerned and their increasing numbers.

In the absence of policies and measures for the creation of local employment, many young people nonetheless desired a share of the cake they had understood - through TV and consumer marketing - was there for them to take. Criminal activity provided finance, thrills, excitement and the status of having something to do and a reputation to defend. For some of these the pattern of small time criminal involvement may already have been initiated since boyhood days of robbery and schooling in Reformatory schools[11]

The lifestyle of the young person caught up in small-time criminality consisted of robbery, car theft, joyriding, cider and hash parties, court appearances and prison sentences at the end of which the pattern is often repeated. What is significant for these young people is that at a crucial stage of their development - that of choosing a career and lifestyle and formulating an identity - criminality is perceived as a viable option[12].

The growing youth problem focused attention on the need for youth services in St. Teresas Gardens and other nearby communities with similar difficulties. The Donore Boxing club, which has had tremendous success over the years,[13] was set up in the

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[11]One account of childhood in St. Teresas Gardens by a person who later became a problem drug user is put as follows: "I remember when I was about 8 years of age, my older brothers were in Artaine (*Sic* - Artane Reformatory School) I do not remember my father when he died, as I was very young. I was very confused and missed my older friends. I got into a lot of trouble by not going to school. We often went into town and stole sweets from shops, that led to bigger things. I ended up being caught and brought to court. I was sentenced to five years in Clonmel by Justice Kennedy. I did not learn much in Clonmel (Clonmel Reformatory School). I was released in 1975. When I came home I was sent to Bull Alley Teck (*Sic* - Liberties Vocational School). They refused to take me in because of my background. I started robbing again. It was like a job to me. Another year went by. I was caught robbing once more, this time breaking into a shop. I was brought back to court and received two years probation, which I did not keep" (*The Gardens*, October, 1983).

[12]The *Out in the Cold* report published in 1979 outlined this situation for young people as follows: "Having left school and being unemployed means for many young people that they have no secure role or identity. Membership of a gang can provide some sort of identity and, for the young adolescent, can be a means of bridging the gap between childhood and adulthood.

"The street gangs in NCD *(acronym for section of Dublin city where field research was conducted)* are usually very locally based, on a street or block of flats, and on age groups. Most of these gangs have an informal structure and in their own way socialise their members.

"In more favourable circumstances, their energies might be channelled into team games and socially harmless activities, but in the circumstances of NCD, many of the activities of these gangs are delinquent and land the members in the juvenile court (HOPE, 1979).

[13]In a *Sunday Press* newspaper article written by journalist Colman Cassidy in February 26, 1984 - the main focus of which was a forthcoming Concerned Parents Against Drugs (CPAD) march (see Chapter 6) the following piece was inserted in relation to the Donore Boxing Club: "here up to 30

early seventies as a direct response to the needs of youth. A large youth centre on the grounds of the local church was completed in 1972. The raising of money and the building of the centre concentrated the energies of many who believed in local community and youth work. According to the local newsletter, the centre represented the "hopes of all who work for the unity of the parish"(Anonymous, 1971). Ironically the centre's completion highlighted the complex divisions in the whole parish of Donore and exposed the different assumptions parish members had in relation to class, religion, sex and youth. It was seemingly alright, to form Ladies clubs but not discos for young people; youth clubs tended to be organised by the people in the houses for the people in the flats; and while there was a broadly representative management committee its decisions could be vetoed by the parish priest. This latter point in particular was resented by people from the flats who had contributed financially, or otherwise raised finance for the building of the centre in the first place. A meeting between the St. Teresas Gardens Tenants Association and about twenty five youths, aged 16-20, who hung around corners, heard that the youths "were refused permission to the Boy's Club - also the youth centre" for the reason that neither centre "caters for this age group" (St. Teresas Gardens Tenants Association, 1972). In the continuous conflicts between different factions seeking use of the centre nobody won out and the centre became run down in a matter of a few years[14].

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young turks aged 9 to 13 gather, most nights trained by Karl Geraghty and Derek Mallon, who give of their time three or four nights a week to train the youngster. Geraghty like one of the two senior trainers, Bernie Bracken, comes from Drimnagh. Another senior trainer, Tony Mahon, a former ABA champion in far-off days in London, puts the bantam weight, Bobby McCarthy through his paces. There are great hopes held out for him says trainer, Mahon, who works on him along with Mick Dowling, the former European silver medallist. McCarthy however, is a relative newcomer. The real heroes for the young kids who work off their aggression in this pugilist's den are Noel Reid and Noel McEvoy. There's a great atmosphere within the club which seems to symbolise the spirit of the entire community: St. Teresas Gardens is fighting for its very life".

[14]The St. Teresas Gardens Development Committee (STGDC) which was set up in 1978 (see chapters 5 and 6) expended a lot of effort in its first two years trying to negotiate access to the Youth Centre with the local clergy. The committee wanted to use the Centre as a venue for a teenager's disco a suggestion which was strenuously resisted by the then parish priest. Eventually, with a change in the parish clergy in 1980, the STGDC got the use of the centre for both discos and a variety of other community activities.

Low-Demand Area

Throughout the 1970s many of the people from St. Teresas Gardens who either had employment or who had the skills and education to actively seek employment, moved to where the jobs were in the suburbs. The community lost many of its older, reliable tenants. As more people moved out, the vacant flats were designated 'low demand' and became increasingly run down, housing "residual populations" who were "on the lowest incomes with a high incidence of economic and social failure" (Joyce & McCashin, 1982). The estate, at the time hardly thirty years in existence, and like others similar to it, had become a "dumping ground" for squatters or tenants Dublin Corporation found difficult to house elsewhere. The increased concentration of families on low income had - according to one Dublin Corporation official who attended a meeting of community workers, social workers and clergy in 1972 - made social problems "insoluble" (Anonymous, 1973). At the same meeting, a tenants representative outlined the difficulty of "reasoning with troublesome families" a reference to new squatters, some of whom had a lot of criminal involvement. Many of the new tenants had not sufficient points for houses in the area of their choice.[15]. Some believed that if they spent enough time in St. Teresas Gardens they would eventually build up sufficient points to move. In a two year period 1980-81 over one third of the flats in St. Teresas Gardens were vacated and let to new tenants[16]. Gradually, the community was becoming a transit area, where many families "did time" before they moved on to a house elsewhere[17].

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[15]Points are granted to persons applying to the Local Authority for a new tenancy or for transfer to a different tenancy. The points are allocated on the basis of different criteria such as existing accommodation facilities and space, numbers in family, location of work, area of origin, medical or exceptional social circumstances. Different sets of points are allocated according to the applicants' first, second and third choice of a geographical area in the city. The amount of points sufficient to get a tenancy in any one of these areas depends on the number of housing units either being built or being vacated in these same areas. A low number of points could suffice for a tenancy in an estate that is becoming rundown, a moderate number of points for a new estate, while a large number of points would be necessary for an area that is older, well developed and relatively stable.

[16]These figures were provided by Dublin Corporation to the author in 1982 following a direct request.

[17]Bowden's (1983,5) account of of the "open area" policy describes its origins and effects as follows: "The more apparent signs of crime were highlighted by the numbers of kids who joyrided *(sic)* in stolen cars and who stole ladies handbags. People gave up their confidence in the area and wanted to move out.

There was also a decline in the level and quality of local maintenance provision, and the exteriors of the flats and communal areas became run-down. The once proud relationship of both tenants and caretakers to their physical environment was replaced by one of indifference. During an industrial (go-slow) dispute between maintenance workers/caretakers and Dublin Corporation in 1979 there was a build-up of uncollected refuse over a period of seven weeks. Eventually, frustrated with being caught in the centre of the conflict, the tenants dumped their rubbish onto the road in Donore Avenue. During this protest the Gardai were called and there was an incident in which three gardai were injured and a patrol car badly damaged. The incident highlighted the growing tensions between the local population and Dublin Corporation and prompted the Gardai to comment that the conditions people were living in were "intolerable" (*Evening Press,* May 9, 1979). The general deteriorating state of the flats became most visible in the condition of the statue of St. Teresa. Previously this statue was regularly looked after, cleaned, painted and kept with flowers and plants. By the late 1970s it had become unkempt with overgrown surroundings and graffiti sprayed on its back.

The pattern of structurally good quality inner city flats becoming run down and unstable was not unique to St. Teresas Gardens. An article in a community magazine *Liberty People* in December 1978 described as "farcical" the situation whereby squatters in Dublin Corporation's "open areas" are upon eviction almost immediately rehoused in another "open area". An article on the estate, Oliver Bond House, in *Hibernia,* April 24, 1979 referred to the fears of local residents as a result of this policy while a

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Police activity was stepped up almost every night they chased stolen cars at high speed through the flats. The media sensationalised stories of joyriders and crime in the area. The end result was that people wanted to move because they had no confidence in the area. The first people to start moving were those who had tried to restore some sort of order. These were the leading members of the tenants association. This gave the corporation a chance to move people in to the area. A chance to get rid of some of the families who were urgently looking for housing. Those people did not want to live here. They had no pride, no feeling of belonging and did not want to stay. Some were unstable people with domestic problems. This created a feeling in the community that it was now at a point where there was no return - no return to those days when your neighbour was your friend and your lifeline in some cases. The area was not accustomed to having unstable families.

"Crime increased and people were even more apathetic and sought transfers. To this day this open area policy, although its existence is denied by the corporation, is in full operation and now a hard vicious cycle. How therefore is it possible to build a stable community if people are constantly on the move?"

programme on RTE's *Today Tonight* in January 1981, about the Fatima Mansions estate, also focused on open areas and asked the question whether Dublin Corporation was engaged in a policy of deliberately running down such communities? On the same programme Dublin Corporation denied there was any such policy.

The heroin problem

Throughout the early to mid 1970s there was a major increase in armed crime in Ireland much of which can be attributed to Dublin based criminals who wished to repeat the IRA's success in using bank robberies as a source of revenue. In the mid seventies the government responded by declaring a National Emergency and introduced new stringent security measures which included the provision of army convoys for bank shipments. Armed bank robberies became too risky for Dublin criminals and by the late seventies they were looking for new opportunities for criminal activity, and drug-dealing became a convenient outlet.[18] Prior to this period, organised drug-dealing was virtually unknown in Ireland (Government Working Party on Drug Abuse, 1971). There were numerous small-time groups usually consisting of 4-5 people who would pool their resources to purchase drugs on the London market. On returning they would keep a supply for themselves and sell the remainder, among known contacts, for a relatively small profit. The drug most commonly imported in this manner was cannabis but there was also a small demand for heroin[19]. However, during the late 1970s the cost of cannabis in London rose sharply while simultaneously large quantities of heroin of high purity and lower cost became more available (Hartnoll, 1985; Hartnoll *et al,* 1986). Some Dublin criminal gangs, particularly criminal families who previously were

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[18]For a background to these developments see Flynn and Yeates (1985, 17-26 and 46-57)

[19]These details are based on discussions with older drug users, not from St. Teresas Gardens, whom the author subsequently met through his work with the Ana Liffey Drug Project. At the time of these discussions, the drug users concerned had stopped using drugs for some time and participated in a number of focused discussions about drug problems and drug treatment services which existed both In Ireland and England during the late 1960s and early 1970s.

involved in armed robberies and who also had a lot of underground contacts in England and elsewhere, decided to become involved in drug-dealing[20].

Inner city communities like St. Teresas Gardens were wide open to these new ventures. Such communities had their young small-time criminal peer groups, their loosely organised receivers of stolen goods, consumers for these goods and a general resentment of law and order. These factors ensured that a level of criminal activity, which the community deemed to be acceptable, could continue unhindered. In 1977 a new squatter arrived in St. Teresas Gardens. He belonged to a criminal family which had been involved in armed robberies and was at the time he moved into St. Teresas Gardens, getting involved with drug dealing.

St. Teresas Gardens' new squatter very quickly set himself up as a local receiver of stolen goods[21]. . He offered good prices for jewellery, cheque books, credit cards and passports. He formed good relationships and the young people respected, admired and were indebted to him. They socialised with him, drinking alcohol and sometimes smoking cannabis. Such activities were socially and culturally acceptable for these

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[20]The following description of how these criminal families operate their drug-dealing is provided by Raftery (1982): "The gangs operate in roughly the following manner: Contact would be established with an international dealer, usually in Amsterdam, and the quantity and price decided upon. A courier or runner would then be dispatched to collect the heroin and bring it to Ireland. A high proportion of runners are women, as it is reckoned that women are less likely to be suspected and searched by a predominantly male customs and police force. The runner would usually be paid between £4,000 and £5,000 and at least four to five ounces of pure heroin, worth well in excess of £100,000, would be carried on each run. Most of it is brought in through Dublin Airport, and the risks involved are relatively small. Short of stripsearching everyone entering the country, there is little that customs officials can do.

"The heroin- which at this stage is supposedly pure (it is usually between eighty and ninety percent pure) - is then distributed to middle-men. It is stored in 'safe houses' around the city, where it is diluted or cut and divided into £10 packs. Cutting agents can include anything from talcum powder, milk powder and glucose to more dangerous substances such as barbiturates, amphetamines or antibiotics. By the time it reaches the streets, it can be anything between ten and thirty percent pure.

The middle-men then distribute the £10 packs to the sellers who are invariably addicts and would get one or two £10 packs for every ten or twelve they would sell.

"The higher echelons of the organisation have no contact with the sellers, who might not even be aware of their identity. As soon as the various transactions are completed, they will have the money brought to them. They are multi-millionaires. They do not take heroin"

[21]The details of events and activities in St. Teresas Gardens which are outlined in the following pages, are based on conversations with members of the St. Teresas Gardens Development committee, notes taken of meetings with drug users held during 1983-4 and various informal discussions held with other members of the community.

young people and there was nothing extraordinary in drinking, smoking and dropping the occasional pill, usually a barbiturate or an aspirin mixed with cider. In 1978 the new squatter introduced some of these young people to a synthetic opiate - normally used as a painkiller in the treatment of cancer - palfium. This particular supply of palfium came from the robbery of a pharmaceutical factory and the squatter, turned drug dealer, sold it at £2 a tablet. Many of the young people became dependent on the palfium in quite a short period. When they did, the drug dealer introduced heroin for snorting as a low cost substitute. Later again he withdrew the heroin and reoffered the palfium at a higher price. Many of the young people who were now quite drug-dependent, found it difficult to get the same euphoric effect with the palfium and began injecting it to compensate. As palfium tablets do not inject well in a solution, some young people developed abscesses. Eventually, most young people switched to injecting heroin which at this stage, in the late 1970s was being sold at a street market price of £10.

The young people were usually aged 15-17 years when they took their first opiates Some could not wait until they were old enough to use drugs - when they saw the older youth stoned they wanted to be like them.[22] As mentioned above, the youths were well used to alcohol, cannabis and pill-popping. They had also watched their older brothers and sisters engage in such activities and had no evidence that it could cause any extraordinary damage or difficulties - they usually grew out of it. They belonged to various gangs usually 10 or 12 in each, and had experience of petty theft, car robberies and joyriding. The latter activity was particularly popular for thrills before drugs took hold[23]. They would congregate in groups at the street corners, in back fields or down at the local bookmaker shop and pub on Cork Street. Inside the pub the drug dealer organised much of his activities - many of the youth would call to see him in the pub

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[22]A teacher from the Liberties Vocational School, in discussions with the author, reported that some childrens' writings expressed such sentiments.

[23]O'Kelly (1991) observed that it was noticeable that when young people began to use opiates the incidence of 'joyriding' went down.

and exchange various goods for cash payments. It was there that he first introduced them to palfium.

> He started to give us palf for nothing. When we got into the habit of taking drugs, he started to charge us 50p each. Then he started putting up the price. After a couple of months he took them off the market and introduced heroin (*The Gardens,* October,1983).

They would often sit in groups in the pub sharing their palfium tablets and spiking[24] each others drinks, usually when someone went to the toilet. It was common to spike the drink of someone who had not yet touched drugs - "just to get a reaction". In the early stages of this drug using activity many users never considered they were using a highly addictive drug and most would have definitely dismissed the suggestion that they were becoming a "junkie". Junkie was something they clearly associated with heroin users of whom, initially there were very few. Generally they used palfium because they enjoyed it. It was pleasurable and they continued to use it until the local supply ran out. The palfium was normally taken orally but later the young people began to experiment and eventually many were injecting. Injecting behaviour was learned, very much like the other behaviours.

> I mixed two palf and two dike together on my first mainline[25]. I did it with four friends in one of their places. It was their first time to mainline also. There was a chap that was with us who was on the gear[26] for a few years but he started getting involved with us because we were getting involved with the drugs. He showed us how to have a turn-on[27], what way to go about it. I just felt like my head was going to explode and afterwards when

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[24]Mixing a drug with a person's drink without his knowledge
[25]Slang word for intravenous injection.
[26]Slang word for drugs.
[27]Slang word for the act of taking drugs.

it settled into my system I felt great. And I said there's nothing to it I'll do it again[28].

While the supply of palfium in St. Teresas Gardens did inevitably run out, many of those who by then had a "habit" believed they had no option but to switch to heroin, snorting at first, but eventually injecting.

He just withdrew the whole lot for a couple of weeks. So I knocked up on his door and I said 'any chance of an auld palf' and he said 'we've none, but I tell you what, we have a bit of scag'[29]. I said 'what?' He said, 'a bit of scag - it's a lot better than the palf'. So I said, 'what's the story with this scag'. So he said, 'come on in and I'll show you'. He brought us into his gaff[30] and he said 'it's a tenner for this'. Ten pounds! So he shows us a little bit of paper half inch by a half inch and inside it a piece of brown powder and he says, 'there it is' and I says, you want a tenner for that! No way - you'll get nothing off me. I would n't give you twopence for it' So he says, suit yourself'. So I went down and I was thinking about it, and I called my other mate up. So he had a fiver and we went back up. So I says'what way can I take this' and he says 'you can snort it, you can skin pop it or you can mainline it'. So I remember the first words I said to myself was 'no fucking way - they're junkies'. I had a brother who was on it 5-6 years at that stage but it was never a known fact in our house. I remember me ma making the beds or something and she'd find a couple of syringes under the bed. But it never dawned on me that one day I'd be taking it. But I was that badly shaking for the snort, so I said 'fuck it there's my fiver'. The two of us went out with a £10 deal. We split it down the

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[28]Excerpt from an interview conducted with one drug user during 1984.
[29]Slang word for heroin.
[30]Slang word for home, house or flat.

middle and we snorted it and the hit we got off it was fantastic, great. So we started scoring the gear regular. And by this time he had a pusher working for him. Before long we were spending £30 a day[31].

By this time drug users had to support an increasingly expensive habit. Initially a "fix"[32] from palfium had cost £2 but heroin by this stage now cost £10. Many would start with a small daily habit of £20-30 and supported this with an extension of their small time activities such as handbag snatching, mugging, and shop jumpovers[33]. Different youths developed their own particular specialisms in small time crime. Some would be particularly good at robbing shops - concentrating on premises outside the area where they would not be known. Some were good "office-boys" - they would spend the morning going around office blocks dressed as a clerk with a folder and would rob handbags and cashboxes from unattended secretarial offices and cloakrooms especially at morning tea and lunch breaks. Others would rob elderly persons walking home at night. Indeed some would hardly rob at all and would spend their time either "mooching"[34] or supporting their habit through being a messenger for the drug dealer. As these youngsters engaged in more and more robbing, they had more and more money for their drugs and were increasing their habit as a result. It was quite common for them to build up a daily habit of £200.

They offered each other tremendous social and emotional support particularly in the sharing of drugs and needles. The fact that they constituted such a large group among their peers in the area provided them with a lot of security[35]. In St. Teresas Gardens the

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[31]Excerpt from an interview with a drug user during 1984.

[32]The act of taking a drug.

[33]A "jumpover" is a reference to some robbers' tendency to jumpover the counter in a shop in their efforts to steal cash.

[34]"Mooching" is a slang word for continuous begging activity.

[35]Preble and Casey (1969, 7) have highlighted the importance of lifestyle and relationships in the developing career of a heroin user. "The activities these individuals engage in and the relationships they have in common, in the course of their quest for heroin are far more important than the minimal analgesic and euphoric effects of the small amount of heroin available to them. If they can be said to be addicted, it is not so much to heroin, as to the entire career of a heroin user"

heroin users were immediately identifiable as the people who hung around on certain corners - they were the only group who hung around on these corners, and for any outsider they represented the single largest visible group in the community[36]. On the corners they now organised drug and cash exchanges, immediately enquiring of young strangers if they wanted to "score"[37]. Their numbers provided them with security and protection. They were not seriously challenged by any other group in the community for there was no other group in the community that was as visible or had similar numbers. Outwardly, this group of drug users projected a picture of people busily occupied in gainful activity and committed to this new lifestyle to which they had become accustomed.

Heroin-users in St Teresas Gardens had a high level of commitment to the heroin user lifestyle. The lifestyle provided its own internal self-supports - the daily social interaction of group members was built around securing funds for drugs, securing drugs, acquiring and exchanging information with other users on the sources of both, and sustaining interest and commitment to the lifestyle itself. They frequently spoke about giving-up drugs but rarely with much conviction. They poured scorn on the NDATC at Jervis Street, which many considered to be a place you went to in order to get free drugs even if this meant pretending to be giving them up. Their attitude to Coolemine was extremely negative. Many of these criticisms at the time had little foundation as only a few had any real experience of Coolemine. Most attitudes were based on rumours and misinformation - although some of the negative information was also based on fact - that was widespread within the drug-using community itself. They were extremely loyal to each other and to an organised criminal system on which they depended for drug supplies. This criminal system was understood to be violent. Drug users who failed to pay for their drugs or who otherwise defrauded their drug dealer

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[36]This point was repeatedly made to the author by a number of social workers, doctors and nurses who frequented St. Teresas Gardens on an almost daily basis during the course of their work.
[37]"Score" is a slang word for buying illegal drugs.

were punished with violent threats and beatings. Such drug users did not go around openly admitting this but their occasional bruised physical state lent credibility to the suggestions that they were beaten. At the head of this by now large drug-using peer group there was a small number of principal dealers who, if they used heroin themselves, never outwardly displayed this fact. They wore handsome clothes, loud expensive jewellery and drove around in large cars which were regularly changed. They were organised around a single family who were related by direct marriage to the squatter who moved in in 1977 and who by 1979 moved into an expensively refurbished house nearby in Weaver Square[38].

Now the principal base for drug dealing was two flats alongside each other in St. Teresas Gardens. Both flats together were known as the "pharmacy" and it was quite common for queues to form outside as drug users awaited their supply of heroin. The power, wealth and influence of the drug dealers was visible to the whole community so that the impact of the drug problem affected everybody - young and old, whether directly involved or not. It had a major impact on community life. Whereas previously people had learned, usually from their parents, that to cope with social problems they needed to depend on each other and share with each other, this new problem of heroin use was having the opposite effect of making people retreat from social contact and hide from their neighbours. There was a great deal of suspicion and an all pervasive fear of the unknown. As Paul Humphrey, a local community worker pointed out at a seminar organised by the Labour Party in the Gresham Hotel, in April 1984:

> Internally the people were so confused, so fearful, they could not trust each other. Without the trust that for so long had kept the community surviving, the heroin problem could only get worse (STGDC, 1984a).

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[38]Although, at the time, these drug users had the outward signs of wealth, most subsequently, lost whatever wealth they had accumulated and experienced profound personal and social problems.

In the midst of this widespread suspicion, people relied heavily on media images to understand the problem which they were confronting on their doorsteps at a time when it was virtually unknown in Ireland. Heroin conjured up images of black ghetto youths in an American city being pursued by a "Kojak" or a "Starsky" - it was always at a distance. It was to be feared because it was perceived as inherently evil and like many other evils no explanation was necessary. The media contributed to heroin's mystification. The problem was described in the media as the "heroin bushfire" (*Magill,* March 1984) or "menace" (*Evening Press,* January 29, 1982) controlled by "godfathers" (*Irish Independent,* October 16, 1982) "barons" (*Irish Independent,* February 27, 1984) and "peddlers of misery" (*Evening Press*, January 29, 1982). The story of newly-born babies being weaned from heroin taken by their mothers during pregnancy was a "bizarre horror" (*Irish Times,* December 12, 1981). One newspaper article described the work of a rehabilitation programme director as his "war on the needle" (*Irish Press,* February 3, 1982) while another was quoted as referring to some parts of the inner city as "disaster areas" and the only way to "break the cycle for young people" was to "get them out" (*Evening Press,* January 29, 1982). A government sponsored education, prevention, and information programme for teachers, school children and the general public became in media parlance a "new phase in war on drugs" (*Irish Times,* December 6, 1983).

In the midst of these "wars", "unbreakable cycles" and "disaster areas" numerous families came to realise that they too were affected. Such were their fears of the potential consequences of this emerging problem that for many the only response which seemed available to them was to deny its very existence. They tended to deny to themselves that a family member was using heroin. In some families a young son or daughter would literally rob the family of everything of value before they would eventually admit that it was being done for heroin. Paul Humphrey, adapting the war theme referred to above, described the impact of heroin in the community as being like invading forces occupying a country - "Heroin was the conqueror. The people were

conquered"(STGDC, 1984a). By 1981 there were 68 persons in St. Teresas Gardens using heroin, of whom 58 were under the age of 25 (O'Kelly *et al,* 1988)[39].

Conclusion

The overview of drugs policies in the previous chapter concluded that, at the outset of the opiate epidemic in Dublin in the late 1970s, drug treatment policy was dominated by centralised, institutional models as practised by Coolemine Therapeutic Community and the National Drugs Advisory and Treatment Centre. Essentially, these models view drug problems in individualistic terms. Persons with drug problems in St. Teresas Gardens - or anywhere else - had the option of self-referral to these centralised services. In this chapter 3 however, we see that drug problems in St. Teresas Gardens are not simply individualistic. These problems had emerged in a period of new and dramatic social changes, changes which underline serious structural problems in relation to poverty, unemployment, educational deprivation and community disintegration. The needs which are implied by these changes, arguably, lend themselves more to problem-focused treatment approaches - which were advocated in the UK following the publication of the Advisory Council on the Misuse of Drugs Report (ACMD, 1982) - and to other strategies which are focused on tackling local problems within a community dimension. As the above chapter highlighted, the onset of drug problems, quite apart from their effects on individual users, had a serious, demoralising impact on community life in St. Teresas Gardens. Not all community members however, retreated from these problems. As later chapters will show, a number of local people, in conjunction with health board community social workers,

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[39]The impact of heroin-use on the community is quite similar to that described by Burr (1989, 89): "Initially, most parents' knowledge of opiate dependency was derived from the traditional public stereotype of the apathetic 'junkie'; controlled by his craving for heroin and rapidly on a downward path to death, as depicted in films such as The French Connection. This influenced their attitudes to their childrens' opiate use, to addiction and to treatment services. Believing the 'junkie' myth, when they found out their children were on heroin, they generally panicked. Some, unable to face up to the problem, denied they were on heroin. 'I knew my boys were on it several months before I admitted it, but I couldn't admit to myself that things had gone so wrong' said one mother."

became directly involved in seeking appropriate responses to the problems in their midst. However, their initial representations in relation to these problems were not made with existing institutional services such as Coolemine TC and the NDATC. Rather, the focus of their efforts was within the framework of the health board's Community Care Programme which was virtually the only statutory agency with a physical presence and meaningful role in the St. Teresas Gardens community. The next chapter 4, will provide an outline of the health board's Community Care Programme and will give particular consideration to its policies and structures in relation to community social work.

Chapter 4 - Community Care Programme

Introduction

The primary mechanism for developing statutory responses to emerging social problems in the community is the health boards' personal social services within the Community Care Programme. It is within the realm of these services that a response to problem drug use in the late 1970s was anticipated by many health board employees, working on the ground in St. Teresas Gardens, by other professionals working in the community, and by local, community activists. However, at the time that problem drug use first escalated in St. Teresas Gardens, the local health board structures were relatively new and untried. Essentially the drug problem presented an opportunity to the health board to test the efficacy of its Community Care Programme in relation to new and unmet needs. This chapter considers the extent to which community social work services in the Eastern Health Board, during the years of this study, were adequately positioned and structured to respond to problems in the community.

Personal social services

Personal social services is a phrase used to refer "to all those social services, other than health, education, income maintenance, housing, which are directed towards meeting people's social support needs, usually on a community basis" (NESC, 1987, 28). They are services which are concerned with:

> needs and difficulties which inhibit the individual's maximum social functioning, *(his/her)* freedom to develop *(his/her)* personality and to achieve *(his/her)* aspirations through relationships with others; needs which have traditionally been dealt with by personal or family action...; needs for which we usually ascribe some individual responsibility; and needs which

call for a high level of adaptability in the helping process, rather than a uniformity of provision (Webb and Wistow, 1987, 238).

Such services are not as easily described as the main social services; they are an amorphous group of activities which, unlike health and education services, vary immensely according to the setting in which they operate, their target group, and those who are available to deliver these services, whether on a professional or voluntary basis.

Personal social services are usually, but not always, provided by social workers. Others involved in the delivery of these services include voluntary workers, youth workers, community workers, and parish-based religious workers. Statutory provision of personal social services is a relatively recent development in Ireland (NESC, 1987, 80). Prior to the 1960s, community based social services were virtually non-existent and such services as did exist tended to be organised within institutions and in isolation from the community (Department of Health, 1985, 6/7). Services for children, the mentally handicapped, the aged and homeless were, in the main, provided in institutions by state, religious and voluntary organisations with little or no contacts with families or communities of origin (Binchy, 1963, 172-9).

The development of community based social work services occurred during the 1960s with the founding of a number of parish and diocese based social service councils which "brought social workers into the community working side by side with volunteers and other professionals" (Department of Health, 1985, 8). However, as Irish society underwent considerable industrialisation and urbanisation through the 1960s, there also emerged, particularly in the Dublin area, new social problems which required a statutory input into the development of new services. This need for statutory involvement was highlighted by the work of the social service councils *(Ibid., 8)*. There are now a number of government departments and statutory agencies involved in

the provision of personal social services within the community. The eight regional health boards are principally involved, providing - through the Community Care Programme - social work and other services, mainly to families and children at risk within the community, but in some instances to other groups also, particularly the elderly[1].

Following the publication of the *Report of the Public Services Organisation Review Group, 1969* - known as the Devlin Report - the Department of Health was restructured in order that it become more responsible for general policy, planning and organisation, and less involved in the direct funding, administration and coordination of services. Apart from services not deemed suitable for localised management - medical research and health education - executive responsibility has been vested with local bodies, which since 1970 have been the eight regional health boards. These health boards were set up as a result of the Health Act 1970, and they took over from local authorities the responsibility of coordinating and managing the health services within their own catchment areas.

In 1971, following the report of the management consultants, McKinsey, new management structures were recommended for the delivery of health services which divided the work of the new health boards into three separate programmes, General Hospital Care, Special Hospital Care (psychiatric and mental handicap services) and

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[1]The local authorities are also involved with personal social work services. They employ welfare officers who provide a social work service to its housing tenants and particularly to Travellers. Dublin Corporation employs a number of School Attendance Officers who provide a welfare service to children not attending school. The Department of Justice Probation and Welfare Service employ probation officers who provide a social work service to persons on probation in the community and to prisoners. The Probation and Welfare Service also funds a number of voluntary organisations which provide back-up services, such as after-care residence and/or employment training for ex-prisoners, hostels for young offenders and specialist-counselling within the prisons. Comhairle le Leas Oige, a Dublin based youth service council, funds youth and community organisations to provide youth projects in disadvantaged communities. The Department of Social Welfare provides, on an annual basis, once-off grants to voluntary organisations involved in the provision of social services. Generally however, the main statutory involvement with personal social services rests with the Department of Health in relation to planning and policy-making and with the Community Care Programme of the eight regional health boards, in relation to their operation and delivery. Such proposals which exist for the long term development and expansion of such services lie within a Department of Health framework.

Community Care, each of which was headed by a Programme Manager. The Community Care Programme was primarily concerned with services that are "community based where local local knowledge and insight is of great assistance to their efficient administration and where constant communication and contact with the local population is essential" (McKinsey, 1970, 34). Health board regions were broken down into community care areas, each of which has a multi-disciplinary team of medical officers, public health nurses, community welfare officers, social workers, dentists, and other personnel, headed by a Director of Community Care and supported by a local administrative staff. This team it was suggested would "bring to bear on the problems of the family or the individual the concerted efforts of a team rather than the fragmented work of individuals from different services" (Eastern Health Board, 1974, 3/4). In the Eastern Health Board region ten community care teams were developed in 1974/75; eight of these are in Dublin and the remaining two are in Kildare and Wicklow.

Within the Community Care Programme's spectrum of health and welfare services, the personal social services constitute but a small part[2]. The development of personal social service within the Community Care Programme got off to a slow start in the early 1970s. Prior to the Community Care Programme, social workers were normally employed by voluntary organisations - usually social service councils which were at the height of their strength in the early 1970s. The 1970 Health Act did not lay down a legislative framework for social work services, although the early development of the Community Care Programme, as already mentioned, did seek to link health and social

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[2]In addition to personal social services, the Community Care Programme covers a wide variety of other health and welfare services. The range of community care services includes: preventive services - health education, immunisations, child health examinations and control of infectious diseases; primary health services - general practitioner and pharmacy services, home nursing and dental, ophthalmic and aural services; and welfare services - social work, income maintenance, home-helps and personal social services. In relation to the latter category of welfare services, the Community Care Programme also provides grants to voluntary organisations, under section 65 of the Health Act (1953), to provide additional services, including residential homes for children in care, child nurseries, meals on wheels and day centres for the elderly, and various other services for the homeless, and families at risk in the community (NESC, 1987, 28).

services together. In the early period of the health board's restructuring - that is during the period when there was no local community care structure - it made grants available to some voluntary organisations and parish committees to employ social workers, as an interim arrangement. Guidelines issued to the health boards by the Department of Health in 1973, in relation to the development of social work services, targeted three particular groups in need - children, the aged and the handicapped - for social work attention (Department of Health, 1985). These guidelines also suggested that health boards should appoint social workers for the purposes of advising local communities on the coordination of social services - statutory and voluntary. From 1975, as a local community care structure began to develop, there was an escalation in the direct employment of social workers. By 1976, there were nine senior social workers and 41 community based social workers employed directly by the Eastern Health Board, which by 1983 had increased to 11 and 76 respectively. The period 1974-83 can be considered as one in which there was a general increase in the employment of social workers, throughout the country (NESC, 1987).

Social work

Social work draws heavily from the social sciences, and unlike medical treatment, much of its practice concentrates on the self determination of need and the development of independence. A phrase often used to highlight the social work objective is that "it helps people realise their potential"(Vickery, 1977, 117). It is a vague statement but it is indicative of social work's ambiguity, for social work is often difficult to describe. In the Irish situation during the 1970s, these difficulties were compounded by social work's relatively new role and function in social service delivery. As pointed out previously, social work services were included in the newly formed Community Care Programme. Many of the other medical personnel who were also integrated into this new Programme came from a background of *already* providing public health care programmes, but from within a structure which had no social workers. Many health

board employees such as public health nurses and medical officers - who had previously worked for the local health authorities - found it difficult to comprehend the social work role[3].

At its most basic level, and within a traditional casework model, the social work focus is with individuals and derives from "the right of human beings to be treated not just as *a* human being but as *this* human being with his personal differences" (Biestek, 1974, 25). Social work identifies within any individual suffering social distress, those aspects of their situation which they themselves can control and manage, and assists the individual in making the necessary changes for restoring control. In assessing individual situations, social work tends to avoid the ascription of pre-conceived problem definitions and to engage in what Gilbert *et al* (1980, 64) describe as a "process of enquiry" and not a "label or taxonomy".

Important social work value considerations are that "each person has an inherent capacity and drive toward change which can make life more fulfilling" and that "each person has a responsibility for *(himself/herself)* and for *(his/her)* fellow human beings - including society" (Morales and Sheafer, 1977, 76). Within a social work approach therefore, there is a great deal of emphasis on client self-determination of need and joint decision-making between worker and client in relation to problem solving. Pincus and Minahan (1973, 156 & 165) have emphasised that people should only become social work clients when an agreed contract between them and the social worker has been established. The contract clarifies the aims of the social work intervention and the methods and approaches to be used. What the worker brings to the social work relationship is warmth, empathy and understanding of the client's situation. These are key aspects of social work intervention and are elaborated in detail by Gilbert *et. al.*

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[3]In a Profile of Community Care Area 3 (Eastern Health Board, 1978) social workers expressed concern that "other community care personnel appear unsure about the role of the social worker" and that they were receiving "inappropriate referrals".

(1980, 48/50) who stress that little can be achieved in social work if workers cannot identify with or demonstrate some affinity with their clients and their situations. Social work also brings to the helping relationship a knowledge of human and social behaviour and a skill in communication and interaction which facilitate the client's development of awareness, knowledge and decision-making.

Within the realm of community and social problems to which social work is applied, there exists of course people, including many drug users, who are perceived as having a problem but who do not accept that there is a situation needing change. Furthermore, there may be those who do not wish to change or perhaps have limited capacity for change itself. In such instances the question may be asked what is the role of social work? Clearly it is not possible to operate a direct social work service - in the manner described above - to persons who do not recognise the necessity for it, and in many instances there is little a social worker can do beyond recognising this fact. Uncomfortable as it may be for social workers - or other professionals - to be aware that individuals are living a lifestyle which is perceived as ultimately inhibiting their opportunities for self-fulfilment, the legal right to intervene is quite limited, and generally within a social work value system, there is adherence to a person's right to determine their own needs and basically to refuse intervention. It is possible and sometimes desirable to continue to inform such persons of the availability of a service should they subsequently decide to use it. This approach is generally referred to as outreach and consists of providing advice and information on services and a level of contact and support to persons who potentially could change their attitudes towards availing of such services. This is particularly possible if, as a result of the outreach contact, they manage to build up a relationship with the social worker. This approach has a particular application to drug problems in relation to people who, while they have problems associated with their use of drugs, may not recognise this, but nonetheless would benefit from outreach contact.

At the time of the establishment of the Community Care Programmes in Ireland, social work was moving in the direction of what is known as an unitary or systems approach, and one with which newly trained social workers both in Ireland and the UK tended to be most familiar. The focus of systems social work is on the interactions between individuals and their environment. It is an approach which often assumes that "individuals' problems are not viewed as individual pathology, but as a manifestation of social disorganisation" (Midleman and Goldberg, 1974, 12). One author on this approach Goldstein (1976, 4/5), describes social work as a "form of social intervention which enhances, conserves and augments the means by which persons, individually and/or collectively, can resolve disruptions in their social existence". Within this approach the social worker is professionally guided by the "combined recognition of the individual as a unique and active organism, the social environment as a dynamic force and the effects of their reciprocal interaction". In some respects the problem or issue, around which social workers intervene, derives from this latter interaction, which Bartlett describes as the "relation between the coping activity of people and the demand from the environment" (Bartlett, 1970,116).

Compton and Galaway (1984, 6) have posed the question "does changing the nature of the interaction mean changing the individual or changing the environment?". This particular dilemma has for long been the focus of some tension among social workers and it is resolved, if only theoretically, by proponents of the unitary approach by arguing that the purpose of social work is to be concerned with both change processes. The chief proponents of the unitary approach Pincus and Minahan (1973, 9) have provided the following definition of social work:

> Social work is concerned with the interactions between people and their social environment which affect the ability of people to accomplish their life tasks, alleviate distress, and realize their aspirations and values. The purpose of social work therefore is to (1) enhance the problem-solving and

coping capacities of people, (2) link people with systems that provide them with resources, services and opportunities, (3) promote the effective and humane operation of these systems, and (4) contribute to the development and improvement of social policy.

On the practical side, the dilemma posed above raises questions and choices for social workers in relation to the time, effort and resources they assign to these various approaches, and which approach they see as having primary importance. Naturally an involvement in social policy making can only happen at the expense of a lesser involvement in direct client-oriented work. On the other hand, client-oriented work which takes place in a social policy vacuum can lack overall objective, direction and focus.

Social work and health board management tensions[4]

As mentioned previously there were few community social workers employed in Ireland before the early 1970s[5]. The newly structured health boards were, during the mid to late 1970s, the leading employers of social workers. Furthermore, following the recommendations of the *Report of the Committee on Reformatory and Industrial Schools, 1970*[6], the health boards had responsibility for developing new family and child care services. These developments gained greater impetus following the appointment by the government of the *Task Force on Child Care Services in 1974*[7]. In

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[4]In addition to the reports which are cited in this section, the author has also drawn from his own notes and recollections of his period as a health board social worker during 1980-83, a period during which health board social workers as a group, initiated, what turned out to be an unsuccessful campaign to set up a separate health board programme for personal social services.

[5]One report in 1963 suggested that the "bulk of our newly qualified social workers each year" emigrate (Binchy, 1963, 177).

[6]This report recommended the abolition of the institutional system of residential care and for its replacement by group homes and argued that the whole child care system should be geared towards the "prevention of family breakdown and problems consequent on it" (Kennedy, 1970).

[7]This *Task Force* was given the responsibility of preparing a new Children's Bill and "updating and modernising the law in relation to children". The interim report of the *Task Force* published in 1975 highlighted the extent to which new thinking was penetrating policy-making. It supported the principles of minimum intervention into the lives of deprived children and recommended the provision

the context of these developments, it would reasonably have been expected, within this new health board structure, that new approaches in social work would be aired and practised and, in particular that social workers in addition to providing on-the-ground services, would also have an input into service planning, development and policy making. This was not to be so. The primary focus of social work activities, within the health board structures, was direct service, and by the mid 1980s, Eastern Health Board social workers were widely critical of their exclusion from other roles. Although, social workers identified funding as a problem[8], they were equally concerned with the absence of effective management structures for service planning, development and operation.

During 1983-5, Eastern Health Board social workers formed a *Campaign for the Development of Social Services*. This campaign group produced a document, *The Future of Personal Social Services in Health Boards* (CDSS, 1983), which outlined social workers' lack of confidence in the Community Care Programme's capacity to efficiently manage and operate personal social services, and services to children in particular. In highlighting the deficiencies of the Community Care Programme, social workers argued that because it is structured around a medical model of care[9], it is

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of "a wide range of preventive and day care services in local areas to meet the needs of deprived children whose total needs are not being met within their own families" (Task Force, 1975,10). As a result of this recommendation five neighbourhood youth projects were set up by the Department of Health under the management of local health boards. The *Final Report* of the *Task Force* was published in 1980 and it contained a number of recommendations for a complete overhaul of the structures and services for children at risk. The report envisaged that a broader range of community based family support services should be constituted as a separate body of services within the Community Care Programme - a minority report envisaged these services being provided through a separate health board programme (Task Force, 1980). However, the *Final Report* was published at a time when there was a different economic climate than that which existed in the aftermath of the *Interim Report*, and whereas the latter's publication was followed by the setting up of pilot Neighbourhood Youth Projects, to date these projects remain as pilots, and the recommendations of the *Final Report* have not yet been implemented

[8]Five years after the publication of the *Task Force Report on Child Care Services*, the *Committee on Social Work Report* (Department of Health, 1985, 11-13) pointed out that although demands on their services had been increasing steadily - a trebling of "reported instances of non-accidental injury to children" in the period 1981-5 was reported - there had been no overall increase in the numbers of social workers employed.

[9]In 1972, the Minister for Health decided that the Directors of Community Care were all to be medical officers. The McKinsey Report (1971) upon which the health board reorganisation was planned, had envisaged that the Director of Community Care's role would be to assess and identify need and coordinate a local plan in consultation with the various disciplines. It had not concluded that the

unsuited to the management and delivery of social work services. One senior social worker (McAndrew, 1985, 3) describes the problem as follows:

> ...social work practice and the ethos by which we work is always being filtered, firstly, through the level of Director of Community Care - they interpret problems, decisions, ideas for change through a medical prism, if you like. They are doctors; we have to explain social work and social work intervention to them - that dilutes the understanding of social work intervention. Then, they dilute it further when *they* talk to the administrators about the difficulties *we* are experiencing *(emphasis added).*

Of deep concern to a number of social workers and a fact that undoubtedly contributed to the formation of the Campaign for the Development of Social Services, was that many of their number had made an important contribution to developing 'green-field' preventive services for children and families, where previously there was no such services and they had done this in difficult financial circumstances. The fact that in 1985, fifteen years after the formation of the health boards, these initiatives lacked the recognition of a supportive management structure, was likely to contribute both to stress for the individual workers concerned and to tension in management-worker relationships. This point was picked up by O'Cinnéide (CDSS, 1985, 17) in a paper delivered to a seminar which was organised by the Campaign for the Development of Social Services:

> Another touchstone is the competence and morale of staff in the personal social services. The present structures are not conducive to the recruitment, personal development, support, self-confidence and advancement of staff.

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position needed to be filled by a medical officer. Other professional and administrative groups have consistently objected to the monopolisation of this post which has since been the subject of an ongoing controversy and intermittent dispute between the Department of Health and various health service personnel.

> The good work that is being done and the high standards that are being maintained owe a great deal to the enthusiasms and commitment of key individuals. We know enough about management theory to know that you cannot depend on it that people will be enthusiastic; you must so organise things that they are more likely to be.

Community work approaches[10]

Another tension has derived from the role of community workers within social service delivery. At the time that social work services were expanding in the health boards, social work was in the process of describing and developing a community work role. Although social work is primarily concerned with responding to the needs of individuals and families, it also has a history of focusing on communities and community work has been seen as one of those social work components which needed to be integrated within an unitary model. Seebohm (1968) recognised "community work, as a specialist function, within a social work context". Seebohm's report states

> ...that the different divisions between methods of social work are as artificial as the difference between various forms of casework and that in his daily work the social worker needs all these methods to enable (him/her) to respond appropriately to social problems which involve individual, family, group and community aspects *(Ibid., 558)*.

More recently Barclay (1982, 198) reinforced this point and highlighted the necessity for personal social services to develop a "close working partnership with citizens focusing more closely on the community and its strengths". In practical terms, it seems

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[10]In preparing this section of the study, the author drew from separate, retrospective discussions which he held with a number of health board community workers, during 1991, including: Noelle Spring (Community Care Area 6); Cecilia Forrestal (Area 6 and previously Area 7); Francis Chance (Area 1) and Pat Tobin (previously Area 6). He also drew from his own notes and recollections of meetings of a health board community workers support group, of which he was a member, during 1981-5.

unrealistic for community social work to ignore the social and environmental conditions which often surround and contribute to the social problems which their clients are experiencing, particularly if they find themselves working with families who live in communities where there are chronic problems of unemployment, low educational attainment, low standard housing and inadequate social and recreational facilities[11]. Social work solely with individuals is as Webb and Wistow (1987, 260) have pointed out, "bound to be of limited effect" in areas "where the community environment itself is a major impediment to healthy individual development". For some social workers, to work at a micro level, assisting individuals "to realise their potential" seems quite futile if the individuals concerned are likely to have little or no impact on these chronic problems, many of which - as already outlined in chapter 3 in relation to St. Teresas Gardens - are related to wider, structural and political factors.

In the mid to late 1970s atmosphere of new community oriented concepts in child care, an expanding network of community care social workers - including both those employed by voluntary and statutory organisations - and, also, the development of other community oriented initiatives within state welfare, education and training services, there was a great deal of focus on the potential of community responses to local problems[12]. Already, during the 1960s, a range of Catholic Church-inspired social service councils were developed for the purposes of providing community-based social services through the involvement of local Catholic organisations[13]. As

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[11]Throughout the period 1978-85 the efforts of the EHB social work team in Community Care Area 3 - covering an area from Christchurch/Patrick Street to Island Bridge in the south inner city and Harolds X, Terenure and Rathfarnam in outer city, with a total population of 110,000 approx. - were concentrated (80%) in five major flat complexes in the south inner city, which were characterised by high unemployment, low education attainment and the lack of recreation amenity. These flat complexes were quite similar in terms of social needs as St. Teresas Gardens, described in Chapter 2.

[12]This focus encouraged debate about community work about its origins, its functions, its varying methods, and the role of social work within it. Quite a number of social workers were involved in this debate and were particularly involved in a number of national community work conferences which were held in Waterford 1978 and 1980 and Galway 1979. These conferences were the forerunner of the Community Workers' Co-op (CWC) - a national organisation for community workers, which was set up in 1981.

[13]One of the earliest and largest of these - the Kilkenny Social Service Council - is described by Kennedy (1980).

O'Cinnéide and Walsh (1990) have pointed out, these councils provided opportunities for "lay participation in new forms of Christian service". In many respects, the concept of community in this approach is equated with that of voluntarism - lay volunteers, motivated by social concern and social reform, involved in the provision of welfare services to the disadvantaged and in improving the overall local coordination of such services[14]. As the health boards' Community Care Programme took shape during the 1970s however, the community dimension in relation to local social care took on alternative meanings and departed somewhat from both the concepts of lay voluntarism[15] and of community work as a social work approach.

In this alternative approach - which was influenced by community work developments in the UK[16], by the activities of the First EC Programme to Combat Poverty[17] and by

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[14]In the community work literature, this approach is likened to community organisation, which is described by Ross (1967, 39) as follows: "...a process by which a community identifies its needs or objectives, orders (or ranks) these needs or objectives, develops the confidence and will to work at these needs or objectives, finds the resources (internal and/or external) to deal with these needs or objectives, takes action in respect to them, and in so doing extends and develops cooperative and collaborative attitudes and practices in the community." See also Hendriks (1968) and Perlman and Gurin (1972) for an elaboration of this approach.

[15]Social service councils, on their own behalf recognised the value of a new shift in thinking in relation to 'community' and in an important document published by the National Federation of Social Service Councils (1978, 3) they argued that "Social service councils can help provide structures through which the local community's self-determination and and self-help can find expression. In so far as social service councils help local communities identify their own needs and facilitate their growth in communal autonomy, they succeed in creatively liberating the real, though often latent, resources of talent awaiting expression in every community".

[16]The reports *Community Work and Social Change* (Calouste Gulbenkian Foundation, 1968) and *Current Issues in Community Work* (Calouste Gulbenkian Foundation, 1973), elaborated on a number of key concepts and issues in relation to community work, including community work origins, trends, aims, values, methods, employment and training. These contributed immensely to community work developing a distinctive role and function in the UK and in particular to it developing a separate role to that of social work. See also Thomas (1983) for a major review of community work in the UK.

[17]In 1974, the National Committee on Pilot Schemes to Combat Poverty was set up by the National Coalition Government with 50% funding from the EC Commission. The programme had three general objectives: to set up practical interventions in areas of deprivation or among groups of people in need; to increase public awareness of poverty; and to contribute to the development of long term policies to tackle poverty (NCPSCP, 1980). The Programme drew heavily from the experiences of the British Anti-Poverty Programme (Loney, 1983) and the American War on Poverty (Marris and Rein, 1964). Its underlying philosophy was that "poverty was largely a result of inequality requiring quite basic changes in the social, economic, and political structures" (NCPSCP, 1980, 223). This was quite a radical position to be adopted by a state funded body and represented a major departure from traditional social service attitudes. Not surprisingly, the Combat Poverty Programme had a difficult relationship with more established institutions. Rejecting the more benevolent approach of traditional social services towards the poor and minority groups, the Poverty Programme set about to work "with" people and not "for" them. They encouraged local groups to unite and organise in the search for solutions to their problems. This approach undermined the position of many established local power groups and individuals who began to raise objections. The programme was steeped in conflict. In one of its

the proliferation of a range of community responses in other other fields, such as health, education and training [18]- there was an increased focus on involving targeted, disadvantaged groups in the self-assessment of needs and in developing local responses in which *they* had a direct role. This approach was given greater impetus following the decision of the Department of Health to recruit community workers into the Community Care Programme.[19] However, in the Eastern Health Board region, there has been considerable controversy in relation to these community work posts, which in turn heightened social work/management relationships.

The National Economic and Social Council's Community Care review identified the main conflict as relating to whether community work activities should be focused on the assessment of needs and voluntary efforts in entire community care areas - as favoured by some health board managers - or more narrowly-defined, neighbourhood (or interest-group) focused community development - as favoured by a number of community workers, particularly in the Eastern Health Board region (NESC, 1987, 50). This review also reported conflict in relation to community workers reporting relationships - although a Department of Health circular had specified that community

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contracted projects members of the management committee were involved in a civil protest during which five people were arrested and one - a local social worker and secretary of the project's management committee - spent a few days in prison for refusing to be bound over to the peace (Dennett *et al.*, 1982, 84). A directly funded project in Cork was also involved with a contentious local issue in which it took the side of local parents when they disputed with church authorities the type of schooling to be provided in their local area *(Ibid.)*.

[18]Since the1960s a number of new approaches to community development have emerged, and particularly since the mid 1970's and throughout the 1980's there has a been a significant increase in the number of individuals and organisations involved in community development in Ireland (Whelan, 1981). These developments embrace a wide range of ideas, intentions and activities which are focused on groups of people who share common interests and which become manifest in a number of different services, grassroots campaigns and professional activities. For a discussion of the various activities, influences and issues which have emerged in Irish community development since the 1960s see NCPSCP (1980), Jackson (1984), Community Workers' Coop (1988), Cullen (1989), Combat Poverty Agency (1990), O'Cinnéide and Walsh (1990), Kelleher and McCarthy (1990), and Whelan and Kelleher (1992).

[19]The principal functions of these new community workers were, according to a Department of Health memorandum, to "identify social need" and advise on priorities in meeting it, as well as liaising with various voluntary groups involved in social service provision (Department of Health, 1978). This new development reflected, according to the department, a "willingness of the health boards and particularly the programme managers, who look after community care, to recognise that the time has come to concentrate on community as a means of prevention and for the provision of the most relevant and flexible of services" *(Ibid)*.

workers were to report to senior social workers, some community workers have advocated alternative reporting relationships *(Ibid)*. Essentially these conflicts highlighted a debate on whether community work was concerned with improved organisation of voluntary services - as favoured by health board management -; improved delivery of social work services - as favoured by many senior social workers - or, localised community development initiatives with disadvantaged groups - as favoured by many community workers[20]. The latter group in a document which they produced in 1985, highlighted their preference for community work as a distinctive discipline within health board community care teams and with a separate reporting structure to that of social work (Health Board Community Workers Group, 1985, 17)[21]. This document was critical of what its authors saw as health board management's "lack of understanding of the need for communities to have access to vital resources" and *its* interpretation of non-medical interventions into social problems as "cheap voluntary models" (*Ibid.*, 12)[22].

The tensions between health board management and community workers escalated during 1983 following a dispute arising from the transfer of a community worker from

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[20]The approach favoured by this group of community workers was akin to that described by Webb and Wistow (1987, 260): "The term 'community development' is used primarily to denote work with neighbourhood groups. Community development.....is seen as a process whereby local groups are assisted to clarify their needs and objectives and to take collective action to attempt to meet them. It emphasises the involvement of the people themselves in determining and meeting their own needs. The role of a community worker is that of a source of information and expertise, a stimulator, a catalyst and an encourager".

[21]This document elaborated on the community work approach favoured by this group of community workers: "Primarily, it involves the active participation and involvement of people in their own affairs. If this is a nominal involvement, people can become even more alienated from the process. Active participation implies an involvement in planning, management, delivery and assessment. A second condition in a community development process is that the process is responding to the needs and experiences of people within a community, and not of the organisations and institutions trying to set up in it. Thirdly, it is necessary to recognise that a community development process does not usually just happen spontaneously. More often it needs resources, professional skills, and knowledge. Finally, a community development process may need to involve a worker or agency/institution working within the orbit of a community's sense of values and experiences and the order, pace and style of the development is, in many ways, determined by these" (Health Board Community Workers Group, 1985, 5).

[22]The National Federation of Social Service Councils indicated their own concerns with statutory attitudes to the voluntary sector and in their document *A Chance to Care*, they emphasised that statutory agencies needed to appreciate that "there are other roles for voluntary agencies apart from purely supplementing the statutory services" (National Federation of Social Services Council, 1978, 9)

one community care area to a community work vacancy which had arisen in another. This dispute arose because health board management wished to utilise this vacancy for the purposes of employing a social caseworker. This dispute was drawn out over a two year period and had a very unsettling effect on health board community workers. It was followed by a second dispute[23] concerning a community work post in yet another community care area, where again health board management wished to have this post utilised for the purposes of employing a social caseworker[24]. The position adopted by health board management in both disputes, at the time, lent some credibility to a growing fear among community workers that health board management had decided to rundown their complement of community work personnel through their non-replacement according as they moved-on to other employments[25].

Conclusion

In the 10-15 year period before the 'opiate epidemic' in the St. Teresas Gardens area, there was an important and unprecedented development of social services in Ireland.

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[23]Neither of these disputes are documented. However, during 1983-5 the author was a member of a group of community workers, community social workers and community project workers in the Eastern Health Board area who met regularly for the purposes of discussing common issues and other matters. Both these disputes were discussed regularly at these meetings. The author has also since interviewed the community workers at the centre of both disputes.

[24]Arising from this latter dispute, the health board employees' trade union decided to take industrial action against their employers. On the eve of this action, health board management met union representatives and a settlement was reached whereby a new community work position was created in a community care area which was not directly involved in the dispute, in compensation for the conversion of a community work post to casework in the area in which the dispute had taken place. While, the industrial action was averted as a result of this agreement, it emerged, shortly afterwards, that the new community work position to which the health board had referred, had already been in place weeks previously and in fact constituted the filling of a community work post in that area which had been vacant for the previous 5 years. Among health board community workers, none of whom had been invited by their trade union to the last minute management negotiations - although one of their number was a member of the executive of the local union branch - the agreed settlement constituted a demoralising defeat.

[25]Health board community workers interviewed for this study highlighted their perceptions that management seemed to be using vacant community work positions as a means of placating aggrieved senior social workers who complained they had insufficient casework personnel to effectively respond to the local demand for these services. Indeed, in 1983, community workers reported that there was no community work post in five of the ten Eastern Health Board community care areas. They further reported that "in some areas it was a decision taken by social work teams and senior social workers not to have a community work dimension to their work and in such areas community work posts were converted to casework duties" (Eastern Health Board Community Workers, 1983, 5-6).

The creation of the Community Care Programme in the regional health boards was undoubtedly the most important of these developments. The rhetoric and objectives of community care clearly suggested that *it* was the ideal vehicle for a community-focused response to drug problems, and certainly during the 1970s there was a major increase in the numbers of health board personnel engaged in community social work and with opportunities to identify and respond to local problems.

However, this chapter has described a number of practical problems and conflicts concerning the operation of social services in the Community Care Programme. These raise questions about the Community Care Programme's capacity both, to manage social service activities and, to provide support and direction to community work efforts. The next chapter 5 will show how the drug problem in St. Teresas Gardens was first identified within local social services and how initial responses to this problem were developed within community work models. The remaining chapters therefore, will provide an opportunity to detail how community/health board cooperation on the drugs issue worked in practice and how closely this conforms to or deviates from the rhetoric of community care.

Chapter 5 - Local responses to drug problems in the context of the health board's Community Care Programme

Introduction

In the previous chapter the general context of the Community Care Programme was described and particular tensions in relation to the operation of personal social services and the utilisation of community development approaches were highlighted. In this chapter the focus is on the efforts of social workers who, becoming aware of the predicament of St. Teresas Gardens and its worsening social environment, made various attempts to assess local needs and develop appropriate responses. In particular there is a focus on the community work approach adopted by social workers after 1975. This chapter also considers the first two years of the Youth Development Project (YDP) which constituted the Community Care Programme's first official involvement, in the form of a project, with the drug problem. As pointed out in chapter 2, previous health board involvement with the drug problem was through the Special Hospital Care Programme - the programme which was concerned with psychiatric and mental handicap services. The YDP, therefore, was a totally new area of work for community care and it presents a good opportunity to examine the operations of community care on a micro level.

Social work in St. Teresas Gardens

In 1972, Moira Higgins, was the first full-time paid community social worker in St. Teresas Gardens.[1] She was employed by the parish clergy who were reimbursed by the

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[1]The background to Higgins's appointment and her social work role were outlined in discussions with the author in 1988. Her appointment followed a meeting which was held in the Donore Avenue presbytery, attended by representatives of the Tenant's Association, the St. Vincent de Paul Society, Dublin Corporation, St. Kevin's (now St. James's psychiatric service), Eastern Health Board, teachers, welfare officers and local priests. The meeting discussed the area's problems and it concluded with the suggestion that a social worker be employed to co-ordinate the various community based services in the area.

health board. Higgins was the first of a number of health board social workers who became involved in developing responses to social need in St Teresas Gardens. She operated from a disused garage opposite the church on Donore Avenue. Her catchment was the whole Donore Avenue parish, but in practice, most of her work was in St. Teresas Gardens. At the time of her appointment, the health boards were still only in the early stages of creating a community social work service. Community care teams had not yet developed - there were no local Directors of Community Care, senior social workers, or local social work teams. There was no clear job description and on the ground, social workers, with no professional supervision, were more or less expected "to do their own thing". By having Higgins employed directly by the parish clergy, through a health board grant, a social service council model of social care was being followed which implied that social workers, working to a local parish committee, should engage in quite an amount of welfare advice and information, and on a more personal level they should provide a supportive casework service to local families. However, the management structure, whereby Higgins was employed directly by the local clergy was unsatisfactory primarily because of the lack of direction or professional support. Eventually the health board took over her direct employment and she was moved from a parish office in Donore Avenue to an office in the health board's own premises at Brú Caoimhghin, a welfare home for elderly people which was located two hundred yards away on Cork Street.[2] After eighteen months working in the

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[2]A number of other social workers who later formed the Community Care Area 3, social work team, commenced their social work involvement in a similar manner as Higgins. These were mainly members of religious orders who were based in parish centres in Rialto, James's Street, Oliver Bond House and Meath Street. They were provided with small cash grants from the health board. Although they were not directly employed, unlike Higgins, they had internal support systems within their religious orders. In 1976, both the religious order social workers and a small number of newly employed health board social workers were brought together to form the Community Care social work team. *A Profile of Community Care Area 3* (Eastern Health Board, 1978) listed in addition to five religious sisters - one of whom was employed by the health board as senior social worker - six other social workers, three of whom were based in the south inner city, one in Rathfarnam health centre and two were attached to the Department of Child Psychiatry in St. James's hospital.This team was based in two large rooms in the health centre in South Earl Street (off Meath Street) until August 1980 when the team was based in the Community Care headquarters for Area 3 in offices in Lord Edward Street. However, the senior social worker both prior to and after her team's move to Lord Edward Street, based herself in Terenure health centre, where in addition to senior duties, she also carried a social work caseload.

community, Higgins resigned to study a professional social work course and it was six months before she was replaced by Deirdre Hickey.

Hickey, one of the first social workers to be employed directly by the health board, saw herself very much as a caseworker. Locally, Hickey was perceived as a community organiser, a person who could intervene at a community and group level. She preferred the role of caseworker for which she was trained. However, she questioned the appropriateness of casework in a "very unorganised area" (Hickey, 1975, 5). Her assessment of St Teresas Gardens and the distress of individuals living within it was that these problems were related to a complex social process, to which she did not feel casework could respond. Furthermore, she became aware that seven separate agencies were providing social work services to the community in a very fragmented, uncoordinated way. She drew up a report in which she recommended the acquisition of a multi-purpose premises near, or in the area, which could be shared by all the various community based personnel and social work agencies who operated services in the area.[3] Significantly, Hickey's report acknowledged the limitations of casework in community circumstances such as those in St. Teresas Gardens at the time.

[3]These recommendations are outlined in *Report on Area of Donore Ave.*, (Hickey,1975)

Community work approach[4]

Hickey's eventual replacement, Terrie Kearney, was appointed in 1975 and she was keenly interested in adopting a community oriented role and she interpreted her brief as one to develop local services and activities *in conjunction* with interested community residents[5]. At the time that she took up post in St. Teresas Gardens, Kearney was part of the group of social workers who participated in the round of discussions leading to the formation of the Community Workers' Coopeative (CWC)[6]. Within this group of

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[4]The main source materials for this section of the study are: an interview with health board social worker (Kearney, 1991); an interview with Dublin Corporation Playgroups Adviser (Doheny, 1991) - who was actively involved with Kearney in developing community playgroups 1978-80; interviews with members of the St. Teresas Gardens Development Committee (Humphrey, 1991; Martin, 1991); various discussions with other members of the same committee; and, a number documents listed below which have been selected from files which were kept by the STGDC. These select documents are:
Connor, J. (1989): *Report on St. Teresas Gardens.*
Eastern Health Board (1978): *Profile of Community Care Area 3.*
Eastern Health Board (1980): *Report on community work dimension to work of area team 3.*
Kearney T. (1978): *The Thursday Club Report.*
Kearney, T. (1979): *Summary of Budget Proposal for Community Work in St. Teresas Gardens.*
Kearney, T. (1980a): *Report to health board on local drug problems.*
Kearney, T. (1980b): *Correspondence in relation to financial reimbursements.*
Kearney, T. (1980c): *Correspondence in relation to Neighbourhood Youth Project.*
O'Kelly, F. (1978/81): *Correspondence with Health Education Bureau.*
O'Kelly, F. (1982): *Notes for a talk with doctors.*
STGDC (1978a): *Committee Progress Report.*
STGDC (1978b): *St. Teresas Gardens Summer Project*, report.
STGDC (1978c): *Development Committee, Community Rooms; information sheet.*
STGDC (1979a): *January/February Newsletter.*
STGDC (1979b): *Correspondence from Department of Health concerning the assignment of a youth worker to St. Teresas Gardens.*
STGDC (1979c): *Information notes for prospective city councillors.*
STGDC (1979d): *Community Development Committee - notes on progress.*
STGDC (1979e): *Correspondence in relation to use of Youth Centre.*
STGDC (1979f): *Summer Project Report.*
STGDC (1979g): *Newsletter.*

[5]A report from social workers (Eastern Health Board, 1980) in which Kearney had a major hand elaborated on the community work dimension as follows: "We are aware that the delivery of casework services without resources stands little chance of affecting *(sic)* long term change for individuals and families. Communities which are alienated from the wider trends in society respond by apathy or hostility. Young people are further alienated by wider society and by their own families and neighbours. On a geographic area, community development is concerned with the problems of living, of health, welfare, well-being for young, aged and families. All these are interrelated and intervention at one level affects the systems of the others. There is an interrelatedness too, for people, to the situation they find themselves in with their neighbour and the problems they encounter there; there is the relationship to the environment and resources of their immediate neighbourhood and the effect national and local policies have on the development of people within communities. Community work is concerned about these things and in working with people to identify their needs, developing themselves and acquiring more resources and services to meet those needs. In a community, there is no clear distinguishing line of demarcation between the 'sick' and the 'well', 'deviant' and the 'weak' the 'strong'. One of our aims would be to improve the social functioning of the community to develop strengths within it to cope better with the 'sick', the 'deviant' or the 'weak'".

[6]See chapter 4

social workers she was directly involved in the debate on whether social workers had a community work role and the particular implications for this role in the context of both the expanding numbers of social workers and the fact that this growth was primarily taking place in community care.[7] Kearney (1991) reports that, initially, the health board was supportive to her undertaking a community work role. The local community care team was still not properly in place and Kearney tended to meet regularly with senior health board management in relation to her work.[8] At this management level, she was encouraged to reach out to local community residents and if possible to involve them in her social work efforts. Unlike newly developing community social work services elsewhere, Kearney was quite fortunate in being located close to the South City Area Resources Project (SCARP), which was funded by the Combat Poverty Programme, and through this project she was able to get additional support for community work in St. Teresas Gardens[9].

In 1977, Kearney initiated the idea of a summer project in St. Teresas Gardens, the basic objective of which was to operate recreational activities for local children during the summer months. The first publicly-funded, children's summer project had already taken place in the Liberties in 1975 and, by 1977, there were 20 summer projects in Dublin.[10] She assigned a social work student on placement to coordinate this project,

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[7]Kearney had a very active involvement in organising a number of community work conferences in Waterford and Galway in the years preceeding the formation of CWC. When the CWC itself was set up in 1981 she became less involved as at the time she had moved to a non-community work position in the health board.

[8]A number of social workers who worked in Community Care Area 3 in the late 1970s have pointed out that following the appointment of a Director of Community Care in 1979, the lines of communication between the social work team and health board management became confused. Previously social workers had become used to dealing with health board management directly at the latter's offices nearby in Thomas Street. At the time of the appointment of a Director of Community Care, his role and function in relation to the social work team was perceived by some workers as an additional and unnecessary layer of management. The situation improved somewhat in 1980, when the social work team was relocated from the health centre in South Earl Street to the area headquarters in Lord Edward Street. The new location offered greater prospects of access to the Director of Community Care. Some social workers (including this author) however, would argue that greater access to the Director of Community Care did not necessarily mean greater access to decision-making.

[9]See for example the support given by SCARP to Kearney in summer projects (STGDC, 1979d).

[10]The funding for children's summer projects was provided by Dublin Corporation and the scheme was administered by the Catholic Youth Council. Funding covered the costs of employing a full-time coordinator for 6-10 weeks and a small grant towards transport costs.

and a number of outside helpers were used. During the operation of the project, a number of local adults became involved and expressed interest in taking up the responsibility themselves for a project the following year. By February 1978, they had organised themselves into a local committee and had applied to the Catholic Youth Council for a grant to operate the project with their own coordinator, Willie Martin. This was agreed and he was appointed. The advantages of a local coordinator were immense. A summer project report (STGDC, 1978b) pointed out that Martin was popular locally and had support from various groups. He was seen as enthusiastic, and a good organiser. There was a lot of goodwill for the project but Martin had some difficulty getting local people to plan their involvement in an ordered way. Despite this, the project was a major success and was later described as "the foundation stone for community development" (Bowden, 1983, 4) in St Teresas Gardens. As a project it has been repeated most years since.[11]

The success of the summer project led to further self-organised developments, the most important of which was the setting up of the St. Teresas Gardens Development Committee (STGDC) in October 1978, again with Kearney's support and assistance. Seven members of the committee participated in a residential youth and community training programme organised by Comhairle Le Leas Oige (STGDC, 1979d). The STGDC set about developing the Small Club - two disused shops on the front block of the flats facing onto Donore Avenue - as its immediate priority. The centre was decorated by local youth through a grant scheme from the Department of Education[12]. The South City Area Resources Project provided assistance in getting this grant. A community playgroup, women's club and an old folks club was set up. The community playgroup was particularly successful; there was a "high level of involvement of

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[11] A full outline of the project's objectives and activities, and a list of its helpers is provided in a report by STGDC (1978b).

[12] Details of the refurbishment and and advertisement for jobs were announced in the committee's newsletter (STGDC, 1979a)

childrens' mothers and it was self-financing" (Doheny, 1991)[13]. The committee's newsletter (STGDC, 1979a) reported a range of community developments including all of the above, a non-stop draw, a club for retired men and progress in acquiring the main youth centre for a disco - earlier attempts to operate this disco were frustrated by opposition from the parish priest[14]. The committee also engaged a squatter re-settlement programme with Dublin Corporation which succeeded in negotiating tenancies for 17 squatters[15]. Throughout her involvement in these local activities, Kearney regularly reported to health board management and there was general recognition that the community social work service in St. Teresas Gardens was developing with a direct community dimension. Kearney's first few years in St. Teresas Gardens therefore, may be considered to have contributed to the development of a useful model for community social work wherein there was both the active involvement of community members and a genuine discussion of needs and responses within the health board's fledgeling structures.

Work with young people

Arising from discussions with local people, Kearney's primary concerns became focused on the growing numbers of young people in the community, who, as pointed out in chapter 3, were leaving school early and becoming involved in crime and drug-related activities. In 1978, she established a drop-in club[16] for the youth in the Small

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[13]Doheny also highlighted the enthusiasm that had been generated locally through the activities of the STGDC. For her the difference was that there was high level of community support for, and parental involvement in, playgroup activities, which were generally difficult objectives to achieve under the best of circumstances.

[14]A letter to the secretary of the STGDC written on behalf of the parish priest, while granting permission for the use of the hall for the purposes of a fancy dress competition and a bonny baby competition, refused permission for discos "due to the parish priest's ban on all discos in the youth centre". (STGDC, 1979e).

[15]The squatter resettlement programme arose from an eviction in February 1978, when a young family of five children was evicted for squatting. As a result of this programme it was reported that squatting was reduced to nil (STGDC, 1979c).

[16]The establishment of this drop-in club followed a period of intense outreach work undertaken by student social workers on placement and during which contact was made with young people in the streets and gradually, these were invited to participate in group sessions with a view to setting up the club. A report on this outreach phase noted: "This group was seen to operate informally around the

Club which basically consisted of pool, table-tennis and card-playing. The attendance was mainly youths aged 14-17. Through this drop-in club Kearney and members of the STGDC became aware in 1978 of the seriousness of the growing drug problem in the area[17]. Concerned that the young people who were using drugs were already quite vulnerable, Kearney became jointly involved with the STGDC in devising a formal local response. Because the drug problem was so new, and because the few services for drug users which existed at the time were specialist, Kearney initially believed that services should be encouraged to make direct efforts to reach out to those in need in the community. However, the outcome of preliminary discussions with staff in the National Drugs Advisory and Treatment Centre (NDATC) suggested that the only role for this service would be to provide centre-based treatment to the youths concerned, provided Kearney succeeded in convincing both the youths and their parents to attend the centre[18]. She did not believe that either the youths or their parents - if indeed parents had knowledge of their children's drug use - would attend the NDATC.

Kearney formed the view that a more realistic option was to provide services to these youths through a community oriented youth project, similar to the Neighbourhood Youth Project's which had been set up as a result of the *Interim Report* of the Task Force on Child Care Services (Kearney, 1980b)[19]. Youth workers with outreach skills

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area. It was clear that little was being offered to them in the community, by statutory bodies, in terms of services for youth. At the same time, what was being offered had low take-up or was not seen by individuals as meeting their needs. Thus it is hoped to establish them as a group, provide the resource of premises and this will form the basis of a service from which the group can decide on its own use of available resources in terms of itself" (Kearney, 1978, 2).

[17]Kearney and the two local voluntary workers who were most involved with this club - Paul Humphrey and Willie Martin - had remarkably, similar recollections of this period: reporting their concerns that youths were coming into the club intoxicated; their surprise when they realised the youths were using drugs; their worry when they realised that the youths excluded them - the leaders - from secret discussions; and, alarm on realising that the drugs being used were opiates and that some youths had already begun injecting.

[18]In an interview Kearney (1991), recalled being quite taken aback on realising the gap that there seemed to be between institutional services and the drug problems as these were manifesting in the community.

[19]The *Task Force* envisaged the wide scope of the Neighbourhood Youth Projects as follows: "A Neighbourhood Youth Project would try to discover the urgent needs of the most deprived young people in the neighbourhood and devise the most useful ways of responding to them. It might provide special services and facilities to meet defined needs or, alternatively, act as a headquarters and back-up service for unattached youthwork with such young people in the neighbourhood, developing links with other facilities and activities when required. It should use and develop the skills of voluntary workers in

would, she believed, be able to develop positive contacts with the young people on the streets within their own environment and where appropriate provide them with preventive messages and/or encourage them to seek medical and other treatments *(Ibid)*[20]. In adopting this line, Kearney was implicitly adopting a model of drug problems which saw such problems in terms of the social and community background against which they occurred; in rejecting this line, staff from the NDATC were adopting a different model, one which saw drug users in clinical, individualistic terms. What remained to be seen was whether, and to what extent, senior management in the Eastern Health Board would actively support Kearney and other field workers who were eager to promote a community care response to drug problems in St. Teresas Gardens.

As it turned out, Kearney's request for planned support from the health board was to little avail. Whereas previously she understood that health board management was supportive to her community efforts[21], she found it extremely difficult to mobilise their interest in the drug problem. At the outset of setting up the drop-in club for youths, Kearney had anticipated health board funding. This support never materialised and she failed to get reimbursements for personal expenditure on basic supplies like tea, biscuits, milk and sugar[22]. The centre had little in the way of equipment and supplies and eventually, in 1980, it was closed. As Kearney presented her account[23] of the local

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the neighbourhood. To support the kind of work described, we envisage that some new activities would have to be developed. Attentions should be given not only to providing recreational activities but also to stimulating learning activities in areas of practical use (Task Force, 1975, 16).

[20]One attempt to re-assign to St. Teresas Gardens a worker from a Neighbourhood Youth Project in a North Dublin suburb which had been closed shortly after it was set up, failed to make any impact. The reassignment had taken place without any planning and without any consideration of the worker's objectives, methods of work, reporting procedures and resources and other supports which would be required in his work. The worker left the area within a few months. Before he left the area this worker drew up a report for the health board in which he described St. Teresas Gardens as in a "very disintegrated and depressed state" (Connor, 1979). In this report, Connor recommended the setting up of a community resource centre for the purposes of integrating a range of social and other helping services in the community *(Ibid.)* - a recommendation similar to that made by Hickey (1975).

[21]Kearney (1991) was quite insistent that her early work in St. Teresas Gardens was openly supported by management personnel. Indeed, there are indications that proposals in relation to a Neighbourhood Youth Project were first suggested by management (Kearney, 1980b).

[22]A proposal (Kearney, 1979) for funds for various community and youth activities mentioned personal expenses which had been accrued by both Kearney and another worker.

[23]In a report to the health board in March 1980, Kearney summed up the drug problem as known to her which included 20 persons known to her personally who were taking 8/10 palfium tablets per day -

situation to health board managers, it appeared to her that she was not believed. This disbelief was also reflected in the response of city councillors, many of whom were also approached. Fergus O'Kelly, a local medical practitioner who in 1979 informed Dublin's Chief Medical Officer of a widespread epidemic of Hepatitis B secondary to heroin use by hypodermic injection[24], had similar experiences of not being believed by city councillors. He reports that on one occasion at a public meeting in local community premises, he was accused by a city councillor of deliberately exaggerating the problem (O'Kelly, 1991)[25]. What was quite apparent to Kearney, O'Kelly and others who were professionally involved in St. Teresas Gardens at the time, was that a major, unprecedented epidemic of heroin-use was developing among young people in the community, and it appeared that nobody with any real authority believed that this was really happening[26]. At one stage Kearney arranged a visit from a senior Department of Health civil servant to the afternoon club but nothing concrete developed as a result of this meeting[27].

"These young people are in age group of 14 years and over. The drugs are readily available and easily available in the neighbourhood through about six drug pushers. I also know six addicts who inject themselves on hard drugs. Some of the group have also told me how palfium is readily available in local pubs and many people including young married women are beginning to use them for increased stimulation" (Kearney, 1980a). Kearney described the situation as an urgent health problem and advised the health board to adopt the tactics of information, outreach counselling and the training of local concerned persons" *(Ibid).*

[24]O'Kelly (1982) in a presentation to a seminar of doctors described how his medical practice first became involved with the drug problem: "Our first contact with this problem was over two years ago when my partner was asked to see an 18 yr. old youth who had a history of heroin addiction. He was seen by ourselves and Jervis Street over the next two months until we learned of his death by over-dosage. Our next contact was with a very worried mother who suspected her 14 and 15 yr. old sons of using drugs. Her suspicions were accurate and despite referral to all type of agencies they are still abusing. Soon after this, we began seeing cases of Hepatitis B secondary to hypodermic injection. At the same time, many members of the local community, public health nurses, social workers and other community workers became aware and alarmed at the rapidly escalating problem. We now know of 40 heroin users - ages range from 12 -25 yrs."

[25]O'Kelly (1991) also reported that at the same meeting a second councillor - and TD - maintained that with his contacts with Garda superintendents in Kevin Street station, he could have the problem sorted out quickly - while some politicians were unwilling to accept that there was a problem, it appeared that those who did wanted a "quick fix".

[26]This unwillingness of some to believe the seriousness of the problem was - as late as 1982 - apparent in responses to John Bradshaw's preliminary qualitative study of heroin use in Dublin and reported by him in Dean *et al* (1983, 3). O'Kelly (1991) also points out that at the time - 1979-82 - many doctors who worked in the same catchment area as himself did not believe that there was such a serious drug problem in their area.

[27]Later in discussions with the author, this civil servant commented that at the time of this visit to St. Teresas Gardens, the official Department of Health position in relation to drug problems was based on the findings in the report of the *Government Working Party on Drug Abuse* (1971) and the *Report on a Study in Dublin Post-Primary Schoolchildren, 1970* (Nevin et al, 1971). The civil servant agreed that

In 1978 and again in 1980, Kearney - with the backing of O'Kelly[28] - approached the Health Education Bureau (HEB) to support a locally-based drug prevention programme. The HEB refused to become involved arguing that the sponsoring of such a project was a matter for the Eastern Health Board and that it had not been approached by the health board on the matter (O'Kelly, 1978/80). Kearney was herself a health board social worker but the approach from the health board which the HEB was referring to was one from senior health board management. Kearney had approached the Health Education Bureau, because she felt she had done her best and failed to persuade her own management to respond. By approaching the HEB directly, Kearney was, in fact, bypassing established administrative procedures, whereby such approaches from one statutory agency to another are expected to take place only with the prior agreement, and involvement, of management personnel. Although, Kearney was aware that her actions were contributing to tense relationships with her own management, she believed that, because little was happening as a result of her internally-focused efforts, she had little option but to bypass normal administrative procedures.

At the time, it appeared to Kearney that the health board's developing attitude towards the drug problem was that the financial responsibility for the work with youths belonged to other statutory services, and not to it. Health board management conveyed to her that the role of local social workers was to provide a casework service; direct social work counselling with priority health board clients - children and families at risk. Drug-using youths were not considered priority clients. Officially however, the health board had responsibility for all young people (under the age of 16 years) who were at-risk in the community and the position it adopted in relation to drug-using youths in St.

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the Department's failure to respond quickly to the information being provided by Kearney and others in the field, exposed a major weakness in the way in which the Community Care Programme was structured to respond to developing health and social problems.

[28]In an interview for this study O'Kelly (1991) recalled participating in a HEB organised course on drugs in 1982 - for medical practitioners, in which the problem was described, in one of the most important inputs, as 'classless'. Given the growing incidence of heroin-users coming to his medical practice, he found it difficult to accept this official view of drug problems.

Teresas Gardens was a negation of this responsibility. In August 1980, Kearney moved to another position within the service.

Youth Development Project proposal, 1980/81[29]

Kearney was replaced by a former student of hers, Patricia Daly, who, like Kearney, interpreted her role as one of providing a community based casework service and, in conjunction with community groups, organising a local response to the growing drug problem and other local needs. At the time of Daly's appointment - September 1980 - the social work team for community care area 3 consisted of one senior and six social workers, five of whom were based in the inner city, of whom two were using a

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[29]The main source material for this section of the study are: author's own notes and recollections; interviews with YDP committee members - (Humphrey, 1991), (Bowden, 1991), (King, 1991), (O'Kelly, 1991) and (Smyth, 1991); interview with YDP project leader (Walker, 1991); interview with Eastern Health Board's Senior Administrative Officer (Flanagan, 1991); and, the documents listed below which have been selected from a number which were stored by author, the chairperson of the STGDC and the chairperson of the YDP committee. These documents include:

Bowden, M. (1982): *Community Response to the Drug Problem*, paper presented to seminar on Youth, Community and Drugs held in Liberties Vocational School on October 16th.
Comhairle le Leas Oige (1982): *Report on Drug Abuse in Dublin.*
Cullen, B. (1980): - *Minutes of meeting held in St. James's Hospital*, November, 18th.
Cullen, B. (1981a): *Indicating figures on the extent of heroin abuse in inner city part of Community Care Area 3.*
Cullen, B. (1981b): *Submission to Dublin City Council proposed working party on drug abuse in Dublin, and related correspondence to the Director of Community Care.*
Deasy, F. (1982): *Notes on paper presented to seminar on Youth, Community and Drugs held in Liberties Vocational School on October 16th.*
Eastern Health Board (1982a): *Drug Abuse in Dublin - a joint community/health board response.* Programme Manager.
Eastern Health Board (1982b): *Report on Drug Abuse.*
Eastern Health Board (1982c): *Minutes of meeting concerning the proposed YDP, Weaver Square, held at offices of Programme Manager, 23/12/82.*
Leissner, A. (1982): *Notes on paper presented to seminar on Youth, Community and Drugs held in Liberties Vocational School on October 16th.*
North Star Hotel, (1982): *Minutes of preliminary meeting on drugs with social workers, community workers from North inner city, South inner city, Ballymun, and Clondalkin.*
Sean McDermott Street, (1982): *Proposal for Local Drug Related Day Care Centre in Sean McDermott Street (Drop-in Centre); also correspondence in relation to this proposal from Department of Health.*
STGDC (1980): *Community Drug Treatment and Education Programme*, December.
STGDC (1981): *Community Drug Treatment and Education Programme*, July.
STGDC (1983b): *Correspondence with Government Ministers in relation to YDP proposals.*
Walker, H. (1982a): *Preliminary thoughts on establishing the Weaver Square project*, July report.
Walker, H. (1982b): *Job Description;* draft, August, 24th.
Walker, H. (1982c): *Notes for discussion*, November report.
YDP Committee (1981/85a): *Minutes & Notes. - including chairperson's notes.*
YDP Committee (1981/85b): *Correspondence.*
YDP Committee (1981/85c): *Reports.*
YDP Committee (1982): *Submission in relation to a one-day seminar held on October 16th, 1982,*

community based model. Therefore, despite the tensions - at health board management level - which had begun to emerge in relation to community work during the latter part of Kearney's period, the local social work team remained supportive to community approaches.

Despite working in the community for only one year, Daly made considerable headway with pursuing proposals for a localised health board response. Her commencement in employment coincided with the move of Community Care Area 3 social workers from the health centre in South Earl Street to the area administrative offices in Lord Edward St. This gave the social workers closer access to local health board management and Daly availed of this. Dr. Murphy, Director of Community Care in Area 3, encouraged her to prepare detailed proposals for a drugs project in the community. He also agreed to convene a consultative meeting for the purposes of exploring ways of responding to the drug problem. This meeting was held in November 1980 and it included representatives from social workers, doctors, NDATC, Coolemine Therapeutic Community, Stanhope Street Alcoholism Centre, Juvenile Liaison Officers, and Probation Officers. The meeting discussed the drug problem in St. Teresas Gardens and a number of suggestions for proceeding were made, including programmes of early intervention for young people at risk, the provision of "recreational, educational and vocational alternatives" and "drug treatment" (Cullen, 1980). There were strongly expressed views that these kind of proposals "were being dealt with in a vacuum unless some authority came up with the money to fund the programme, and that this was what needed most immediate exploration" *(Ibid)*. The meeting finished with Murphy assuring everybody that Daly would now "start the process of having a drug treatment programme drawn up" *(Ibid)*.

At last it appeared that action on the ground was being supported by health board management. Daly's initial proposals were outlined in a document - *Community Drug Treatment & Education Programme* (STGDC, 1980) - which was drawn up in

December 1980. The objectives of her proposals were very broad and included the provision of individual counselling, family therapy, educational, recreational and vocational programmes for persons aged 9-18 who were using drugs and alcohol. They also proposed to offer preventive drugs education and alternative recreation, education and vocational preparation for young people who were at risk of using drugs. It was envisaged that a premises would be acquired for the programme and that initially two workers would be employed. It was also hoped that effective link-ups would happen between education services and youth bodies.

Daly's proposals were submitted to the health board in the name of the STGDC. Daly's vision of community involvement in the programme was that it should be seen as an STGDC initiative and thereafter their input into the management and operation of the programme would ensure it would always have a community focus[30]. What she envisaged was that the project would be managed by a committee made up of a number of local professional workers, representatives of the main drug treatment agencies and two representatives of the STGDC - in fact this committee began to have preliminary meetings during the summer of 1981, although it did not, and in fact never did, have an official mandate as management committee of the proposed project.

In consultation with members of the committee, Daly prepared an updated proposal on the project and submitted this to the health board. The proposal provided for the provision of a community youth development project that would operate outreach and structured programmes for young people at risk of drugs within the community, with a staff of 3 and a start-up budget of £50,000 including staff - £30,000; running costs £10,000 and redecoration £10,000[31]. It was envisaged that the programme would

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[30]It is interesting that Daly adopted this position for at no stage did health board management acknowledge the STGDC as having a role in preparing, initiating or operating the YDP. It was only when the health board needed to make arrangements with STGDC, as tenants of the "Small Club" in 1983, for the sharing of heating and lighting costs, that any formal communication with this committee, in relation to the YDP, took place.

[31]These are all 1981 prices.

operate from four classrooms in the national school premises at Weaver Square, 200 yards from St. Teresas Gardens. The classrooms were large 25' x 18'. They had not been used for quite some time and one of them needed renovation. It was also, at this stage, proposed that the project be referred to as the Youth Development Project (YDP).[32] In August 1981, at a meeting between the Programme Manager and Daly and other health board personnel, verbal approval for this new project was granted, pending satisfactory engineering assessments of the building in Weaver Square[33]. Significantly, this was the first meeting held at such a senior level within the health board's Community Care Programme, at which a decision was taken to approve the development of a community-focused drug project. For those locally based health board personnel who attended this meeting, it was in many respects a cause for celebration - protracted efforts to elicit an institutional response to the drug problem were at long last bearing fruit.

The YDP Committee

The membership of the YDP committee was representative of the project's support from both professional and local interests in the community[34]. Although committee

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[32]Details of this updated proposal are to be found in the document STGDC (1981).

[33]This meeting was attended by the author who in the following October took up Daly's community work and YDP responsibilities as a result of her leaving to take up further study.

[34]It was a broadly based committee consisting of Fergus O'Kelly (general medical practitioner - Cork Street), Sean McArdle (curate - Donore Avenue Presbytery), Patricia Smyth (probation and welfare officer - Dublin 8), Mary Salmon (public health nurse - St. Teresas Gardens), Paul Humphrey (chairperson of St. Teresas Gardens Development Committee), Matthew Bowden (secretary of St Teresas Gardens Development Committee), Terry Doyle (principal teacher - Liberties Vocational School), Patricia Daly (social worker - Eastern Health Board), the late Sam Anglin (Coolemine Therapeutic Community) and Ray Kavanagh (assistant section officer in community care offices - Eastern Health Board). In October 1981, the author of this study replaced Patricia Daly as social worker in St. Teresas Gardens and he took her place on the YDP committee. In December 1981, Michael King replaced Terry Doyle as principal of Liberties Vocational School and also took his place on the YDP committee and became its chairman In January 1982 Peggy Comberton (social worker - National Drugs Advisory and Treatment Centre) was assigned to the committee. In the same month John McCormack (psychiatrist - Eastern Health Board) also joined the committee at the suggestion of health board senior management. He left the following year and was replaced by Christy Hogan a psychiatric nurse in the health board's community psychiatric service. In August 1982, Sam Anglin also left the committee to return to his home in the United States. Mary Salmon resigned from the committee in August 1982 to move to Cork, and Pat Smyth resigned in March 1984, following a transfer to Limerick. None of these three members were replaced.

members were enthusiastic about undertaking tasks in relation to the YDP they were - at the outset - quite unsure of their function and role. The committee was set up by Patricia Daly, ostensibly for the purposes of becoming the management committee of the proposed YDP. However, the only formal basis for this status was Daly's assurance that this was the Eastern Health Board's intentions - an assurance which Daly had no authority to give. Nonetheless, the fact that the health board, on a local level, had agreed that its local officers, the author of this study and local administrative officer, Ray Kavanagh, were members of the committee was an indication of the health board's approval of the committee's existence and its perceived terms of reference. The committee therefore, went about its business in the latter half of 1981, on the understanding that, at the appropriate time, it would become the official management committee of the health board's proposed YDP.

From the outset, the committee referred to itself as the YDP Management Committee. Committee minutes were normally headed *Management Committee*, as was some correspondence to external bodies, AnCO, VEC and South Inner City Community Development Association (YDP Committee 1981/5a; YDP Committee, 1981/5b). At its October 1981 meeting it discussed a committee structure and appointed a chairman and secretary. The post of treasurer was left open until such time as it had money, a situation which actually never arose. The committee, also at its October meeting, decided to meet monthly, to undertake some local research and to visit some other community based youth projects in the city. At each of its subsequent monthly meetings the committee received reports on the progress of the proposed YDP from either its project leader (after she was appointed in July 1982) or other health board officials - usually Ray Kavanagh or the author of this study. However, these health board officials were rarely in a position to give definitive answers in relation to the health board's position on a number of issues as these arose.

In October 1981, the committee decided to undertake a piece of research on local drug problems. Committee members with direct experience of the problem supplied figures/information on this experience. These included figures from a GP practice, a Public Health Nurse, the social work team for community care area 3, and the probation officer for postal district 8. The information supplied provided a clear overview of the seriousness of the local drug problem[35]. The YDP committee submitted a report on these figures to the Eastern Health Board in November 1981 (Cullen, 1981a). The report established a significant core of heroin users in St Teresas Gardens and neighbouring flat complexes. Although the figures were not compiled with precise scientific methods they provided the first piece of research evidence that heroin-use was common in the area.[36] The YDP committee considered the findings of the research report as a vindication of the community efforts which had been put into developing a local response to the drug problem. The committee was also quite satisfied that by undertaking the research it had demonstrated an ability to get on with doing the tasks that were essential for managing the YDP. The research, by giving a measure of

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[35]The GP practice reported that it had direct knowledge of thirty drug users, including five youngsters who were aged 16 years and under, one of whom a 12 year old boy had a two year history of heroin use and had been treated for serum hepatitis. The remaining drug users were in the age group 17-25. Most of the people reported came from St Teresas Gardens and the rest from neighbouring flat complexes. The public health nurse reported twenty two drug users all from St Teresas Gardens. They included three families where three sets of siblings were all using heroin, and three mothers who were using heroin at the time of the birth of their infants. She also reported fourteen young children who were at serious social risk because of their drug using parents. The social work service reported 12 families with whom they were involved because of children-at-risk situations and where parents were using drugs. In all there were 18 drug users and 26 children at risk. Two of the families came from St. Teresas Gardens and the remainder came from neighbouring flat complexes The probation officer for Dublin 8 reported knowledge of 6 drug users from St. Teresas Gardens who were aged 13-23. A further eighteen probationers in neighbouring flat complexes were also known to the service as drug users. In addition to this information from practice records the committee also compiled prevalence figures based on local information supplied by two local community workers and the local curate. This information was provided at a meeting with the author at which the local people concerned discussed each flat in St. Teresas Gardens in turn, and a unique (non-identifiable) record was kept for each person whom was perceived as using drugs. On the basis of this approach it was estimated that there were 57 individual heroin users in St. Teresas Gardens, 18 of whom were under the age of 18 years.(Cullen, 1981a).

[36]Later research was to show that the figure of 57 persons using heroin in 1981 was in fact an underestimate (O'Kelly, 1988). Dr. John Bradshaw who in 1982 compiled a preliminary report on Irish drug problems for the Medico Social Research Board commented that "off-hand" he knew of "no higher prevalence figures than" the figure of 57 heroin users in St Teresas Gardens, "anywhere in the world" (Bradshaw, 1982, 3). At the time, the figure of 57 was 11 less than what was eventually estimated by O'Kelly for the same year.

the problem, provided the committee with its first yardstick for measuring its own progress.

Relations between YDP committee and health board management

In January 1982, the Eastern Health Board Programme Manager for Community Care invited the YDP committee, together with local health board officials - including the Director of Community Care, Dr. Murphy and senior social worker, Dermot McMahon, to a meeting in his offices in Emmet House; this meeting was also attended by Dr. Michael Kelly of the NDATC. During the meeting an update on the project's development was considered and a draft document, which was prepared by YDP committee members and entitled *Drug Abuse in Dublin: A Joint Community/Health Board Response,* was approved. This document outlined the general background and context of the drug problem in the Dublin 8 community. It pointed out that a response to "this new drug problem" needed to:

> (i) incorporate the community dimension into treatment and rehabilitation, and (ii) design drug education and prevention programmes that confront the wider social, economic and even political aspects of addiction and dependency (Eastern Health Board, 1982a).

The document provided an outline of the YDP under the following headings - objective, target group, management, finance and funding, staff, programme design, drug education and research and evaluation. The document pointed out that the main funding for capital outlay, staff (project leader and two project workers) and current costs was with the Eastern Health Board, and that additional funding and resources would be sought from other appropriate sources. In the section on project management, it was made clear that a management committee would be nominated by the Director of Community Care, that this committee would give direction to the project, meet at least

once a month and report quarterly to the Director of Community Care. The document was later circulated by the Eastern Health Board's Programme Manager's office to a variety of agencies and individuals with a specific interest in the YDP. At the January 1982 meeting, consideration was also given to the next stage of the project. Committee members pointed out the workload in terms of research, programme design and premises design had increased a lot and that it was now time to recruit a project leader to develop this process further. This was agreed at the meeting. This meeting was an important boost to the confidence of the YDP committee and particularly now that health board management had decided to employ a project leader for the project, committee members believed that YDP objectives would soon translate into meaningful actions.

However, concurrent developments from late 1981 onwards indicate that while the health board was willing to develop a response to drug problems in conjunction with community interests as represented by the YDP committee, it attributed an increasing importance to the involvement of existing institutional services, particularly the NDATC. At this stage the Community Care Programme Manager had assigned drug related activities to a Senior Administrative Officer, Aine Flanagan. Flanagan had previously worked in the senior management team in the Special Hospitals Programme where among, her responsibilities, were included drug and alcohol problems. From the outset of her involvement with the YDP in 1981, Flanagan emphasised that the project should not proceed without the agreement of existing drugs services and that in particular it should have the consent of the NDATC. This emphasis contrasted with that of health board social workers who both previously and currently (in 1981) were involved with the YDP. Their position was that St. Teresas Gardens had been let down by existing institutional services and that a new initiative needed to concentrate its energies and resources into mobilising those within the community - professional and local - who were supportive of the YDP's objectives. The fact that the YDP committee

had attracted the active involvement of a range of community interests underlined the significance of this approach[37].

An example of the health board's determination to involve the NDATC in a direct manner was a meeting which Flanagan organised in November 1981 with the NDATC director, Dr. Michael Kelly[38]. The meeting was attended by local health board officials, including this author, but YDP committee members who were not health board officials were not invited. The only practical outcome to this meeting was that the NDATC director agreed to nominate a member of his social work team to attend YDP committee meetings. Yet, prior to its happening, the health board billed the meeting as being crucial in relation to securing the NDATC's endorsement of the YDP proposal[39]. Without this endorsement it was suggested that the YDP could not proceed. While it was quite clear during the meeting that the NDATC director was not refusing an endorsement of the YDP, it was also clear that because of his other commitments he was in no position to be of much practical use to the YDP in terms of assisting it in setting up or in providing ongoing support. The meeting had more symbolic than practical importance and it underlined the health board's deference to the NDATC in drug-related matters[40]. The situation here was that a YDP proposal was being

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[37]The community approach was supported, not only by local social work personnel, but by the Director of Community Care, Kevin Murphy, who in the previous twelve months had taken a deep interest in community problems and was openly and wholeheartedly supportive of community efforts. However, following Aine Flanagan's assignment to drug problems, the Director of Community Care had a less influential role in the progress of the health board's response to drug problems. Indeed, in November 1981, the Director of Community Care was admonished by senior health board management as a result of a document which the author of this study had submitted to the office of the Lord Mayor of Dublin. The document included an analysis and outline of the community dimension to drug problems. The Director of Community care was criticised because the document had been submitted to an external agency - Lord Mayor's office - without management's prior consent (Cullen, 1981b).

[38]A background report on the progress of the YDP (Cullen, 1982, 2) noted that a meeting took place in November 1981 "between Community Care Area 3 workers, Emmet House Administrative Officer and Dr. Michael Kelly of Jervis Street Centre, to seek advice and suggestions on the actual workings of the proposed day centre."

[39]So crucial did Flanagan consider this meeting that those local health board officials who attended it were advised in advance to be ready to make themselves available for the meeting at minimum notice, as the Director of the NDATC was an extremely busy person.

[40]At the time of this meeting its significance was less apparent than later - in 1983 - when the health board suggested that the YDP should be modelled on the Talbot Centre - a new drugs project in the North inner city which was set up by the health board with the direct involvement and assistance of the NDATC - see chapter 7.

developed because the existing services had been considered to be inadequate to the problems in St. Teresas Gardens; it was being developed by the community Care Programme because of its presence on the ground in the community and because the problem had manifested itself in the operations and work of its own personnel. Why the YDP needed the agreement of the NDATC was never made clear. Significantly, the increased necessity to involve the NDATC, coincided with the health board's reorganisation of management responsibility in relation to drug problems.

The first project leader

The advertisement for a project leader was placed by the Eastern Health Board in March 1982 and the YDP committee's chairperson, Michael King, was invited to participate in the interviewing board. King's participation in this interview board was understood by other committee members as an indication of the health board's support to their work. The project leader, Helen Walker, was eventually appointed in July 1982. The project leader had considerable experience with social services in Scotland and her most recent position had been as team leader in an Intermediate Treatment Centre. Not only did she succeed in being appointed to the project leader position, but around the same time she interviewed for and was successful in gaining a position as senior social worker with the health board. The health board decided to employ her as a senior social worker and to offer her the option of being seconded directly to the YDP, which she accepted.

The project leader very quickly compiled a report setting out a strategy for establishing the YDP in Weaver Square.[41] Her report dealt with what could be achieved in the short term with minimum action and also what needed to be done to put the long term objectives of the YDP into operation. She proposed to set up an advice centre in local premises which would provide basic information and assist people to reach whatever

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[41]This strategy is outlined in a report by Walker (1982a).

existing services were already available. Such a service would enable the YDP to make contact with the core group of drug users and their families and at the same time to form links with the various personnel and services operating in the area. It would also afford an opportunity for her to quantify the local problem. She envisaged undertaking this work between September 1982 and January 1983, by which time it was hoped to have an accurate picture of the project's potential target group, as well as having a clear plan for the acquisition of other resources for the project, including premises, personnel and budget.

The project leader made it clear that the pursuance of her short term strategy needed to be linked to progress in relation to other long term items, specifically the provision of staff and the refurbishment of the Weaver Square premises. Her report included a preliminary programme design for the Weaver Square building, an outline of staffing, equipment and materials needs, and a summary of the commitments which would be required from other services. The project leader suggested that from evidence available there was a significant number of young persons aged 12-16 in the community who were either frequently using or experimenting with drugs and that their use of drugs was likely to be related to other problems. She envisaged reaching the drug problem through "concern about other difficulties" which could be responded to "in a practical way" (Walker, 1982a). By developing a flexible range of group programmes in the Weaver Square building, the project would be assisting the community in "impinging on the present lifestyle which is currently supporting the drug culture and other related problems" and "in offering direct alternatives to drug use" *(Ibid.)* By advocating these programmes, Walker was being supportive of the line already adopted by other key workers in the community and YDP committee members, that drug problems needed to be responded to from a social, community perspective rather than from the more clinical, individualistic approach.

The main focus of the Weaver Square building arising from Walker's proposals would be a day programme incorporating a range of activities including: remedial teaching, individual counselling, group sessions, activity sessions (craft, drama, art, cooking and sports) and family meetings. The Weaver Square building would also incorporate a range of drug advice, information, education and prevention services to the general community. The project leader envisaged commencing a limited version of these latter drug services as her short term strategy and considered that their operation would build a foundation for the day programme when it became available. In relation to staffing, the project leader envisaged employing two project workers - one for youth and community work and the other for the purposes of providing counselling and groupwork services. In addition to these posts and a secretary/receptionist, she also suggested two new part time posts for the day programme when it was set up. These were a cook/project worker and a caretaker/project worker. She envisaged that these posts be filled "by persons living in the area and would add a valuable dimension to the overall project team, through their direct experience and understanding of the community" *(Ibid)*. The project leader's report also spelled out the kind of cooperation she would be seeking from other agencies including an involvement from the education services, probation, ANCO, the Health Education Bureau, Coolemine Therapeutic Community and Comhairle Le Leas Oige[42].

Walker's document constituted an important and significant elaboration of the aims and intentions of YDP committee members and they clarified many of the practical features of a community based service. They also indicated a shift towards a problem-focused response to drug problems and away from drug-specialist, addiction-focused services.

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[42]An internal report on drug problems produced by Comhairle Le Leas Oige in 1982, emphasised the necessity for it to be more supportive in responding to the needs of disadvantaged youth. The report recommended that "Comhairle staff try to work in close harmony with professionals in the areas they serve, encouraging where possible an integrated action/approach to community problems. That contact be made with community organisations where they exist to help them to come to a deeper appreciation of the needs of young people and the dangers, eg drugs, which they confront and that Comhairle should encourage projects/activities where adults and young people can work side by side (Comhairle Le Leas Oige, 1982).

In some respects the proposals represented a practical application of the generalist model which a few years later was described in relation to the UK experience by Strang (1989).

YDP Progress

As the project leader's long term proposals hinged on the Weaver Square building and resources for its redecoration becoming available, one of her first tasks was to assess the building's suitability and potential. The school which was owned by the Irish Sisters of Mercy had experienced a downward trend in the numbers of pupils attending, not unlike many other schools in the inner city, and a trend that was obviously linked to population decline. Part of the school was already being used as a family resource centre and the STGDC had plans to redecorate one of the rooms as a training/seminar room. The section earmarked for the YDP was a separate wing which fronted Weaver Square although it did not have an opening onto it. It consisted of four large classrooms and toilets. In October 1981, health board officials met the Irish Sisters of Mercy and established their willingness to arrange a suitable lease or licence.

The health board's architect in consultation with the project leader drew up renovation and redecoration plans for the building. These plans which were available by late September 1982, were impressive and demonstrated a creative use of the space available in Weaver Square [43]. The plan proposed to create quite a large area on the ground floor for drop-in, advice and information, interview assessment or counselling, toilets and kitchen service, while it was proposed to decorate and equip two large activity cum group discussion rooms on the first floor. These first floor rooms would be the base for the day programme activities. The plans very much reflected the thinking that the YDP should have both a drop-in space which could have public

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[43] The plans are outlined in a report by Walker (1982c).

accessibility and separate activity-room space within which planned programmed work could take place.

However the renovation work required was quite substantial and far in excess of what was originally suggested in Patricia Daly's submission a year previously. In fact a preliminary estimate for the renovations was in the order of £80,000. It was made quite clear by health board management that this kind of money was not available, although it agreed to make further submissions to the Department of Health on the matter (Eastern Health Board, 1982c). The health board also suggested that the refurbishing could be done by an AnCO Community Youth Training Project [44].

The suggestion that the YDP premises could be renovated through an ANCO training scheme was viewed by some YDP committee members as likely to cause unacceptable delays in setting up the project. The project leader was also unhappy with the suggestion and at this stage - December 1982 - she became concerned at the absence of decisiveness in relation to the YDP's funding. In her report (Walker, 1982c), the project leader presented an outline of two separate options for the YDP to proceed. The options were presented in the context of differing funding situations as the funding position for the YDP was not, at the time, fully clarified by the health board. One meeting which the project leader attended with health board management in December 1982 left her with an impression that there was no money available to employ staff. At the same meeting the health board wanted to know what work she was doing "on the ground" - in other words "how many drug users was she counselling" and so on (Walker, 1991). The project leader was undermined by this comment. She had set out a short term strategy for involving herself in outreach and advice/information work but she had been determined not to commence this until there was evidence that progress

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[44]Under this scheme AnCO trainees would provide the labour and the sponsoring agency (in this case a, company Eastern Community Works Ltd which was set up by senior health board officials for the purpose of utilising this scheme) would provide the materials for renovation work on a project which met the schemes criteria - namely that it be for social service, youth, sporting or cultural developments and that it not be commercial.

was being made on the long term resourcing of the project. For its part, the health board seemed unable or unwilling to make a long term commitment to funding.

The project leader's concerns had already heightened as a result of funding problems in relation to a seminar on local drug problems which was held in October 1982. The seminar on the theme "community responses to the drug problem" (YDP Committee, 1982), was organised for the purposes of introducing the YDP, its committee and project leader to the wider community, and to youth and social services in the area. The seminar was addressed by three separate speakers - Aryeh Leissner (Lecturer in Youth and Community Work, University of Keele), Frank Deasy (Management Committee member, Ballymun Youth Action Project) and Matthew Bowden (Secretary of STGDC).[45] The seminar was attended by teachers, youth workers, community leaders, social workers, community workers, probation officers, school attendance officers, doctors and nurses from the Dublin 8 area. It was quite a successful seminar and proved particularly useful for various workers in the area to make contact with each other. From an organisational perspective however the seminar revealed the extent to which there were funding problems with the YDP. Although the Health Education Bureau had agreed to reimburse 50% of the seminar costs (totaling no more than £500) the health board found it extremely difficult to fund the seminar, despite giving it approval at an earlier stage. Two days before the seminar its organisers faced the prospect of cancelling it for lack of funding.

Eventually the seminar went ahead on foot of an order signed by the Programme Manager (YDP Committee, 1981/85a - 29/9/82). It was an ominous sign to the committee that a minor expenditure required such a high level decision. Although, during the seminar, the Programme Manager restated the health board's continued commitment to the YDP, the committee was concerned that according as the project

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[45]The notes of the main contributors to this seminar are outlined in Bowden (1982), Deasy (1982) and Leissner (1982).

leader progressed with her plans (and funding proposals) for the project, the health board was becoming less and less interested in it. A key question being asked by committee members was whether the health board and/or the Department of Health really believed that a serious community drug problem existed. The fact that they had employed a project leader and indirectly given the YDP committee a sanction to operate was evidence that the problem merited health board attention. But most committee members were increasingly concerned that this attention derived more from a political need - to say that something was being done - rather than any deeper commitment to the problem itself. If this commitment existed, it was argued, the project leader's proposals and plans would have generated genuine dialogue and discussion among health board management. It appeared, in short, that health board commitments to a community care response to drug problems was superficial.

The committee's concerns were given greater impetus as a result of contacts made with it by researcher, the late Dr. John Bradshaw during the summer of 1982[46]. Bradshaw, acting on behalf of the Medico-Social Research Board sought the committee's cooperation in compiling prevalence research on drug misuse in Dublin. Bradshaw was proposing to conduct research in two phases: the first was a qualitative study to be based on interviews with key community personnel and the second was to be a quantitative study involving the collection of data from individual drug users. The full research report was published in May 1983 (Dean *et al,* 1983). In seeking the committee's cooperation in this research, Bradshaw argued that the then Minister for Health did believe there was a serious problem with heroin use in the inner city but needed the evidence of a scientific study to prove it to his own officials[47]. At the time, the infamous *Gregory Deal* ensured the parliamentary support of independent TD, Tony Gregory for a minority government in return for a widely-ranging social plan -

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[46]YDP committee minutes noted that Bradshaw had been invited out of retirement to conduct this study (YDP Committee, 1981/85a - 29/9/82).

[47]These arguments were made by Bradshaw in direct discussions with author.

which included action on drug problems - for the north inner city (*Irish Times*, March 10, 1982, 8)[48]. As a result of Gregory's balance of power position he had regular access to various government ministers, including the Minister for Health. On the 20th May 1982, Gregory, along with a local curate, a teacher, an EHB community officer, a probation officer and three local parents, met with the Minister for Health and provided him with an account of the drug problem in the Sean McDermott Street area, where the then current estimate of drug users was "50-60 between the ages of 12-18" (Seán McDermott Street, 1982). As a result of this meeting the Department of Health began to take a more direct interest in the drug problem.

YDP committee members cooperated with Bradshaw in conducting his first phase study. This study was compiled in the Autumn and circulated to a number of key policy makers. Bradshaw later commented that a number of people "expressed the view that the various supposed addicts and those trying to help them locally had, perhaps unwittingly, greatly exaggerated the problem and so therefore had the report" (Dean *et al*, 1983). It appeared that while Gregory with the support of many community workers was pushing the Minister for Health in one direction, others were pulling him back. The doubts of officialdom won and it appeared that action was to await the outcome of Bradshaw's quantitative study.

For the YDP Committee, at the time, it appeared that commitments already granted in relation to the locally based drug project must now await the outcome of even further research, in which it was expected to participate. The committee discussed this matter and having considered what were now obvious political dimensions to Bradshaw's second phase study, and for other reasons - particularly their concern that a

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[48]Drug problems had not featured as an election issue in the North inner city in either of the General Elections held in June 1981 or February 1982. However, in the months prior to the February election, there was growing concern in the area about the problem and on January 18th 1982 a meeting of community activists from both the South and North inner city, Clondalkin and Ballymun was held in the North Star Hotel, to discuss common concerns in relation to the drug problem. Among the attendance at this meeting was Tony Gregory -later to become a TD in the February General Election - and the then Leader of the Labour Party and Tanaiste, Michael O'Leary TD (North Star Hotel, 1982).

comprehensive survey would raise local expectations that an official response was imminent - refused to participate any further in the study. Furthermore, members of the committee expressed strong views that the information collected to date, and submitted already to the health board, was sufficient to warrant a substantial official response and that little was to be gained, at this stage, by participating in further research[49].

The committee, at the time, was already meeting for over one year and many members were becoming quite despondent at the slow progress in securing resources. In particular the lack of progress with the Weaver Square premises - which dominated committee discussions - was most frustrating (YDP Committee, 1981/85a - July 1982-83). Although finance was an essential problem in progressing with the premises, there were additional technical problems in relation to fire approval and planning permission *(Ibid)*. Committee member, Paul Humphrey later expressed the view that these delays were a deliberate ploy by the health board and pointed out that "if it was n't the fire escape" that was holding matters up "it was the refurbishing costs, then it was the lease, then it was the fire escape again"(Humphrey, 1991). His views are considerably borne out by the comment from Flanagan (1991) - in an interview with the author - that from the outset the health board had doubted the feasibility of the Weaver Square building. Such doubts were never expressed to the YDP committee at the time.

Progress was slow in a number of other areas and it appeared to the committee at least that that this lack of progress was directly related to a lack of funding. In November 1982, Michael King the chairman of the YDP committee wrote to the EHB programme manager expressing the committee's concerns and worries in relation to the project's

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[49]The minutes of the YDP committee meeting note the following: "Each individual member of the committee told Dr. Bradshaw of the difficulties of (his) method. Fergus O'Kelly said that as far as he was aware the figures obtained in the committee's own prevalence study were not mere guesses. He said that his input into the report was based on the medical reports of addicts. Paul Humphrey, Matthew Bowden and Sean McArdle informed Dr. Bradshaw of their input into the study, saying that it too was based on known fact. Dr. Bradshaw commenting on this, asked would the information found be believed. Paul Humphrey asserted the committee's position by informing Dr. Bradshaw that in the community of St. Teresas gardens, according to his knowledge and experience of the area, (his) survey would not and could not work" (YDP Committee, 1981/85a - 27/10/82).

development, pointing out that the YDP intentions to "assess with rigour the effectiveness" of its approach to "working with youth in affected communities" could not be achieved "if only a small level of funding became available". The letter sought clarification on whether there are "now any barriers to the renovation and early opening of the premises in Weaver Square" and "when will the remaining staff be appointed"(YDP Committee, 1981/85b - 25/11/82).

Although this letter was acknowledged it failed to elicit a detailed response. The YDP chairman telephoned the health board on a number of occasions but failed to make contact with senior management personnel. A second letter (YDP Committee, 1981/85b - 15/12/82) was sent in December 1982, which pointed out that progress in the project's development was not in keeping with decisions taken at the meeting held the previous January. The letter also sought clarifications on whether there was a timescale for the committee to take over the direct management of the project and what arrangements were to be made for a financial/budgeting system. This letter was also acknowledged and despite other efforts by the YDP chairman to make telephone contact with senior health board management, there was no formal contact until late February 1983.

Project leader's resignation

By this stage however, the project leader had resigned and the YDP was plunged into a deep crisis. In her letter of resignation to the health board in January 1983, the project leader pointed out that she found it impossible to reconcile her position with the fact that nothing in the way of advancement of the proposed project had happened in the previous seven months. It seemed to her that the project would not get off the ground in

the foreseeable future because of apparent lack of commitment by the health board and lack of finance[50].

Committee members were bitterly disappointed with the turn of events. They were particularly annoyed with the circumstances of the project leader's resignation and that the committee had not received a response to correspondence with the health board. There was quite an amount of anger, with committee members expressing "upset", "frustration" and feelings of being "let down" and "misled". Paul Humphrey argued that there was a "wrong attitude" among health board management.[51] It appeared to him that the health board's strategy was quite deliberate. They had no real commitment to this project and they were allowing themselves to be involved in order to keep the lid on the problem[52]. So long as health board management could say they had a project in St. Teresas Gardens - even though they themselves were frustrating this project - they could avoid negative publicity and deflect political demands. There was quite a lot of support for Humphrey's arguments, particularly from Bowden, Cullen, McArdle, Smyth and O'Kelly. There was also a strong sense that the conflict was a political one[53] and that the health board needed to be responded to in some political manner. Committee members had been meeting in good faith for well over one year. Their willingness to respond to the problems in their midst had been channelled into the YDP proposal. While officially, the health board was supportive to these efforts, the attitude of key management personnel toward the project appeared antagonistic and to be designed to precipitate conflict with committee members.

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[50]The project leader's resignation to the health board was read out at the January 1983 meeting of the YDP and its details noted (YDP Committee, 1981/85a - 27/1/83).

[51]These comments were recorded by the YDP Committee chairman in his notes of the meeting (YDP Committee, 1981/85a - 27/1/83).

[52]O'Kelly (1991) observed that each of the issues which were delaying the YDP was separately creditable but when the YDP was looked at in its totality it was reasonable to believe that the health board was bringing the committee around in circles as a delaying tactic for the reason that there was no policy at a management level and a deep reluctance to admit this.

[53]The YDP chairman, in an interview (1991) for this study, observed that senior people whom the YDP committee were dealing with seemed constantly unable to disclose their hands or to discuss matters openly. There was, he suggested, a lack of frankness in the health board's dealings with the committee and it seemed unable to respond to complex political demands in any other than a defensive manner.

The committee found itself facing two separate options: first that it should fold up as a committee and do so with full publicity, highlighting what was considered to be the health board's ineptitude in the matter; and second that it should seek direct negotiations with the Minister for Health and his Department, thus putting political pressure on the health board. It was decided that a further attempt would be made to get a response from the health board and that other attempts would be made to pressurise the Minister for Health and his department. The YDP chairman wrote again to the health board pointing out that the "inability to establish a timetable for the setting up of the Project questions the standing of the committee in relation to the project" (YDP Committee, 1981/85b - 8/2//92; A). He insisted that clarification on the points he had already made, in previous correspondence, was needed within two weeks. He also wrote to the Minister for Health on the same matter pointing out that "we cannot offer a service due to the inability of the Eastern Health Board to determine a timetable for the renovation and equipping of premises" (YDP Committee, 1981/85b - 8/2//92; B).

In the meantime, the two local representatives on the YDP committee decided to write their own letter, on behalf of the STGDC, to the Minister for Health in which they expressed their "concern at the lack of evidence of funding for the YDP" (STGDC, 1983b). They also made direct representations to local TD, the late Frank Cluskey, to approach the Minister - who was in the same political party - on their behalf. The health board's explanation as to the delay in proceeding with the YDP - as conveyed to the STGDC via return correspondence from the Minister for Health - was the awaiting of technical reports on the premises at Weaver Square. Whatever about this reply's lack of reference to other matters of concern to the YDP committee and the STGDC, it appeared that the involvement of the Minister's office was beginning to shake the health board somewhat, as the following week the health board contacted the YDP chairman and sought a meeting with him in late February. At this meeting, which was not minuted, the health board assured the YDP chairman,verbally, that: the project would go ahead; that it was budgeted for; that a licence had been obtained from the Irish

Sisters of Mercy regarding premises; planning application had been published; that the advertisement for a new project leader would appear shortly; and that AnCO would undertake the work of refurbishing the building with the health board supplying the materials[54].

In relation to other staff for the project - two full-time project workers had previously been promised- the health board pointed out that these two posts had now been cut by the administration and that only the post of project leader stood. It was the health board's hope that counselling staff could be seconded from other parts of the health board service or that trainee staff (i.e. persons employed on youth employment schemes) could be used in operating the project *(Ibid)*. On hearing the chairman's report of this meeting, the YDP committee found the health board's position in relation to staffing totally unsatisfactory. Some members were disheartened that it appeared that health board management had been engaged in a slow process of wearing down commitments in relation to staffing and other matters. As far as the committee understood it, these commitments had been formally communicated to the committee in the document which was approved at the January 1982 meeting. It was decided that the committee should seek further clarification from the health board and that the latter should be informed of the committee's minimum requirements for a satisfactory service *(Ibid)*.

On behalf of the committee, the YDP chairman again wrote to the health board on March 4, 1983 rejecting the health board's latest proposals and outlining the committee's minimum conditions for a Project offering a professional response to drug problems, as: "the appointment of a project leader and two full time professional staff; the provision of adequate premises; the provision of an adequate budget and supply of

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[54]The YDP chairman's report of the meeting with the health board is contained in YDP minutes (YDP Committee, 1981/85a - 23/2/83).

ancillary services; and, the provision of a satisfactory temporary premises from which to launch the project" (YDP Committee, 1981/85b).

In relation to the final point, the committee had reached the conclusion that if, as it now appeared, the health board intended renovating the Weaver Square building with an AnCO training scheme, it was unlikely that the building would be ready for use for at least eighteen months after building work commenced. In this event, a temporary premises would be necessary. When contacted in relation to a meeting on the above four points, the health board suggested that any meeting be deferred until such time as a new project leader was appointed (YDP Committee, 1981/85a - 27/4/83).

At this stage in March 1983, it was five years since social worker Terrie Kearney had first become aware of the local drug problem; it was a little over two years since the health board director of community care had convened a consultative meeting on local drug problems; it was eighteen months since the YDP committee had submitted a research report on the prevalence of drug problems; and, it was a little over twelve months since the health board had formally approved a document which set out the aims, objectives and arrangements for the YDP initiative. However, - apart from the drop-in club set up by Kearney in 1978 - nothing by way of direct, health board actions had yet taken place with drug users in St. Teresas Gardens. Among those local people involved with joint health board responses there was deep concern that this involvement had not translated into meaningful outcomes and that it may have distracted local efforts from other alternative and, perhaps more useful, activities[55].

In the meantime, other events lent new political and public dimensions to the drug problem, and these also affected the direction the YDP took when a new project leader

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[55]Certainly, members of the STGDC - Humphrey and Bowden - who were on the YDP Committee were concerned that as voluntary workers in the community the YDP had demanded an excess of energies out of proportion to its achievements.

was eventually appointed. John Bradshaw's second phase study referred to earlier in this chapter was published in May 1983. This study was based on field research conducted in an area of the north inner city which was experiencing a similar level of heroin use as St. Teresas Gardens. The prevalence figures revealed by Bradshaw showed a situation "worse than the available figures for certain New York ghetto areas"(Dean *et al,* 1983). The publication of the survey results caused a major public and media stir. The Government responded by setting up a *Governmental Task Force on Drug Abuse*, while in May 1983, RTE's *Today Tonight* [56] broadcast a full feature length programme on the subject.

At last, it appeared that the drug problem in the inner city was beginning to command mainstream political attention. In the inner city, and in St. Teresas Gardens in particular, the media and political interest in the drug problem contributed to a renewed community interest and commitment to tackle the problem locally. In June 1983, the Concerned Parents Against Drugs (CPAD) - a locally based movement to prevent the supply of illegal drugs - was formed in St. Teresas Gardens. This group was founded against a background of what was locally perceived as the failure of statutory responses. The early activities of this group and the circumstances leading up to its founding are outlined in Chapter 6.

Conclusion

In the previous chapter the relationship between community care management and social work/community work responses to social problems was discussed in a general context. In this chapter 5, the focus has been on these relationships within the specific context of St. Teresas Gardens and its social predicament. From the outset of the health board's involvement in St. Teresas Gardens in the early 1970s, a number of issues

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[56]Radio Telefís Eireann (RTE) is Ireland's semi-state broadcasting station and *Today Tonight* was its most important current affairs programme.

arose in relation to the role and function of community based social workers and the relationships between health board management and community organisations. These issues mirror many of those discussed in chapter 4.

Firstly, the health board demonstrated grave reluctance in acknowledging the emerging needs in relation to drug problems in St. Teresas Gardens. The identification of the drug problem in St. Teresas Gardens originated primarily from the health board's own officers and contracted doctors who were working in the community. There are indications that health board management - and indeed local political representatives - either refused to believe the information provided by their own workers or hoped to establish that responsibility for dealing with this new problem lay not with it, but with other statutory authorities, such as the education and youth services. These developments raise fundamental questions in relation to the health board's capacity - at the time - to understand and acknowledge its own responsibilities in relation to medical and social needs. Furthermore, concerns are raised in relation to the efficacy of the Community Care Programme and in particular its capacity to act independently and confidently in relation to the setting up and development of new community-based services. There are clear indications that community care central management constrained itself from acting out of deference to institutional structures - particularly the National Drugs Advisory and Treatment Centre (NDATC).

Secondly, from the outset of community-based social work in St. Teresas Gardens, it was quite clear that traditional casework approaches had limited potential and that community work approaches should be tried. The various social workers assigned to duties in St. Teresas Gardens advocated a community dimension to the work. Health board management initially made some positive gestures in relation to this community dimension. Gradually, however the health board developed a caution in relation to developments in St. Teresas Gardens, reflecting its overall caution to community work generally. Consequently, the initial support for community work eventually dwindled

to the point where workers on the ground experienced deep frustration and disappointment with their health board managers.

Thirdly, the health board demonstrated an inability to negotiate clear relationships with local community groups. While it was willing to meet the YDP committee and agree to some of its requests, the committee was given no formal recognition and the STGDC was virtually ignored. The YDP committee also experienced tremendous difficulty in establishing a correspondence with health board management - letters were not responded to except by acknowledgement and telephone calls were not returned. In fact, the health board succeeded in alienating a committee which constituted its most important link to the community it hoped to serve and it demonstrated a greater concern with negotiating with and involving the main institutional service - the NADTC - in its proposals to respond to community drug problems.

Fourthly, the health board lacked commitment to open dialogue in exploring proposals for developing the YDP. While the YDP's project leader, Helen Walker, had wide consultations in relation to programme design, premises refurbishing, staffing and budgeting, it appeared to her and her colleagues on the YDP committee that according as she progressed these proposals, health board management was unwilling to engage in any real discussion on the sole basis that they were cost-prohibitive.

Finally, the health board showed a lack of openness and frankness in its handling of these issues. There are indications that committee members' suspicions that it was being dealt with in a political manner were justified. A considerable amount of the committee's energies were taken up dealing with the Weaver Square building at a time when the health board, unknown to the committee, had grave doubts about using this premises. While the health board had funding difficulties in relation to the project, these were never fully outlined or explained to the committee. While the committee - through the January 1982 meeting - was given a significant role in the YDP, this never

translated into meaningful or open contact between committee members and senior health board management. What was, in 1981, a collection of individuals who were involved directly in either a professional or voluntary role in St. Teresas Gardens, and who were committed to exploring a new health board initiative, had, by 1983, mainly as a result of their dealing with health board management, become a committee of dispirited sceptics.

Despite, or perhaps because of these difficulties, significant community developments continued to take place in St. Teresas Gardens. In particular, the local partnership between members of the STGDC and community social workers - initiated by Kearney and continued by Daly and the author - resulted in activities which were to have a generally positive impact on the local community. These developments are discussed in the next chapter 6.

Chapter 6 - Local community developments in St. Teresas Gardens

Introduction

In chapter 3, the predicament of St. Teresas Gardens leading up to and following the outbreak of heroin-use in the late 1970s was described. The effects of this problem in terms of increased criminal activity and widespread fear, suspicion and denial were also outlined. A picture was painted of a community disintegrating, lacking in cohesion and also lacking the capacity to effectively organise its own response to the problems which confronted it. In the midst of this disorganisation, however, there was a small number of community members who did become directly involved with efforts to tackle local problems primarily through their involvement with the STGDC. As outlined in chapter 5, a health board community worker, Terrie Kearney, was instrumental in initiating this committee and in supporting its members in their activities. By the time of Kearney's departure in 1980, tensions between social work/community work and health board management had begun to develop and, in theory at least, there was the possibility that the local partnership between community social workers and the STGDC would be discontinued. Certainly, the situation was not helped by the health board's performance in relation to the YDP proposal and this contributed to a great deal of scepticism among local community activists. However, despite their potential for tension, relationships between local health board personnel and the STGDC continued to prosper and during the years 1981-5 these relationships contributed to a wide range of community developments. These developments are discussed in this chapter 6, under the following general headings:

- progress in the development of the STGDC
- the emergence and development of the Concerned Parents Against Drugs
- progress in youth development programmes

Progress in the development of STGDC[1]

Although, during the period following Kearney's departure, there was a short lull in the direct community activities of the STGDC, by 1982 it had begun to reorganise itself. The committee focused on developing projects - two in particular: the launch of a community magazine and the operation of a leadership training programme - that were considered capable of improving community cohesion. In April 1982, the committee launched "The Gardens", a once-off community magazine. The primary motivation for publishing this magazine was as a counter to bad publicity given earlier to the community in the media[2]. The magazine was considered important for providing local people with an update of what was going on in the area. It could, according to Willie Martin: "consolidate positive community attitudes and feelings about where you live, and who you know" as well as provide "opportunities for sharing talents, skills and ideas" (Martin, 1982). The magazine was generally considered a success. The various tasks involved in magazine production meant there were good possibilities for participation. Stories were written locally; committee members raised advertising

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[1]In addition to published documents, the discussion in this section is drawn from the author's notes and recollections from when he worked alongside the STGDC, 1981-3, interviews which he conducted with the following members of the STGDC: Humphrey (1991); Bowden (1991); and Martin (1991) and the various unpublished documents listed below.

Humphrey, P. (1982): *Speech made at public meeting in Youth Centre at launch of "The Gardens" magazine.*

Humphrey, P (1987): *Speech made to Public Meeting in St. Teresas Gardens to review the work of the STGDC.*

Martin, W. (1982): *Speech made at public meeting in Youth Centre at the launch of "The Gardens"magazine.*

STGDC (1982a): *Minutes of public meeting to discuss general issues of concern in the community. with particular attention to issue of Dublin Corporation flats maintenance*, March 29.

STGDC (1982b): *Report on meeting between delegation from St. Teresas Gardens Development Committee and officials from Dublin Corporation, maintenance and community and environment departments*, May 26th.

STGDC (1982c): *Annual General Meeting Report.*

STGDC (1982d): *Proposal for a six month training programme for local leaders in St. Teresas Gardens.*

STGDC (1983c): *Notes and script from the drama "Fighting Back".*

[2]For example see Rogers (1981), Dougherty (1982) and Molloy (1982). The media had according to Willie Martin, at the launch of the magazine, forgotten that: "What they describe as ghettoes or trouble spots are in fact our homes. We live in them. We confront the problems. We live out the joys. It is therefore hurtful for us to see people come into our homes and give false impressions to strangers on how we live, work and enjoy ourselves" (Martin, 1982).

revenue; they also did the layout, wrote and edited the copy and eventually sold the magazine door-to-door around the flats (STGDC, 1982c).

The magazine also had a successful press launch, the main purpose of which was to focus media attention both on the positive developments that were taking place in the community and on the STGDC's internal analysis of the drugs problems it was confronting. In referring to this as the community's most "serious social problem" the statement issued by the STGDC, pinpointed the distinction between any individual's "contact with heroin" and the "likelihood of a whole community experiencing a heroin" problem and made it clear that any "treatment and rehabilitation must account" for the "social and economic conditions surrounding" the drug problem (Humphrey, 1982). This statement also warned that the area's problems could not be properly tackled without a concerted effort to also tackle housing maintenance and transience, unemployment, education, the lack of funds for pre-school facilities as well as the drug and youth problems. The press launch attracted favourable coverage (*E. Press,* April 30, 1982; *Irish Times,* April 30, 1982: *In Dublin,* April 1982), which contributed to the committee's sense of achievement and confidence (STGDC, 1982c).

During the summer of 1982, the STGDC successfully negotiated funding from An Comhairle Oiliuna (AnCO) - the national training authority - to undertake a community workers' training programme for local leaders. Additional funding commitments came from a number of statutory and voluntary agencies, including the Department of Environment, Dublin Corporation and the Catholic Social Service Conference. The Eastern Health Board agreed to second the author of this study to work with the STGDC as coordinator of the training programme.[3] The STGDC signed a contract for

[3]While the author continued to be directly employed by the health board, 50% of his salary costs were paid to the health board by the STGDC.

operating the programme with AnCO in September 1982 and by October the course commenced (STGDC, 1982d)[4].

One of the most important outcomes of the training programme was that it provided STGDC members with the resources and opportunity to build up contacts with other community groups, to engage in an ongoing dialogue with them, and to belong, as a result, to a wider network of community workers. Another important outcome was that a survey was conducted which provided vital information on local problems. The details of this survey, together with other articles on the community and the training course, were published in a report *Fighting Back* which was distributed to each flat in the community and officially launched in April 1983 (STGDC, 1983a).

For the launch of *Fighting Back* the STGDC put together a drama presentation and a slide show which together communicated in accessible language and visual imagery what they saw as the tragedy of St. Teresas Gardens. The drama told the story of a returned emigrant, Gerard Caring, who, along with his pregnant wife, moves into St. Teresas Gardens and becomes involved in developing local activities and particularly in tackling the drug problem. Eventually, after a succession of failures and forgotten premises, he becomes disillusioned and along with his family he decides to seek a new life by transfering to a house in the suburbs. It was a familiar story for people in St. Teresas Gardens[5], which perhaps for the first time was openly portrayed as an

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[4]There were eight participants on the programme, six of whom were members of the STGDC. The primary focus of the programme was to develop a positive, confident attitude towards one's own community; to express one's sense of community through a variety of methods, including art, drama, photography and video; and to get organised in one's own community through the acquisition of skills and resources. The training approach in the course was to explore participants' own life experiences in relation to their own community, and in reflecting on these to critically evaluate their contribution to local development. There was also a heavy emphasis on sharing one's sense of community with community groups from completely different social and geographic settings and these included visits to various groups in Dublin, Kilkenny, Connemara and Omagh.

[5]The story, while fictional had undertones which were based on reality (STGDC, 1983c). During the previous year, 1982, the STGDC had successfully mobilised the local community in a campaign for improved maintenance provision (STGDC, 1982a). The outcome of this campaign was an apparent agreement with Dublin Corporation for definite maintenance improvements (STGDC, 1982b). These improvements never happened (STGDC, 1982c). *Fighting Back's* improvisation was directly based on these experiences.

individual and community tragedy. The drama was written and performed by course participants and had an enormous impact on the audience[6]. Its real success was that ordinary local people had access to the issues confronting the community, and afterwards many expressed a determination to tackle local problems.

The training course and the presentation of the drama *Fighting Back* was a watershed in the development of the STGDC and presented it with an opportunity to undertake the task of community organising with greater knowledge, skill and indeed resources[7].

The emergence and development of the Concerned Parents Against Drugs (CPAD)[8]

In the weeks following the presentation of *Fighting Back* a number of residents, mainly women, became directly involved in meetings - convened by the STGDC - to discuss the community's future and to formulate plans for tackling local problems. Inevitably, people's concerns to do something about local issues, focused on responding to the drug problem on a collective basis. It was not the first time that local people wanted to do something concrete about this problem. Two years previously, in 1981, the STGDC

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[6]The drama was subsequently performed at an international adult education conference which was held in Leicester, England in July 1983.

[7]Paul Humphrey (1987) later commented: "We also began to get ourselves organised as a committee, so that we learned a little about government bodies; and how to get money out of them. In 1982 most people on the development committee at the time did a course down in Brown Street with AnCO. The course was a community workers course and in the course a few of us learned how to go about getting things moving in our own community. That meant that we also knew how to go about getting money - how to raise money, how to get it from the government."

[8]The discussion in this section is drawn from the author's notes and recollections of the period 1983/4. During this period, the author attended most public meetings in St. Teresas Gardens. He also advised members of the CPAD and STGDC in relation to dealing with media and journalists. Furthermore, the author had several informal discussions with persons - young and old- who had participated in various CPAD activities and with the local Catholic curate (McArdle, 1988). The author also conducted focused interviews with two key founding members of the CPAD (Humphrey, 1991; Martin; 1991). The following unpublished documents have also been useful:
Humphrey, P. (1984): *Information paper on Small Club.*
Humphrey, P. (1986): *Correspondence in relation to CPAD.*
Humphrey, P (1987): *Speech made to Public Meeting in St. Teresas Gardens to review the work of the STGDC.*
STGDC (1982a): *Annual General Meeting Report.*
STGDC (1983d): *Report on delegation from St. Teresas Gardens Anti-Drug Committee and officials from Dublin Corporation on maintenance, community and environment departments, November 14th.*

had organised a public meeting on drug awareness in the youth centre on Donore Avenue (STGDC, 1982c). There was a large attendance and speakers included representatives from the Garda Drug Squad, Coolemine Therapeutic Community and Jervis Street NDATC[9]. Many floor speakers described their personal experiences of the drug problem - they were mainly parents who had children who were heroin users and they could not understand what had happened. They were confused and they did not know how to cope with this new problem. In the main, their contributions to the meeting were in the form of questions to the platform speakers as to: why was it their children? what could they do? where could they go for help? The speeches from the platform speakers provided little reassurance that effective institutional responses were imminent[10].

The meeting concluded with the attendance signing a petition to the then Minister for Health calling on him to respond immediately to requests for a local treatment programme for young people, the provision of additional detoxification facilities and residential treatment units, and the introduction of an education campaign in national schools on drug problems.[11]

Following this meeting, a parent's support group was set up and this met on a number of occasions in the Small Club. Its attendance consisted of a small group of parents, mainly mothers, who continued to seek explanations for their children's drug use. At some of these meetings the issue of local dealers was also raised. Some who raised it later regretted they had done so. They pointed out that subsequently they had been

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[9]The main speaker was Denis Mullins, the then head of the Garda Drug Squad. He praised the STGDC for organising the meeting and he highlighted the importance of community response and awareness in tackling the drug problem. He also revealed that at any one time in the city of Dublin there were no more than three drug squad detectives on duty.

[10]The primary information sources in relation to this meeting are interviews which the author conducted with key personnel involved with the organising of this meeting - Humphrey (1991); Bowden (1991); Martin (1991): and O'Kelly (1991).

[11]The particular format used for this meeting was repeated later that summer in two nearby areas, Rialto and Meath Street. The author was involved in the organising of both of these meetings.

intimidated by drug dealers[12]. One meeting of the group was scheduled for late June 1981. In the days prior to the meeting there was an incident whereby a number of local youths had overdosed on heroin and become quite sick. There was widespread anger in the community and the parents' meeting provided an opportunity to focus this anger. Consequently, there was a large attendance of about fifty persons at the meeting. Some of the attendance wanted to tackle alleged drug dealers there and then. The situation was quite volatile and one of the guest speakers defused it by suggesting that a delegation of the attendance bring the petition which they had prepared at the previous public meeting to the Minister for Health's office and at the same time to issue a public statement highlighting their concern about the problem[13]. This strategy was adopted but while it succeeded in highlighting the issue in the media (*Irish Times*, June 11, 1981), it also reinforced the extent to which local drug dealers were feared and the subtle manner in which these fears were heightened. One resident in St Teresas Gardens was reported in the Evening Herald as having said at the time:

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[12]This observation is made on the basis of comments made to the author by some parents who had attended such meetings. When, the author commenced work in St. Teresas Gardens in October 1982, he tried to revamp these meetings. Two meetings took place and attendance was low. The primary focus of discussion was the fears which people experienced in relation to attending meetings which were concerned with drugs. These fears were, seemingly, based on a widespread view that drug dealers would interpret any form of local action against drugs as an attempt to undermine their activities and that consequently they would take whatever actions were considered necessary to prevent such local actions. A similar pattern emerged in relation to parents' meetings which were organised in the Meath Street area. At one meeting, a parent complained that following her outspoken contribution to a previous meeting - at which she had been openly critical of drug dealers and had mentioned they were present at the meeting - she had been verbally intimidated by the same drug dealers. Parent meetings in the Meath Street area also ceased to take place, as a result.

[13]This guest speaker was Frank Deasy - a founder of the Ballymun Youth Action Project (YAP). He later recalled - in discussions with the author - that the meeting's attenders had looked to both him and the other speaker - also a founder of YAP - as experts in community responses and capable therefore, of providing an answer - any answer - to the area's problems. However, while YAP had been founded as a result of the major drug problems in Ballymun - including one fatal overdose - both Deasy and the second YAP representative were bewildered by what they had heard and seen in St. Teresas Gardens. In public meetings in Ballymun, local people who were trying to understand drug problems had begun to discuss these openly in the context of patterns of family behaviour and addictions. In contrast, local people in St. Teresas Gardens were discussing heroin deals, drug pushers, injecting patterns in a manner that indicated that these behaviours were part of everyday experience and that the community was totally consumed by this problem to the almost exclusion of others. For Deasy, St. Teresas Gardens was like something he had only heard of or seen on American television. Paradoxically, it was to him and his colleague from YAP that people looked for "expertise" and "solutions". The situation is not unlike that of an English inner city community's "panic" response as described by Burr (1989, 89). O'Kelly (1991) has pointed out that it was not in the life experience of older local people to be talking about "junkies" and "smack". Because, such discussions eventually became acceptable, the problem being discussed became lesser or more normal.

> We've thought of getting up vigilantes but taking the law into our own hands would probably mean a bloodbath and it would mostly be our blood (Rogers, 1981).

Gradually, the parents' meetings in St Teresas Gardens fizzled out and the drug issue lost its impetus. There were no further public meetings on the issue of drugs in the south inner city for two years. It was in the aftermath of this brief anti-drugs campaign in St Teresas Gardens, that the STGDC focused its efforts on community reorganising[14].

Now, two years later in 1983, with a renewed community interest in tackling drug problems following the *Fighting Back* drama, there was greater confidence in the potential of collective, community action. There was also the fact that the area's problems were further exacerbated because by this stage - in 1983 - it had become an important point for heroin distribution in South Dublin. The local drug dealers had expanded their market and were supplying a much larger population and, consequently, attracting into the area - according to local estimates - two hundred separate drug users per day[15]. It was not uncommon for many of these to come for drugs in a distraught "strung out"[16] condition and once they purchased or "scored"[17] their supply, many would then inject this on the nearest stairway and balcony. So not only was the community coping with the problem of its own members using heroin, it had to

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[14]Paul Humphrey (1987) later commented: "In 1981 we said instead of doing something for the drug problem that's there now, we asked is there anything we can do to stop it getting worse? So we set up youth clubs in the youth centre; we set up a boy's club and a girl's club. Through these clubs we knew the young people who were growing up. We knew who was likely to use drugs and who wasn't and we were able to work with them so that they wouldn't go onto the drugs."

[15]This figure is widely used by residents of St. Teresas Gardens and by many of those who interviewed for this study. The origins of the figure, however, are unclear and there is no mechanism for validating it. There is little doubt, however, that there was a large number of persons coming to St. Teresas Gardens for a drug supply. The author of this study, regularly frequented the area and was constantly conscious of persons arriving - mainly by taxi - for the purposes of buying drugs. Fergus O'Kelly (1991) made similar observations. The figure of two hundred therefore, may be accurate; it may be an overestimate. It is indeed, possible, that it is an underestimate.

[16]Slang word for intoxication.

[17]Slang word for buying drugs.

contend with strangers coming and going to buy it. Some outside heroin-users decided to squat into vacant flats so that they would be much nearer a regular supply, or indeed become involved in the distribution themselves in order to support their own addiction. One group of three drug using sisters squatted into a flat which was previously rented by the drug dealer referred to in Chapter 3. This flat became a "shooting gallery"[18] for heroin users - a base for the buying, distribution and use of the drug. Although the flat was eventually burned out in an accidental fire in November 1982, other vacant flats were occasionally used for similar purposes. By 1983, local people had become increasingly infuriated with the large numbers of people who were coming into the flats from outside the community to buy drugs and who also used these drugs in the community, in empty flats, on the stairways and on balconies[19].

Although, local people were keen to take action against the drug problem, the type and form of action to be taken remained unclear until following the broadcast of an RTE programme on drug problems in May 1983. The programme, which was produced following the publication of John Bradshaw's report on drugs in the north inner city, was generally sensationalist. It included a sequence of a drug user injecting himself - this film sequence has often been repeated by RTE in subsequent programmes about drugs.[20] St Teresas Gardens, filmed from a helicopter above and, from a bedroom window in the nearby Coombe hospital, was portrayed as a no-go, depraved place and described by a young girl with a Dublin middle class accent, as one of the areas where heroin was most freely available. Local people who were attending weekly community meetings were infuriated and hurt by the manner in which this comment was broadcast and with the general portrayal of their community. However, they were also interested

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[18]Slang phrase for a place where drug users could assemble for the purposes of using drugs.

[19]One woman later described the situation as follows: "There was plenty of drug addicts. You could n't open your doors. I was going to keep on throwing buckets on my steps, and over the balconies - sick everywhere, syringes, matches, cider bottles everywhere. There was a lot of addicts coming from surrounding areas" (Gardens, 1981/85).

[20]The injecting scene attracted quite an amount of public criticism and one politician, Dr. M. Woods from Fianna Fáil said: "RTE's graphic portrayal of users injecting heroin into their veins bordered on the grotesque" (*Irish Independent*, May 26, 1983).

in coverage of drug problems in Hardwicke St Flats, on the north side of the city. There, when a small number of drug dealers moved into the area for the first time, a local committee which included a Sinn Féin activist, Christy Burke, and which had the support of local curate Jim Smyth, called on the dealers, asking them to stop dealing or leave. The dealers obliged. RTE was accused by Hardwicke Street residents of unbalanced coverage of this incident - they portrayed Sinn Fein as infiltrating the anti-drugs movement. Many from St Teresas Gardens saw the action of the Hardwicke Street residents as a model for the action needed in their own area and it was decided to organise a public meeting for getting the drug dealers to stop.

The meeting was held on Monday 20th June 1983 with about fifty people - mostly women - attending.[21] The meeting was a relatively calm affair and openly focused on four named drug dealers and whether and by what means they should be warned to stop their activities[22]. During the course of the meeting a delegation visited the named persons to convey the views of the meeting and returned to report that three of the four persons who were at home had agreed to stop. The meeting then focused on suggestions for monitoring this agreement and among the suggestions were: that the drug dealers be kept under surveillance and that drug users from other areas be prevented entering St. Teresas Gardens to purchase drugs. It was agreed that pressure be kept on the drug dealers with further drugs meetings and that an anti-drugs committee not be formed lest community members abrogate individual responsibility to do something about the problem. After the meeting, drug users approaching the flats complex looking for a supply of drugs were turned away; perimeter patrols were organised by roster and arrangements were made with taxi companies to drop passengers at the flats' single entrance on Donore Avenue. These decisions were taken

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[21]This meeting and most other public meetings in St. Teresas Gardens which were held during the 1983/4 period were attended by the author. The account of this meeting and of subsequent CPAD activities is based on the author's direct recollections of these events and discussions held with a number of the key actors, including members of the STGDC, leading members of the CPAD and other community members who participated in patrols, marches and various anti-drug activities.

[22]During the meeting there was unanimity in relation to the four named persons being drug dealers.

and implemented by persons of whom only a few had previous involvement in community activities. The decisions signalled the formation of the Concerned Parents Against Drugs (CPAD) - ordinary people who were acting on a mandate which they believed they had been given from their neighbours.

The action of the CPAD caused an overnight crisis in the supply of heroin in Dublin. News of the action had spread rapidly to the drug using population and the services which worked with them[23]. Many who worked in those services had a huge sense of relief that at last something major, practical and definite was happening to confront the problem of heroin supply in a very direct way[24]. Meanwhile in St Teresas Gardens, the action gained momentum as more and more people signed their names for patrol shifts. CPAD members brought a number of drug users to NDATC and arranged treatments. Other drug users encouraged by the extent of popular response decided to go "cold turkey"[25] and in fact many of the people who decided to use that particular option during the summer of 1983 subsequently managed to stay off opiate drugs.[26]

Future meetings of the CPAD grew in numbers and additional aims and rules were formulated. Distinctions were made between drug-users as victims and drug dealers as persons who amassed visible personal wealth. Procedures were adopted for dealing with alleged drug dealers. Allegations of drug dealing were only ever to be made at public meetings and not in pub or street conversations[27]. The CPAD would protect

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[23]The following morning the author received a number of phone calls from social work personnel who were working in other parts of the city and who had become aware of what had happened in St. Teresas Gardens. In some instances, drug-using clients had reported difficulties in getting a heroin supply as a result of what had happened.

[24]In conversations with the author in 1983, personnel from senior health board management and from the NDATC praised CPAD actions.

[25]Slang word which describes the condition of drug withdrawal symptoms.

[26]The author is personally aware of eighteen persons from St. Teresas Gardens who through individual efforts and community support, but no official treatment, permanently - by their own account - stopped using heroin during the summer of 1983. The author is also aware of others who stopped using heroin temporarily.

[27]Naturally, in a small community like St. Teresas Gardens, false allegations can easily be spread through rumour before there is sufficient opportunity for them to be countered. Surprisingly during 1983, there were few allegations of this type and generally, it appeared that such allegations which were made - in or out of public meetings - had substance.

people who made such allegations but there would be no protection for those who gossipped outside. The "protection of the people" as this was referred to was in sharp contrast to the situation which existed two years previously when those people who had spoken up at public meetings were subsequently, allegedly intimidated.

It was also made clear that allegations of drug dealing had to be backed at public meetings, by evidence. The type of evidence subsequently used in such meetings during 1983-4 was of the type normally accepted in courts and it was usually the testimony of former colleagues of drug dealers - drug users, former users, or indeed former dealers - providing information of actual - but recent - sales. Once evidence was given, alleged dealers - if they were present - had opportunities to respond. If they were absent, they were requested to attend the following meeting. If they then failed to turn up, the matter was dealt with in their absence. This rarely happened. Alleged dealers usually attended such meetings. In some instances they admitted they were dealers. In others, where this was denied, they were questioned by a number of people, and often in the process admitted guilt. In some instances, the meetings would conclude that there was no evidence of drug dealing. Decisions were made by the counting of hands of those voting and attending meetings. If a meeting decided that the evidence was substantial, alleged dealers were warned to cease their activities further. During the period June 1983-June 1984, a total of nine alleged drug dealers were confronted in this manner by CPAD in St. Teresas Gardens. The evidence against two of these was found to be inconclusive; two others openly admitted dealing and agreed to stop; two others refused to stop but left the community voluntarily; three others were forced to leaving having decided to recommence drug dealing after previously agreeing to stop.

The activities of this latter group of three became apparent in September 1983[28] .The three were summoned to the next meeting of the CPAD, where they admitted their

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28 This development arose from an incident whereby two local drug users were found by two leading CPAD members at the back of the flats in St Teresas Gardens unconscious from a drugs overdose. The

continued involvement in drug dealing[29]. The meeting took the view that the three had had sufficient time to give up drug dealing over the summer months and there was now no alternative for them but to leave the flats. They were given a week to leave. The following day the three alleged drug dealers made clear their intention to prepare court proceedings to prevent named CPAD members from putting them out.[30] A second meeting of the CPAD, convened hurriedly that evening, decided that the three alleged dealers should be put out of the flats that night. Immediately, following that meeting - in an action which had mass participation - the flats of the three persons - who had temporarily absented themselves - were stripped of their furniture which was piled in a bundle in the centre of the square. The mass participation was to ensure that no individual persons would be singled out for retaliation.[31]

These evictions represented an extremely difficult decision for the CPAD, not least because the three people concerned were themselves local, had family ties in the

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CPAD members resuscitated the drug users and brought them to hospital. The incident caused alarm in St. Teresas Gardens. The CPAD undertook enquiries as to who had sold the drugs - including interviews with the two youngsters - and were convinced as a result, that the drug dealer concerned was operating from a local flat. Other enquiries indicated the involvement of two colleagues of this suspected drug dealer.

[29]Initially the three drug dealers - who are all related by marriage to the drug dealer referred to in chapter 3 - denied their involvement but this was reversed when family members of one of the three insisted that not only was he dealing, but he had sought family assistance in his activities.

[30]Affidavits were prepared by the three and circulated in the form of a solicitor's letter to a number of named CPAD members and indicated that a high court injunction would be sought seeking to restrain any attempt to have them put out. CPAD members understood that if a court injunction was granted the three would be provided with police protection. It was for this reason that a decision was taken to evict the three immediately.

[31]Although the author was not present at this meeting or the mass action he arrived in the area shortly after it had finished. He spoke to several local people about what had happened and the following morning he spoke to a local priest who had been present and a second visiting priest from a neighbouring parish who had also been present. Later, in the author's work with various people in the community, the incident was regularly recalled and discussed in graphic detail. A description provided by Paul Humphrey is familiar: "On the night of the evictions, people as old as 75 years came out to do their duty, that was to rid the scum that was after ripping our community apart for three years. They stood side by side and lifted everything from the china to the video out so carefully that you would think it had been done by a professional contract. Nothing went missing, nothing broken and the three flats were empty in just 20 minutes (no joke). The people were not at home when all this was happening because they knew it was taking place. They had been given the choice to go themselves before 10pm or come back and pick up their belongings. One man came back at 11 pm with a lorry and said nothing, then the other two followed. Later the guards came along and wanted to speak with the chairman. Once you form a committee, certain people are recognised as the leaders, so the guards were told that there was no chairman, that it was a joint effort, 'we are all involved in this'. 'We are all concerned parents' and there was a huge clap and singing" (Humphrey, 1986).

community, and had grown up with many of the people now responsible for putting them out. However, it was a high point in the CPAD campaign, principally because, for something that had so much potential for violence, it was actually achieved peacefully. It was also widely celebrated[32]. At this point, the CPAD in St. Teresas Gardens, became a deep source of encouragement to communities in other parts of the city. The first three months of the CPAD campaign had been successful primarily because the drug dealers had yielded to the moral will of an organised community. By September 1983, the community and drug dealers were in open conflict and only one side could be expected to have won. Two years previously it would have been expected that the community would have lost. Indeed, in the week leading up to the evictions, many in the community believed that once again the drug dealers would triumph. Ironically, what convinced a number of CPAD members to pursue the evictions, was the decision of the three alleged drug dealers to pursue a court injunction which if successful would provide them with police protection. This decision exposed their vulnerability[33]. The actions of the St. Teresas Gardens CPAD attracted a lot of publicity, most of which was favourable. Broadcast programmes such as *Scene-Around-Six* (BBC), *Today Tonight* (RTE), *Newsnight* (BBC) and *Spotlight* (UTV) and *This Week* (RTE) all covered these events in a generally positive manner. There was also publicity in a number of print media. The media coverage ensured that news of the CPAD actions was spreading to other communities.

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[32]A victory dance was organised for Halloween night, an event which attracted much media attentions. It took place in the Youth Centre and, there according to Denis Geoghegan writing in *In Dublin:* "Ten years of misery, despair and powerlessness caused by the supply and sale of heroin was lost in the dancing and singing that went on until the early hours of the morning" (Geoghegan, 1983). The November issue of *The Gardens* described the dance as the "best four hours of dancing that we'd ever been to."

[33]It is important not to underemphasise the significance of this point. Many who became involved with the CPAD in St. Teresas Gardens had little faith in law enforcement institutions. As a rule, many internal conflicts were resolved without resort to the police or the courts. The fact that drug dealers who previously hid behind the community's antipathy to the police, were now taking the route of threatened court action was received locally with contempt. The three drug dealers were well known in criminal circles throughout Dublin. The solicitor's letter which indicated their intention to seek court protection was copied and widely circulated in these and various other community circles. The message was clear: drug dealers are resorting to the police and the courts for protection; if this is the case it should be possible for them to be dealt with effectively in the community.

In August 1983, a CPAD group was set up in Dolphin House, in the same neighbourhood. Other groups were set up in Fatima Mansions, Bridgefoot Street and Oliver Bond - all flat complexes in the south inner city. In December 1983, a number of CPAD groups, with the active support of local community TD Tony Gregory, were set up in the North inner city. There, the activities and structures of CPAD were, like the St Teresas Gardens group characterised by mass meetings, marches, patrols and where it was thought necessary, by evictions.[34] By the end of 1983 there were solid CPAD groups being formed all over working class Dublin. In CPAD meetings which were now taking place in these other parts of the city the St Teresas Gardens contingent were loudly applauded and their words of advice were listened to keenly.

The apparent transformation in the fortunes of St. Teresas Gardens was dramatic. The drug problem which many considered to have been responsible for the virtual destruction of community life as it had been previously practised had become the catalyst for uniting people in a manner they had long forgotten. It was a unique development and for many who participated in it, it highlighted at one and the same time, both, the potential of community-focused efforts and, the inefficacy of institutional responses. In explaining their actions during the summer of 1983, many CPAD activists have continuously pointed out that what they did they did only because they had been promised so much and so little had been delivered[35].

Following the initial success of the CPAD, the STGDC decided to capitalise on the community's ascendancy and to seek other improvements in the local situation (Humphrey, 1987). It redecorated part of the Small Club premises and set up an office

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[34]See Rafferty (1984, 12/13) for an account of the CPAD in the North inner city.

[35]At the time of the CPAD actions there was among those who were most closely involved a high level of resentment with what was seen as the lack of progress with statutory responses. Willie Martin from the STGDC commented as follows: "I still remember what life was like in St. Teresas Gardens before June 1983. The blood, the urine, the vomit. The mugging of old people. The constant turmoil in which the people of the area were trying to bring up their children. I watched the lorries which came to take away the families who just could n't take anymore. I remember the government responses to the drug problem, the constant frustration in trying to convince them that there was a problem, and the anger in knowing you might as well bang your head against a brick wall. I remember the attitude of the police, day in day out, arresting young users, getting information, then letting them go. I might add the information they were seeking had nothing to do with pushers or drugs" (Gardens, 1981/85).

there. Initially the office was set up to organise the local summer project. But the office was also used as an organisational hub for the CPAD. A tea/coffee facility was set up so that people who were involved in the CPAD could come along and discuss previous events and new strategies, and so that visitors to the area - who were increasing in number - would be made welcome and would always have an assembled group of people to meet. By August 1983, the Small Club also became a temporary base for the Eastern Health Board's YDP. In time, the YDP the CPAD and the STGDC were to become inextricably linked through the sharing of this common base[36].

In September 1983, the STGDC negotiated an arrangement with Dublin Corporation whereby any prospective tenant for St Teresas Gardens had to go through a local vetting procedure. Paul Humphrey, chairman of the STGDC was identified as the local community worker and he was given the responsibility of investigating prospective tenants - the only real local concern was that new tenants would not be persons who were likely to sell, encourage or facilitate the selling of, drugs. The decision to allow new tenants into the area was referred to large public meetings.

This arrangement continued for as long as large meetings happened on a regular basis, which was for the next two years. It was an important improvement in the management of the estate, not only because it might exclude possible drug dealers from living in the area - although it did not always succeed in this - but because it encouraged and facilitated the movement back into the area of former local tenants or extended families of existing residents, all of whom were now coming to the area out of positive choice. In the first few months of operating this procedure, twenty families who had in previous years transfered to the suburbs of Tallaght and Clondalkin, moved back to St Teresas Gardens.[37]

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[36] An outline of the range of activities in the Small Club is provided by Humphrey (1984).
[37] Paul Humphrey provided this figure during a seminar on drug problems held in the Gresham Hotel in April 1984 (STGDC, 1984a).

Using newly made contacts with Dublin Corporation, the STGDC also negotiated some support from local state bodies for the CPAD actions. There was a small empty flat at the entrance to St. Teresas Gardens, which was known as "The Hut". The flat had previously been used as a maintenance depot by Dublin Corporation. The STGDC successfully negotiated with local officials to use the flat as a base for night patrols, where people could drink tea, or sit in from the cold and at the same time keep watch on the main entrance to the flats. Dublin Corporation also provided paint for redecoration. Delph, cutlery and various kitchen equipment and utensils were provided by local health board administration officials. The rules on the use of the base were quite strict and enforced. It was only for the use of persons who were rostered to do patrols and alcoholic drink was not allowed.

The STGDC also seized the opportunity of improved relations with Dublin Corporation to pursue the issue of local complaints in relation to flats maintenance. Maintenance improvements, especially in relation to public lighting, the securing of refuse chutes, and the general cleaning of the communal areas became obvious. It was through activities like this that the STGDC adopted a greater leadership role within the community. Its chairman, Paul Humphrey, was perceived as a local advice, information and resource worker - during one meeting with senior officials from Dublin Corporation, one senior officer mistakenly believed that Humphrey was their community worker on the ground[38]. Local people, if they had a problem with maintenance,would come down to the Small Club and seek Humphrey's advice. Before long, they were also coming to seek advice on welfare, and various other matters. Humphrey built up his contacts with the local section of the Eastern Health Board and also equipped himself with a detailed knowledge of the welfare system[39]. In February

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[38]Information provided by one of Dublin Corporation's community officers who also attended this meeting.

[39]Humphrey and the local community welfare officer put in place a number of arrangements for shortcutting community welfare application procedures. These arrangements were particularly effective in relation to new tenancies where sometimes there were emergency heating, cooking and clothing needs.Reports (STGDC, 1984c; STGDC, 1985), highlight Humphrey's housing and welfare advice work, and the following breakdown of queries is provided:

1984, the STGDC, utilising a grant which it had received from the Inner City Fund of the Department of Environment, employed Humphrey as local coordinator, a position which he held for the next three years. Effectively, this allowed Humphrey to become full-time manager of the committee's premises, the Small Club, from where he operated a housing and welfare advice service, and together with the author, who in July 1983 was appointed YDP project leader, he negotiated contracts for youth development programmes with a number of statutory agencies.

As the manager of the Small Club - formally from February 1984 and practically from June 1983 - Humphrey endeavoured to consolidate the leadership position of the STGDC in St. Teresas Gardens. The STGDC's concern was that the actions of the CPAD - which it fully supported - were likely to create a volatile situation locally which was open to external and internal exploitation. The main reason for this concern was that while the CPAD had no formal structure it had an informal leadership which, in the main, consisted of those who participated in nightime perimeter patrols. Although informal, this leadership could claim a mandate - its actions were based on decisions already taken at public meetings. However, being informal meant that there was no mechanism for ensuring that only such actions - and no others - in the name of the CPAD, were taken. STGDC concerns also derived from the possibility that an unchallenged informal leadership could wield an influence at public meetings that was out of proportion to the number of its members and furthermore, it was likely to be vulnerable to external direction.

STGDC concerns were particularly heightened following the fourth public meeting of the CPAD in July 1983 prior to which CPAD's informal leadership was approached by representatives of the Sinn Féin newspaper, *An Phoblacht,* and asked whether the

	1983/4	*1984/5*
new housing allocations	68	85
rent and maintenance	80	110
welfare advice	40	98

CPAD wanted publicity. A photographer and a journalist from the newspaper attended the meeting and the subsequent coverage attracted other media interest, most of which was favourable However, suggestions, which gathered momentum, were that *An Phoblacht's* involvement meant that Sinn Féin was also involved[40] and also, that because An Phoblacht had given publicity to the CPAD, *it* was indebted to *An Phoblacht*.[41]. STGDC members were concerned with these developments and endeavoured as a result to take a leading role in influencing media coverage of CPAD activities. In this, it was assisted by its visible presence in the Small Club, which became the natural focal point for any external or media attention to the area. When dealing with broadcast media in particular, Humphrey tended to delay their filming until he had sufficient time to consult public meetings, for the meetings to nominate spokespersons and, for the spokespersons to undertake intense preparation for interviews[42].

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[40]During July, 1983 the BBC (Northern Ireland) news programme Scene-Around-Six, investigated the CPAD story. Initial contact questions from the programme researchers suggested that their initial interest in doing a programme was based on their belief that Sinn Féin was involved.

[41]This suggestion was directly contributed to by Sinn Féin members. At the meeting referred to here some concern about the attendance of An Phoblacht was expressed by STGDC members. In response the photographer, in an emotional speech, argued that the mainstream media were not interested in places like St Teresas Gardens and by implication *An Phoblacht* which was not mainstream was on the side of the community. While his argument was widely applauded, naturally, it belied the general reluctance of the CPAD, at the time, to involve any media none of whom, apart from this photographer and journalist, had been invited to attend CPAD meetings.

[42]The author of this report played an important role, during this period, in preparing spokespersons for media interviews, assisting in the preparation of press statements and in organising media events.

Progress in youth development programmes[43]

Developments in St. Teresas Gardens during the summer of 1983 gave new impetus to the YDP committee. For the committee's July meeting the author, as the new project leader, drew up a report which outlined his current assessment of the project and of the options facing it (YDP Committee, 1981/85c - 9/7/83). Prior to drawing up this report, he had visited a number of voluntary street drug agencies in London and Manchester for the purpose of seeking advice in relation to the YDP proposals. The developing approach of these drug agencies was influenced by the problem-focused recommendations of the Advisory Council on the Misuse of Drugs Report (ACMD, 1982) and their overwhelming advice to the author - particularly in consideration of reported developments with the CPAD - was that the YDP focus on *youth development* and its *community orientation* were likely in the long run to be the project's strongest assets and that these should continue to be emphasised. It was also suggested that the best way in which the project could be initiated was to undertake outreach, drop-in and street counselling work in the short-term and to build towards a full training, education and rehabilitation programme in the long term.

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[43]The discussion in this section is drawn from the author's own notes and recollections as project leader of the Youth Development Project (YDP during 1983-5, informal discussions held with a number of participants and tutors on the various youth development programmes and focused interviews which he conducted with the following members of the YDP committee: King (1991), O'Kelly (1991), Humphrey (1991), Bowden (1991) and Smyth (1991). The following unpublished documents have also been used.

Christy, (1985): *Reflections on an involvement in community work.*

Cullen, B., Humphrey, P., Cullen, J., Farrell, C., O'Donoghue, H. (1984): *Proposal for a 12 month programme of youth development for early school leavers in the St. Teresas Gardens area.*

Cullen, B. (1984a): *Estimates of persons considered to be using drugs or at risk of using heroin in St. Teresas Gardens.*

Humphrey, P (1987): *Speech made to Public Meeting in St. Teresas Gardens to review the work of the STGDC.*

McGuinness, M.(1985): *The Development of a Community Newsletter in St. Teresas Gardens - a casestudy for social work theory and method, senior sophister social studies course, Trinity College*

STGDC (1984b): *Details of financial package, and letters of sanction, from various agencies involved in setting up a youth development programme in St. Teresas Gardens.*

STGDC (1984c): *Report on work of Local Coordinator, 1983/4.*

STGDC (1985): *Report on Work of Local Coordinator, 1984/5.*

YDP Committee (1981/85a): *Minutes & Notes. - including chairperson's notes.*

YDP Committee (1981/85b): *Correspondence.*

YDP Committee (1981/85c): *Reports.*

In his first report to the YDP Committee therefore, the author elaborated on the two concepts *Youth Development* and *Community Response* in some detail[44]. The report proposed that the main focus of the YDP should be to operate youth development programmes for young people who experienced serious problems of breakdown in their normal development. It was a similar proposal to that made by the first project leader twelve months previously[45]. The programmes would include persons who had experienced drug problems but they would not automatically exclude other persons. The ideal premises for operating such programmes was the Weaver Square building. If there was further delay in securing this building, a temporary premises could be used as a base for developing contacts with young people, building a knowledge of their needs and developing programme ideas.

The *second focus* for the project as proposed by the author was for it to develop an outreach programme of advice/counselling for persons with drug problems. He envisaged this service developing primarily through street contact with drug users and where appropriate providing counselling and referral[46]. It was envisaged that this

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[44]The following is an extract from this report. "Youth Development may best be described as a process through which young people become equipped to adapt to and sustain the move from adolescence to adulthood. This process is aided and facilitated by a number of support systems, including, most importantly, the following

- family
- community (peers, friends, youth club, etc.)
- education
- work (or training situation where appropriate)

"Youth Development' becomes problematic with a breakdown in one or more of these support systems. It becomes a problem for the health board with the breakdown of most or all of these support systems at the same time. Within the target area of this project, there has been identified a number of young people for whom these support systems have broken down. For some of these people the clearest manifestation of this breakdown has been their use and abuse of drugs. It is of course manifested through other forms of problem behaviour, sometimes in combination with drug abuse. In responding to this breakdown it is important to realise that solutions to it do not lie exclusively within a single support system. The problem cannot be resolved solely within the family; the community; the school; the training centre or the hospital. A realistic response to such problems is one that attempts to channel a number of different support systems into the one integrated programme for youth development. The basic objective of a 'day centre facility' within a 'Youth Development Project' would be to develop an integrated programme of learning, vocational training and preparation, social skills development, family, group and individual counselling which would prepare and equip attenders for a full and creative role in adult life (YDP Committee, 1981/85c)

[45]See chapter 5.

[46]The central objectives of this outreach programme were: to establish contact with drugs users; link them with existing services; mobilise supportive community personnel; set up locally based self-help

outreach programme could begin immediately within a temporary premises; the author would make the initial contacts and the work would be developed further as soon as the first project worker - who would be an outreach worker - was appointed.

This report also elaborated on the community response concept of the YDP pointing out that it was only in disadvantaged communities that the drug problem had taken hold and that the social conditions which surrounded and contributed to the problem included unemployment, lack of training opportunities, early school-leaving, overcrowding and a "general feeling of living in a community that has become run-down."[47] The report suggested that treatment and rehabilitation approaches which returned drug users to the same social conditions where their drug problem originated were likely to further aggravate the situation and to discourage people who otherwise were interested in changing their situation. The report emphasised the necessity of improving the social experience for young people within their community of origin and of involving community members in the process of rehabilitation. In practical terms, the community response concept meant the project would adopt the following features:

- involvement of local persons and locally based professionals in management of project
- involvement and integration of locally based resources in youth development programme
- outreach advice, counselling and referral service in the community
- involvement of project in other aspects of community life, eg. use of project premises for evening meetings or relevant activities, or involvement of project staff in other ongoing local issues *(Ibid)*.

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groups; refer young people to Youth Development Programmes (when they became available); and, provide ongoing advice and counselling to drug users and their families (YDP Committee, 1981/85c).

[47]The report made reference to a survey which had been conducted by the St. Teresas Gardens Development Committee in April 1983 which showed unemployment in the area at 60% and over 60% of tenants wishing to move out by transfer (STGDC, 1983a).

In spelling out these key concepts in his report, the author proposed that the project proceed to develop in the short term in a temporary premises - concentrating on outreach counselling and contact making with young people - and focus also in the long term on developing the Weaver Square building as a Youth Development Centre, with a full range of youth programmes. The STGDC had agreed to make part of its premises, the "Small Club" available as a temporary premises. The report was accepted by the YDP committee at this July 1983 meeting as a strategic plan for developing the project through its next phase (YDP Committee, 1981/85a - 9/7/83).

One essential difference between this plan and that envisaged by Walker (1982a) was that new developments in St. Teresas Gardens made it more possible for a temporary programme of activities to be undertaken. During the previous year, there was little confidence that temporary short-term programmes could be undertaken unless there was clear evidence of progress in relation to a suitable, long-term premises. In the summer of 1983 however, residents of St. Teresas Gardens had made clear their willingness to support a temporary YDP programme in the Small Club premises[48]. In its 1983 undertaking to develop the project in temporary premises, the YDP committee was satisfied that the health board remained committed to the Weaver Square premises[49].

The project leader commenced the development of youth programmes in August 1983. Initially, he built up a number of outreach contacts with young people and gradually brought them together for exploratory discussions and occasional activities[50]. He

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[48]Through his involvement with the STGDC, the author had had taken the opportunity to discuss the YDP proposals at a number of community fora and to generate local support.

[49]At the time that the YDP committee made this decision, September 1983, there was considerable confusion and latent disagreement between it and the health board as to the primary focus of activities that would take place in the Weaver Square premises. Therefore, while the committee was satisfied to go ahead in temporary premises its members had a strong sense that this was qualified. This and other related matters are discussed in more detail in the following chapter 7.

[50]In developing these contacts, the author reproduced outreach techniques which had been practised by local members of the STGDC over the previous two years in their work with youths in the community. The STGDC had targeted young people who appeared to be peripherally involved with drug using youths, and developed a low key discreet youth work approach with these. Additional efforts

focused on developing cohesion among one group of individuals whom he believed could, in time, become a core group who would become actively involved in their own community. The age range of the group was 17-25 years. Members of the group included some who had previously used heroin and who had also been involved in local crime. It also included young people who had siblings who were drug users. Meetings with the group were arranged on a regular basis and initially focused on their perceptions of need in St. Teresas Gardens. A number of drama workshops were conducted for the group. In October 1983, the group developed a playlet through improvisations which was based on their perceptions of recent activities in the community involving the Concerned Parents Against Drugs. They also developed a video from this play. Technical assistance was provided by a new video company, City Vision[51] and the Youth Employment Agency covered the small production costs involved.[52]

At Halloween 1983, the CPAD held a victory dance to celebrate their local drug action. The youth group organised a Halloween party for the children in the flats to take place on the same day. This children's party involved the group in raising money, publicising the party, arranging activities/games and so forth. Again it was a considered an important success and group members developed their self-confidence and awareness as a group. In the weeks after the Halloween party the author worked with the group in developing a local newsletter. The first issue of the revamped newsletter - *The Gardens*

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were made to get to know these youths and their families, to build up a relationship with them to the point of being available to provide advice, information and counselling at particularly vulnerable points. If, for instance it was noticed that a particular young person was being over-friendly with the drug users he or she was confronted and advised. The leader would also make efforts to include that young person in any forthcoming social plans - visits out of the area, card playing and trips into town. The idea was that the young person would value the relationship with the youth leader sufficiently to take heed of the advice. This approach was developed by members of the STGDC throughout 1982 (Humphrey, 1987) and later research showed that in this year there was a dramatic fall-off in the number of first time heroin users in the community (O'Kelly *et al*, 1988; Cullen, 1984a).

[51]City Vision later produced a number of short and feature films including, in 1986, *Sometime City*, which is based on the pressures of a social work department with an increased caseload of children of drug-using parents and in 1988, *The Courier* which was a fictional account of the criminal organisation of drugs in Dublin.

[52]The youth group brought the video to a number of other youth and community groups throughout the city.

- was distributed in November. After this newsletter was published, the youth group began preparations for a next issue. They also began to make plans for a Christmas party for local children and for revitalising clubs and other activities in the area. In a gradual sense they were becoming an important peer group in St. Teresas Gardens who were perceived in a very positive light by their elders who respected the group's developing commitment to the community[53]. The main work with this group took place in the Small Club and it involved the author working alongside the STGDC. In April 1984, the author, in conjunction with the STGDC, negotiated a Department of Labour Temporary Youth Employment Scheme grant to employ six of the young people as local youth leaders[54].

Throughout 1984 this youth group was the source of tremendous excitement and energy in St. Teresas Gardens - they were doing things which previously had not happened and the things they were doing were very visible within the community. One of the group's most visible activities was the production of the community newsletter,

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[53]The following accounts is provided by one member of this youth group: "There was about 10-12 of us down in the centre. We were coming to our final meeting which was about fundraising. All fundraising I'd done before I got involved in community work had always been - self help of other people's property.....I was amazed by the generosity of the people, both in the community and outside who contributed to the party. That to me was only my first attempt at fundraising (honestly). I felt really good. When the time came for the preparation for the kids Halloween party, anywhere I went for the next couple of days, kids were coming up to me, filled with questions. When's the party, are you running it, how much is it, can I go? I just felt great. That very first party I was involved in was the start of something good. It has gone on to include Christmas partys for young and old, discos, summer projects, footballs, hurling and clubs. The clubs include pool and table tennis." (Christy, 1985)

[54]One of the participants on this scheme later described her experience: "Hello! My name is Margaret and I played a big part in the lead-up to this production. The setting is in the Small club in a small community south side of the city - St. Teresa's Gardens. It was about three years ago when I played my first part in the Small Club. My role included helping out in the Summer Project, Girl's Club and other activities. The main characters around then were Mr Barry Cullen who directed the show by playing social worker in the community for the Eastern Health Board and Mr Paul Humphrey who produced the show. There were a lot of young characters around then that had nothing to do because of unemployment. We used to meet twice a week to talk to each other down in Brown St. Through our meetings we looked at the plot for the show which included scenes where the kids had nowhere to play; there was no football pitch for the boys and the flats weren't being cleaned because the Corpo weren't doing their job right. Then one day the director, producer and ourselves got together and drew up a script for the Department of Labour asking if they would fund us the money to produce this show. The show was staged and got on its way. I was employed with three others as well as our director and producer, to fulfil some of the needs within the community. From then on, I played in two other shows and directed a Summer Project show. Because of all these small parts I was now able to direct eight people on this latest production" (STGDC, 1986).

The Gardens, which was planned, designed and sold by the group itself[55]. The fact that some of the young people were employed on a Youth Scheme added to the importance of what was happening. Unemployment was very visible within the community. The employment of even a small number of young people seemed to signal some hope. Certainly the youth group, and the positive activities of others in the community, was a demonstration that some things could change. The young people were working for their community. The youth group was perceived as a model for the kind of activities which could be developed in the Youth Development Programme in Weaver Square when this particular building became available.

In November 1984, the author, again in conjunction with the STGDC, initiated a 12 month Communication Skills Programme for two groups of eight young people in St. Teresas Gardens. The main funding for this programme was provided by the Department of Labour, with additional funding and resources from the City of Dublin Vocational Education Committee, Catholic Social Service Conference, the Youth Employment Agency and various voluntary sources. The target group for this programme were young people in the 16-25 age group who lived in or near St. Teresas Gardens who were early school leavers and who were unemployed. The programme was divided into two phases - the first twelve weeks consisting of intensive training in basic communication skills - drama, photography, video, graphic layout and design - followed up by an eight month period during which many of these skills were improved and developed through local community projects. The skill/support inputs to

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[55]This account of the newsletter is provided by a student who was on a practice placement in the Small Club during 1984-5: "The newsletter has developed into a publication of ten pages of print with photographs, and its circulation has increased from an initial 500 copies to about 1,200. A group of about 15 local young people are involved as well as two of the community workers in the club. The group meets once a week, and the work involves deciding on content, approaching people for articles, typing and layout, as well as photography. The main criterion in determining content is whether or not an article is of relevance to people living in the Gardens, in this way ensuring a continued community base. Subject matter is varied, and of both an informative and entertaining nature. Coverage is given to local news and events, such as, for example, social events, publicising the summer project activities, local clubs, and so on. Some articles consist of interviews with various people, which the newsletter group undertakes itself. For example, recent editions have included interviews with some of the older people in the Gardens on what they remembered about the flats when they were first built as well as interviews with local children on Halloween" (McGuinness, 1985).

this programme were provided by trained tutors and there were other inputs in the areas of literacy, personal development and assertiveness training (Cullen *et al*, 1984; STGDC, 1984b).

The programme was generally recognised as a major success in St. Teresas Gardens[56]. In the early months of 1985 it had a major output in terms of photography, experimental videos and graphic designs. Midway through the programme it was decided to hold an open day for the purposes of displaying the materials and outputs to funders, participants families and the general community. This open day which was held on March 7th, 1985, attracted quite an amount of positive publicity and the project was featured on RTE *Main News* and *Today Tonight* and TVAM.

In September 1983 the author also used the Small Club for the purpose of developing outreach contacts with drug users and he began to see a number of drug users on a regular, informal basis. He also involved some of them in a weekly group[57]. Many of these drug users had a wide range of emotional, psychological and financial problems on top of their drug use. Their level of commitment to participating in structured programmes around drugs abstinence was quite minimal and, for this reason, few attended the NDATC on a regular basis and fewer again had an interest in the Coolemine programme.

Yet, from initial outreach work, it was apparent that quite an amount could be achieved with this group by providing them with a basic advice/counselling service In particular,

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[56]Recalling the operation of various activities in the Small Club, Humphrey (1987) recalled: " Since 1983 we have run four separate youth programmes in the Small Club. I don't think we can underestimate the effect of these programmes on the area. We must remember that quite a lot of young people got a job out of it - they also got the opportunity to build up their confidence and their skill. We've only to think of a few years ago when all we saw was young people getting a turn-on or something. We set up a darkroom and gave photography classes. We also started a newsletter. The Gardens newsletter was started in October 1983 with one single piece of paper. We should be proud of the fact that today the newsletter still appears - it might not appear regular enough but it does appear."

[57]Many of the details concerning young people's progress into drug use, as outlined in chapter 3 of this study were based on notes from these discussions and from subsequent interviews with individual members.

there was a lot which could be achieved in relation to developing more constructive relationships with their families and their community, especially as the community, through the activities of the CPAD, was quite alert to the drug problem. Since July 1983, some former drug users became involved in community service activities. Such activities offered the prospect of involving drug users in positive relationships with their community. In developing this work further, the author was hoping for the assistance of a project worker who would be a drugs outreach/counsellor and during the last quarter of 1983 health board management made a commitment to appoint a second worker. This second worker, Catherine Lillis, was appointed in January 1984 and her involvement with the YDP is discussed in greater detail in the next chapter 7.

Conclusion

In chapter 3, reference is made to a speech by Paul Humphrey (STGDC, 1984a) in which he described the impact of heroin in the community as like invading forces occupying a country. Similar observations are made by Fergus O'Kelly (1991) where he points out that at the height of the drug problem in St. Teresas Gardens, the community hit "rock bottom". There can be little doubt that, if, in the years 1979-82, St. Teresas Gardens reached such depths of community disorganisation and demoralisation, that, in 1983, a great deal of community cohesion and solidarity was achieved through the formation of the CPAD and other related activities - to extend Humphrey's metaphor: the people were liberated. For O'Kelly, himself a medical practitioner, the formation of the CPAD was a form of "healing" *(Ibid)*[58].

By any standard, this was a dramatic reversal in the downward fortunes of St. Teresas Gardens. From a community, which was demoralised and disintegrating, it became one that was proudly confident and possessed an agreed communal agenda. Ironically, it

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[58]See also Gardens, Vol 1, No. 5, p16 in which O'Kelly writes positively of his impressions of the first year of the CPAD.

was drug problems which created the impetus for this turnaround and, significantly, the transformation occurred despite the health board's delays in developing an appropriate community care response.

The community social work model which had been initiated by Kearney (1975-80) and subsequently developed and improved by Daly (1980-81) and the author (1981-85) contributed immensely to the turnaround in the community's fortunes and, in particular, contributed to community organisation - community work training course - and cohesion and identity - the drama *Fighting Back*, support for magazine, youth clubs and various other youth activities.[59] By the time the CPAD was formed, there was a much improved local organisational capacity than that which existed in previous years, and this contributed to the consolidation of CPAD and other local activities. It provided an important base for negotiating new arrangements with Dublin Corporation and the Eastern Health Board particularly in relation to matters such as housing allocations, local maintenance and welfare services.

The new situation in St. Teresas Gardens also provided the YDP with its first real opportunity to demonstrate the type of activities which were suggested in its previous discussions. Its activities were very localised and were integrated with community structures. Also, these activities had a youth development rather than a drugs treatment focus and included in their participants persons who had previously been involved with heroin-use and others who lived in families where there were older siblings so involved.

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[59]Significantly, developments in St. Teresas Gardens had direct benefits for social work services. During 1983-4 the local social work department reported to the author a decrease in the demand for its casework services. This author recalls that on several occasions he impressed on senior health board officials that they should try to capitalise on their on-the-ground involvement with developments in St. Teresas Gardens rather than adopting a position that was being perceived locally as antagonistic.

In summary, this chapter demonstrates that when community social work links up with involved community members and community structures, effective progress in relation to tackling the type of community problems described in chapter 3 can be made.

Chapter 7 - Conflicts in St. Teresas Gardens

Introduction

The developments in St. Teresas Gardens during 1981-5, involving the CPAD, STGDC and YDP, are described in the previous chapter from a generally, positive perspective. However, these developments, particularly the activities of the CPAD, were not viewed by all in a positive light and in particular they eventually attracted negative media and political criticism. This chapter considers the basis of such criticisms, their impact on ongoing developments in St. Teresa's Gardens and their contribution to the development of community conflict.

The background for community conflict was provided not only by the CPAD but also by the extent to which the health board's Youth Development Project (YDP) was perceived as making inroads into local drug problems, from prevention and treatment perspectives. The developments in St. Teresa's Gardens, as outlined in the previous chapter, arguably, provide a reliable framework within which greater integration of local and institutional efforts to tackle drug problems could be achieved. Certainly, if this was to happen, the obvious vehicle for facilitating this, was the health board's Youth Development Project (YDP). This chapter considers the continued progress of the YDP and it examines the extent to which it impacted on local drug problems and integrated with other local, community efforts.

CPAD - Institutional and local conflicts[1]

Despite, the generally favourable publicity given the CPAD in its early months, this changed quite dramatically in December 1983 with the coverage given it by RTE's *Today Tonight* programme. The programme featured what many in St. Teresa's Gardens considered to be an unduly sympathetic interview with a woman - the wife of a convicted drug dealer - whose home had been picketed by CPAD activists. This CPAD action was pivotal in an allegation on the programme that CPAD activists were vigilantees[2]. The *Today Tonight* programme also featured material from Dolphin House which CPAD activists there understood would not be broadcast. Unlike St Teresas Gardens, the CPAD in Dolphin House did not have a worked out procedure for

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[1]The discussion is this section is drawn from the author's notes and recollections from the period when he worked in St. Teresas Gardens and was closely involved with developments therein. Focused interviews have been conducted with the following since: Humphrey (1991); Martin (1991); O'Kelly (1991) and McArdle (1988). The author has also drawn from the following unpublished documents:
CPAD - St. Teresas Gardens (1983): Press statement.
CPAD - Dolphin House (1983): Press statement.
Humphrey, P (1987): *Speech made to Public Meeting in St. Teresas Gardens to review the work of the STGDC.*
STGDC (1984a): *Speech by committee's chairman, Paul Humphrey to a seminar on drug problems, organised by the Labour Party in the Gresham Hotel, February 5th.*
Today Tonight (1984): *Correspondence in relation Today Tonight coverage of CPAD.*

[2]This woman, was the wife of a convicted drug dealer and she lived in a large house in the Dublin mountains. A few years later she herself was convicted on drug dealing charges. During a CPAD meeting in November 1983 there was a lot of discussion of a fracas which had taken place during the previous weekend outside a city centre disco and which involved this woman, some of her friends and a number of local people one of whom, it was claimed, had been assaulted. Many local people took the view that the incident was an attempt to intimidate CPAD members and that unless immediate action took place, it would be repeated. The meeting decided to march that evening to the home of the woman at the centre of the disco incident. That night a group of fifty protestors carrying placards and shouting slogans assembled outside this woman's house. Eventually, satisfied they had made their point, they departed. The official garda report on the incident described it as "peaceful and orderly" (*Irish Times*, 16/11/83). However, earlier in the day on which this march took place a *Today Tonight* producer had contacted the STGDC chairman seeking permission to film that evening's CPAD meting. The request was refused on the basis that a procedure had been adopted whereby such requests needed at least seven days notice in order for the CPAD to nominate spokespersons and prepare for filming. The meeting went ahead without RTE filming. During the following week the RTE *Today Tonight* producer again contacted the STGDC chairman. During the telephone conversation this producer suggested, according to the STGDC chairman, that he regarded the refusal not to allow filming of the previous CPAD meeting as a deliberate ploy to deprive *Today Tonight* of the opportunity to film the Dublin mountain's march. The march itself featured prominently on *Today Tonight's* programme on drugs which was broadcast in December. It was a pivotal incident around which the programme presenter justified the use of the label "vigilantes" in describing the CPAD. Later one of the programme's producers commented: "As far as the application of the word "vigilante" is concerned; it's one thing to rid your area of drug pushing by community action, but quite another to take off after people well outside your own area.....Whatever one's opinion of certain individuals it comes very close to vigilantism when one gathers together a large number of people and rides off into the night on a show of strength" (*Today Tonight*, 1984).

dealing with the media so that when they were first contacted by *Today Tonight* they cooperated fully, without preconditions. One embarrassing incident, consisting of a very angry exchange with some people shouting and swearing, was broadcast in its entirety[3]. A more serious incident arose from a question which the *Today Tonight* presenter - in an unprecedented address to a public meeting[4] - asked of the CPAD: - Would their actions not lead to a retaliation by the drug dealers and were they not fearful as a result? One local responded:

> We know there is going to be a retaliation. You can't just take £50,000 to £60,000 off a group every week without retaliation. But about their army. We have an army, but nobody knows about them. But we have an army (*Today Tonight,* 1/12/83).

This sequence was broadcast by RTE in the context of making direct connections between the CPAD and Sinn Féin/IRA[5]. In fact local people in Dolphin House later claimed that the army referred to in the above speech was the "army" of local women who had participated in patrols and marches in the community[6].

When the programme was broadcast on December 1, 1983, there was an angry response from Dolphin House and St Teresas Gardens. Dolphin House CPAD, in a press statement, accused *Today Tonight* of "gutter sniping" and said that "we (the local

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[3]During 1986-9, the author lived in Dolphin House and was involved in attempts to develop a local community centre and other community projects. The incident of the *Today Tonight* broadcast was regularly referred to at meetings particularly in the context of local divisions and the reluctance of a number of community members to be involved again in community activities which had a public dimension.

[4]Generally, it is unheard of for journalists assigned to engage directly in such events in this manner. The organisers of meetings of trade unions, political parties and protest campaigns would not allow such public questioning by journalists. A more normal procedure is to facilitate filming of public events - and some but not all private events - and to provide persons for interview. This latter procedure was adopted in relation to media coverage of events in St. Teresas Gardens, primarily because it was insisted upon by the STGDC chairman.

[5]The film sequence in making this connection is particularly significant.as it highlighted the IRA's knee-capping of a youth in Cabra in October, 1982 - an incident which was unrelated to the CPAD and which took place a full nine months before the CPAD was set up.

[6]These claims were made by local people in discussions with author.

community) found the programme more interested in sensationalism, rather than educational or making people aware of the drugs epidemic and ways of combating it" (Dolphin House CPAD, *press statement*, December 2, 1983).

A press release issued by the St Teresas Gardens CPAD condemned "Today Tonight's insistence on referring to" CPAD "as vigilante groups". The statement continued:

> *Today Tonight* have failed to produce evidence that any of these groups have engaged in vigilante activity, or in other activities outside the law. If *Today Tonight* have any such evidence they should refer it to the Gardai, and not run down the legitimate concern of parents through suggestion and misrepresentation (St. Teresas Gardens CPAD, *press statement*, December 2, 1983).

The statement also condemned *Today Tonight's* persistence in "suggesting that Sinn Fein is providing the organisational back-up to the parents groups in inner city communities" The St Teresas Gardens CPAD announced that they were "withdrawing our open invitation to *Today Tonight* to film in our area" and called on other groups to do likewise.

The CPAD antipathy towards *Today Tonight* grew and ultimately became symbolic of the CPAD's increasing isolation from the "establishment"[7]. The establishment - media

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[7]A speech given by Paul Humphrey, chairperson of the STGDC, to a seminar on drugs which was organised by the Labour Party and held on February 5, 1984, highlights the antipathy towards *Today Tonight* and the "establishment": "I want to condemn the media, in particular RTE's *Today Tonight* team for the sensationalist, dramatic approach they had to events in Teresa's Gardens. When *Today Tonight* first approached us in July last to do a programme we willingly assisted because we sincerely hoped that other communities in other areas with a serious drug problem would have something to learn from what we had done. The approach by *Today Tonight* from the outset was dishonest and contemptuous. Twice, they arranged to film meetings and let us down thirty minutes beforehand. They were not interested in questions but simply their own answers. They asked questions of young people who had used drugs despite specific commitments given to their social worker that such questions would not be asked. Ten days before they screened their last two-hour programme, in a frantic attempt to get footage of a meeting in Teresas Gardens, they rang me up two hours before our regular meeting was to commence. They asked me could they film the meeting, to which I responded "No" as the

and political institutions - view was perceived as one which suggested that the CPAD was only superficially dealing with the problem and that members of it were being manipulated by Sinn Féin and that their activities succeeded only in moving the drug problem from one area to the next. This view was expressed quite vehemently by the then Minister for Health, Barry Desmond TD:

> As a consequence of some of the alleged actions by alleged concerned parents, drug pushing has been exported from St. Teresas Gardens out to Terenure where the drug pushers are now instead of being in the inner city. All that happens is that the drug pushers go out there to get their drugs and that is regarded by the Provos as their solution to the problem (Desmond, 1984)[8].

The strength of feeling against this establishment view was highlighted during a city centre march which was organised by the CPAD from a number of Dublin communities on February 29th, 1984. During this march, such was the antipathy of people towards the media that the march organisers succeeded in implementing on the day a total boycott of media interviewers.

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normal procedure was to ask the whole meeting could arrangements be made at a later date. They insisted that they had the right to film the meeting because of the drug problem. I informed them that the agenda for that particular meeting did not involve drugs at all but was to discus a maintenance agreement with Dublin Corporation. They asked me could I not make the meeting about drugs and forget about maintenance. They subjected me personally to a lot of harassment on the phone, but it is even worse when you consider that three years ago we were pleading with *Today Tonight* and other RTE programmes to come out and do a programme about drugs so that the government and the state agencies would believe what we were saying about it. *Today Tonight* answered the call three years late without any commitment to listen" (STGDC, 1984a).

[8]The Minister for Health was criticised for his attitude towards the CPAD by Paul Humphrey at a seminar on February 5th, 1984, which was organised by the Minister's own political party and which he himself attended: "Some people, including Barry Desmond, have suggested that community action against drugs campaigns are sinister, because they have the support of paramilitary organisations. The action in Teresas Gardens was taken by the people of Teresas Gardens. It was taken by them solely. We welcomed the support of other people in our campaign, so long as they were prepared to follow the decisions and actions of the people. We never had any involvement with a paramilitary organisation" (STGDC, 1984a).

The primary effect of the allegation of Sinn Fein manipulation of CPAD was that it publicly attributed to Sinn Féin responsibility for achievements which had been gained by grassroots community action. The political benefits of being associated with such actions was not lost on Sinn Féin members and the publicity surrounding their supposed involvement meant that they wasted little time in demonstrating - on a community level - that their "credits" were well earned[9]. Ultimately, the Sinn Féin involvement with CPAD became a self-fulfilling prophecy. Sinn Fein's involvement suited its electoral strategy which had taken a new direction following the hunger strike campaigns earlier in the 1980s. In the November 1983 by-election in the Dáil constituency of Dublin North Central, caused by the death of George Colley TD, Sinn Fein candidate, Christy Burke, doubled his share of the vote from 3.2% to 7%[10]. Sinn Fein's electoral strategy was to highlight Burke's anti drugs work.[11] In the months following Burke's success, Sinn Féin activists in Tallaght, Clondalkin, Dun Laoghaire and Ballymun came to the fore in setting up CPAD groups. In some areas, Ballymun[12] in particular, Sinn Féin activists set up groups where the demand for local action against drug dealers was neither urgent nor widespread[13]. Some Sinn Féin activists - attempting to emulate the success of Christy Burke - were in a hurry to use the CPAD to build up a profile for their future electoral candidates, something which did nothing to nurture the kind of local organisation which had sustained CPAD groups in other areas, such as St. Teresas Gardens.

In St. Teresas Gardens, Sinn Féin influence came about much more slowly than elsewhere. When it did come about it was more a result of external association with the central committee of the CPAD than it was from internal demands. At the outset of the

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[9]This issue is also discussed in Cullen (1990, 286).

[10]In the local government elections in 1985 and 1991, Burke was elected a Sinn Féin member of Dublin City Council

[11]Sinn Féin's campaign and electoral strategy is covered by Flynn and Yeates (1985, 255).

[12]At the time - 1984 - the drug problem in Ballymun was primarily associated with the overuse of prescription drugs; widespread heroin-use and heroin-dealing were not prominent.

[13]In fact in subsequent CPAD activity in Ballymun, many of the protestors were bused in from other areas.

CPAD in St. Teresas Gardens there were no known members of Sinn Féin involved, and for this reason, Sinn Féin was in no position to manipulate or otherwise unduly influence CPAD activities. Furthermore, the STGDC had a prominent leadership role in the St. Teresas Gardens CPAD, and it was a role which had widespread respect inside the community, and apart from some media, outside the community also. The STGDC involvement and the public profile of its chairman, Paul Humphrey, was such that it was capable of deflecting external attempts at infiltration[14].

Following the December 1983 *Today Tonight* programme, the CPAD became stronger and more self-reliant. Disappointed with the seeming lack of support from both politicians and media, their efforts became more concentrated in setting up new CPAD groups and in improving their overall coordination. In January 1984, a CPAD group was set up in Lower Crumlin a southside inner suburb of Dublin, where the distribution of heroin had become quite prominent. It was the first CPAD group to be set up in an area which was not a high density flat complex and the significance of this point was to become clear as the community set about tackling alleged drug dealers. Unlike the compact physical structures of inner city flat complexes, Lower Crumlin is a sprawling suburb with numerous streets and entrances. The distribution of drugs was not concentrated in any one spot, and local intelligence on who was involved was poor. One CPAD meeting held in Crumlin in February 1984 consisted of a number of local activists publicly apologising for having made numerous false accusations of drug dealing against neighbours in the previous week (some of which had resulted in minor skirmishes).[15] The type of unity which had held people together in inner city flat complexes did not exist in Crumlin. In the working-class suburbs of Ballyfermot, Tallaght, Finglas and Clondalkin, similar factors of size of area and physical layout

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[14]In CPAD's first year - 1983/4 - in St. Teresas Gardens, the closest outside Sinn Féin members came to infiltrating internal decision-making was in April 1984 when Humphrey, along with a number of other CPAD members was arrested for questioning in relation to a kidnapping and was therefore missing from the community when decisions in relation to a media response to these arrests were being taken.

[15]See O'Kane *et al* (1984), Hewitt and Dougherty (1984) and McCann (1984) for journalistic accounts of the CPAD at this time.

limited the impact of the CPAD. A major weakness in the CPAD strategy was exposed and, inevitably, CPAD actions in such areas became dependent on the participation of groups from the more organised areas, particularly St Teresas Gardens[16]. Whereas heretofore, St Teresas Gardens CPAD had acted in other areas only in support of local CPAD activists, in Crumlin and subsequently other suburban areas, St Teresas Gardens activists began to play a more leading role. In Crumlin this involvement by members of the St Teresas Gardens CPAD is reported to have infuriated many local drug dealers[17].

On the night of February 20 1984, Joe Flynn a CPAD supporter from St Teresas Gardens was shot by two gunmen as he spoke to a neighbour. CPAD activists attributed some blame for this shooting to media and politicians. A press statement stressed that:

> .....when politicians and media personnel make statements and newspaper headlines that link Concerned Parents with vigilantes they are providing drug pushers and their terror gangs with a licence to come into innocent communities and shoot at random. They must take their share of the blame for this shooting (*Irish Times*, 22/2/84).

The CPAD statement highlighted the community's continued resolve to continue with their drugs campaign and indeed the strength of this resolve was evident by the large turnout for the CPAD march to government buildings the following week. One newspaper headline which gave advance notice of the march spoke of the "People who took on the pushers" (*Sunday Press*, February 26, 1984).

16This author, for the reasons outlined above does not agree with Bennett's (1988, 37) assertion that the CPAD were "never wrong". Bennett's assertions are based solely on his consideration of the CPAD's methods and techniques with insufficient examination of their intentions which underwent significant transformation following the increased involvement of Sinn Féin and other developments.

17The primary source for this observation is a St. Teresas Gardens resident who was involved in non drug-related criminal activities and who was closely involved with criminal groups in the Crumlin area.

However, behind the scenes in St. Teresas Gardens, the strains of being perceived as the people responsible for the CPAD campaign was beginning to take a toll on many activists and in the wake of the Flynn shooting many people were genuinely worried. The issue of whether people from St. Teresa's Gardens should be involved with groups in other areas was discussed by CPAD's informal leadership and a decision was taken that local CPAD activists should not be actively involved with campaigns in other areas[18]. This decision was promoted by the STGDC whose members were concerned that unless local people from other areas were deciding upon and carrying out their own actions any decisions taken in relation to the barring or expulsion of drug dealers could not be effectively enforced[19].

However, this decision to confine local people's involvement with drug actions to their own local community was vehemently opposed by a small number of persons who were quite prominent in CPAD's informal leadership in St. Teresas Gardens. Thereafter, this group, who had adopted a more hardline attitude towards drug dealers, developed a separate approach to CPAD activity in St. Teresas Gardens than that which had previously been agreed at large CPAD meetings. The most significant development, arising from their stance, was their willingness to take actions for which there was no community mandate. This group - referred to as CPAD-2 in the remainder of this study - became increasingly involved and aligned to the newly formed Central Committee of the CPAD (CCCPAD)[20].

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[18]This decision was taken at a meeting of CPAD's informal leadership which was held two days after the Flynn shooting.

[19]Although, at the time, the STGDC was concerned that the activities of the CPAD could get out of control, it consistently maintained and acknowledged that the progress it was making in relation to a range of other community developments would not be possible if it was not for the activities of the CPAD (Humphrey, 1987).

[20]Since the CPAD was first started, activists from a number of different areas met informally on a regular basis. Their main purpose of meeting was to keep each other informed of the movements of known drug dealers and to share other relevant information. These meetings had no structure and no other agenda. However in early February 1984 it was decided to formalise matters and to put together a structure. The group adopted the name of Central Committee of the Concerned Parents Against Drugs (CCCPAD) and consisted of two representatives of each affiliated group. It was never stated what constituted an affiliated CPAD group other than the self-selection of such affiliates. There was also no agreement as to how representatives should be chosen or how an informal, unstructured group of local residents elect people to a formal centralised organisation. In fact, while according as CPAD groups

As the CCCPAD structure got off the ground, the independence of local groups was increasingly lost to this central committee. Two weeks after the Flynn shooting, a man from Crumlin, who was widely believed to be an associate of an alleged drug dealer, was kidnapped. It was strongly suspected among a number of CPAD-2 activists that this alleged drug dealer had been involved with the Flynn shooting. There was considerable media speculation that the kidnapping had been organised at the request of the CCCPAD, but this was denied by the CCCPAD, at the time. Later however, when the kidnapped man was freed, after other men were arrested (and later convicted and sentenced) for kidnapping a friend of the first kidnapped man, the rumours that CCCPAD had requested the IRA, the military wing of Sinn Féin, to do the kidnappings were rife. These rumours were particularly rife in St. Teresas Gardens and were added to by the open claims by some CPAD-2 members[21]. In the aftermath of this affair, the STGDC were increasingly and openly concerned that CPAD-2 had become a small elitist group which was taking major decisions without consulting local people and later claiming that these were the people's decisions. Inevitably, tensions between the STGDC and CPAD-2 developed.

During June 1984 - one year after the CPAD was set up - the STGDC organised a summer festival consisting of an open-air concert, a hall dance, a sports day, a photographic exhibition, video and film screenings, fancy dress, treasure hunt, and

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were formed and encouraged to have an informal structure, the CCCPAD became more structured and often made wild claims on its representativeness, In the first two years of the CCCPAD there was no official election of CPAD representatives from the St Teresas Gardens, yet CCCPAD meetings were attended by two local people from St. Teresas Gardens CPAD-2, one of whom became its chairman

[21]In the summer of 1984 Sinn Féin contested the European Parliament elections in the Dublin constituency with a candidate who was involved with a CPAD group in Tallaght and who was also a member of CCCPAD. During this election campaign, a walkabout involving the president of Sinn Féin, Gerry Adams MP, was arranged in St. Teresas Gardens. The walkabout clearly did not have the support of every resident, one of whom publicly challenged Mr. Adams and objected to his presence in the area. During an encounter with members of the STGDC, who supported the resident's right to challenge Adams, CCCPAD members, including its two members from CPAD-2 (St. Teresas Gardens), openly defended Adams's visit and suggested that a debt was owed to Sinn Féin and its "friends" for protecting St. Teresas Gardens against gunmen, earlier that year. STGDC members were furious with this response, and pointed out that if Sinn Féin's friends had been invited in to protect the community, the invitation had not come from the community, but rather from the CCCPAD and its associates - CPAD-2 - who lived in the community. This was not the only occasion where CCCPAD members made such claims, although such claims were never openly made at public meetings.

various other community activities. Most of the organising work for the festival was done by young people from the YDP (see previous chapter). The theme of the festival was celebration - to celebrate the coming together of the community a year previously and to push forward with new ideas and developments. It was hoped that through involving people in organising the festival it would be possible to shift local energies away from drug related and into other activities. The STGDC rationale was that, now that people had succeeded in controlling the local supply of heroin, it was necessary to rebuild the community to ensure the heroin problem would not recur. However, while the festival was generally successful, it attracted very little interest from those who were most supportive of CPAD-2. It appeared that these people wished all local community activity to focus on the issue of drugs and the extension of their campaign into other communities in Dublin. The possibilities of engaging them in discussion of other local activities and issues became increasingly remote.

Indeed, CPAD-2's focus on drug-related actions was increasingly heightened during the Summer, 1984, when a number of drug-users who had been imprisoned since prior to the formation of the CPAD, were released from prison and recommenced their drug-use. CPAD-2 members were infuriated. They reasoned that their community actions had been for the purpose of protecting people from using heroin and now the very people who had seemingly most to gain from this protection were, through their use of heroin, undermining the efforts of the community to tackle drugs. A number of these drug users were brought before public meetings held in the late summer of 1984 and warned to sort out their drug problem or face the prospect of more serious action[22]. Eventually, a number of these drug users were barred from St Teresas Gardens for failing to sort out their drug problems. Inevitably, those who were most public in their drug-use, were more easily barred. The decision to bar these people was taken against the publicly expressed advice of STGDC members and the author of this study.

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[22]What was expected was that the drug users would go to the NDATC, the local addiction counsellor or to Coolemine Therapeutic Community.

Previously such advice would have been heeded, but on this occasion, STGDC members were publicly derided for their opposition to the barrings.

Although many local people had supported CPAD-2 by voting in favour of these barrings, their support in having them implemented was not forthcoming. Previous actions against suspected drug dealers were much easier to enforce for these had mass support and they were intended to curb the activities of persons who were clearly perceived as having accumulated personal wealth from drug dealing. Not so with the drug using youths some of whom were quite clearly ill and pathetic. There was simply no local will to mobilise effectively against them. The fact that the barrings had been opposed by STGDC members further contributed to this lack of public will.

The core group of CPAD-2 members became increasingly frustrated that the barrings were not being enforced. There was growing conflict between this group and individual drug users and this conflict intensified in relation to one particular drug user. In December 1984, there was an attack on this drug user during which other members of his family were beaten. In the aftermath of the incident, his father died of a heart attack. The incident completely shocked and divided the local community. At subsequent local public meetings it was claimed by CPAD-2 members that the attack was an action which had the support of the whole community. In fact it was never discussed at a meeting prior to its happening. Many people stopped attending public meetings and there was a return to the kind of community fear which characterised St. Teresas Gardens in the years immediately prior to the formation of the CPAD. The STGDC was quite alarmed at the likely consequences of local divisions and they organised a number of low key meetings with hardline CPAD-2 activists in order to ease the tensions. These meetings had no positive outcome. If anything, the meetings highlighted CPAD-2's entrenchment as they argued that their hardline actions arose out of the successive failures of government approaches including what they saw as the failure of the health

board sponsored YDP, which had not, at that stage in early 1985, commenced drug treatment activities in the proposed centre in Weaver Square[23].

The previous chapter 6 described in some detail the contribution of the CPAD - which originated in St. Teresas Gardens - as a grassroots, collective response to the local drug problem. It has been argued here that media coverage - particularly in the case of Irish television's most important current affairs programme, Today Tonight - was unduly unsympathetic to the CPAD and unfairly represented it as a violent, vigilante-type organisation rather than as a legitimate community action. It has also been argued that this view, which was taken up by authorities outside the area, acted as a self-fulfilling prophecy and contributed consequently both to divisions in the CPAD and to a limiting of its effectiveness. Paradoxically, in the year in which the CPAD was formed, there was some official discussion of the potential and efficacy of community policing as a means for controlling neighbourhood crime (Doyle, 1982; Doyle, 1983; Bennett, 1983)[24]. In the context of official reaction to the CPAD, the rhetoric of 'community policing', is, arguably, as meaningless to the experience of communities such as St. Teresas Gardens, as that of 'community care' - as discussed in chapter 5 - appears to have been to community drug problems.

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[23]As far as the STGDC was concerned, in the aftermath of these meetings, CPAD-2 was no longer a genuine movement for local people. Its actions and decisions were dominated by a few associates who were bound together with a tremendous loyalty. Other community members supported this group, because they felt they owed it to them because of the hard work and commitment they had given the CPAD in its early days. But even this support was now rapidly decreasing, although it was still quite visible. CPAD-2 support was sufficient to undermine the activities of the STGDC which also became quite entrenched. While the STGDC continued an involvement with youth activities for the following two years it lost credibility in relation to other community activities. The entrenchment, bitterness and inevitable personality clashes, caused by these divisions became a major obstacle to future community developments in St. Teresas Gardens. By late 1985 it had become apparent to many local people in St Teresas Gardens that they no longer needed a CPAD group and generally, there was very little CPAD activity in the community for the next three years. CPAD activity in other inner city areas was sporadic during the same period reflecting up and down changes in the organisation of supplies of heroin. It also reflected the success of the CPAD movement itself (O'Kelly, *et al*, 1988) as well as other efforts to tackle the drug problem. In these succeeding years much of the energies of the CPAD groups were concentrated in suburban estates, where for reasons already mentioned, their impact was not as effective.

[24]Hourihan (1986, 26) reports there are indications "that, for whatever reason, people in high-risk areas are less likely to establish and participate in neighbourhood Watch Schemes than are those in more stable, low-risk localities."

The Youth Development Project and health board conflicts[25]

The efforts of both the STGDC and YDP in trying to shift the focus of local community efforts onto issues other than drugs were based on the premise that as a result of CPAD actions taken in 1983 and other developments - such as the commencement of YDP activities - that the drug problem would abate. STGDC/YDP objectives relied considerably on progress in relation to institutional responses to the problem and the efficacy of community-institutional relationships. Following the setting up of the Special Governmental Task Force on Drug Abuse in May 1983, there was a hope among members of STGDC and the YDP committees that a coherent, policy-driven response to the drug problem would develop. The STGDC therefore, made a comprehensive submission to the task force. The report of the task force was never

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[25]The discussion in this section is based on the author's notes and recollections and focused interviews with the following: Flanagan (1991); Lillis (1991); King (1991); O'Kelly (1991); Humphrey (1991); Smyth (1991) and Bowden (1991). The following documents have also bee useful:
Cullen, B. (1984b): *Youth Development Project - Progress Reports.*
Cullen, B. (1984c): *Notes in relation to a residential project activity .*
Cullen, B (1984d): *Correspondence with the Eastern Health Board in relation to complaints made by the health board's Senior Administrative Officer, Ms. Aine Flanagan.*
Cullen, B. (1985a): *Progress report on youth development programme.*
Cullen, (1985b): *Correspondence with Eastern Health Board in relation to project's leaders concerns with destabilisation of the YDP resulting from the Board's management decisions.*
Cullen, B. (1985c): *Report on future role and involvement of EHB in youth development activities in inner city area 3`*
Cullen B. (1986): *Correspondence with the Eastern Health Board in relation to a claim for backdated pay.*
Eastern Health Board (1983): *Correspondence with the Project Leader in relation to his appointment and salary.*
Eastern Health Board (1984): *Correspondence with the Project Leader in relation to complaints made by the Board's Senior Administrative officer,*
Eastern Health Board (1985a): *Correspondence with the Director of Community Care in relation to a report on the Project Leader's performance of duties.*
Eastern Health Board (1985b): *Correspondence with the Director of Community Care in relation to the project's leader's participation in an RTE radio programme.*
Eastern Health Board (1985c): *Correspondence with the project leader in relation to changes in the project leader's salary.*
Eastern Health Board (1986): *Correspondence with former project leader in relation to his claim for backdated pay.*
Government Task Force on Drug Abuse (1983): *Report.*
YDP Committee (1981/85a): *Minutes & Notes. - including chairperson's notes.*
YDP Committee (1981/85b): *Correspondence.*
YDP Committee (1981/85c): *Reports.*
YDP Committee (1983): *Amending of Project as planned, to provide an immediate outreach (advice and counselling) service.*
YDP Committee (1984): *Submission to Eastern Health Board on future development of Weaver Square premises.*

published but a Government statement in September 1983, outlined a number of recommendations and actions which it was intended to take (Department of Health, 1983). The overall emphasis in this Government statement was on strengthening drug control laws and improving institutional treatment services. References to community responses emphasised the need for more Government sponsored vocational-training programmes in the worst affected areas[26]. The statement contained no consideration or elaboration of community-oriented, problem-focused, treatment responses. In effect, the Government statement strengthened the role of existing institutional services in relation to drug treatment and it continued an emphasis on clinical, drugs-focused responses.

The Government's emphasising of institutional-based responses, in effect, constituted a bypassing of developments which had been taking place on a community level and a favouring of traditional, clinical approaches to drug problems which were practised primarily by the NDATC. It seemed as if crucial aspects of the development of Dublin's drug problems, and in particular its community dimension, were to be ignored in deference to consolidating a clinical, medical model. This centralisation of responses to drug problems was evident in the Eastern Health Board's overall management arrangements for the Youth Development Project (YDP). Whereas, this project had emerged from the efforts of social work personnel in community care and developed by them within community care structures, during the Autumn, 1983, a senior management decision was taken - without local area consultations - to transfer responsibility for the YDP from the Community Care Programme to the Special Hospitals Care Programme (psychiatric)[27].

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[26]The actual report made reference to concentrating drug treatment efforts into Community Priority Areas and to the necessity for coordinating efforts in such areas. However, this particular recommendation did not appear in the Government statement (Government Task Force on Drug Abuse, 1983).

[27]Although the health board's Senior Administrative Officer, Aine Flanagan, was employed under the Community Care Programme since 1981, it was decided in 1983 that she retain senior management responsibility for drug problems under the auspices of the Special Hospital Programme Manager in addition to her other responsibilities under the Community Care Programme Manager.

In effect, the Director of Community Care was removed from any direct responsibility to the YDP, although he continued to have a nominal role. Although, since 1980, the Director of Community Care had been directly involved with this initiative and had largely been responsible for bringing together a mixed group of professional and community interests, from 1983 there was greater central management involvement with the monitoring of the YDP and with its ongoing decision-making.

This greater central management involvement with the YDP became obvious during a meeting held with the YDP committee in August 1984, in which health board management emphasised the necessity for a drugs-focused, clinical approach[28] and suggested that the YDP should be modelled on a new centre - the Talbot Centre - which it had, during the summer of 1983, set up in the North inner city[29]. In considering the health board's preference for a Talbot Centre model - which operated traditional, clinical treatment - for the YDP, the committee expressed reservations that this new proposal seemed to be solely concerned with the drugs aspect of the problem whereas the original proposal was perceived as an innovative attempt to have a major impact on the total situation confronting young people at risk in the community. If agreement was given to go ahead with the new proposal, the committee feared that the original YDP proposal would lose its vital youth development features and become simply a crisis response to the problem. Furthermore, the committee expressed concern at the possibilities of confusion between the project planned for Weaver Square and the health

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[28]In setting out its arguments for this approach, the health board emphasised its responsibility to respond to what it saw as the "chief" aspect of the problem, ie drugs, and for other statutory services to focus their efforts on other "non-health" matters such as education, youth and training.

[29]The committee's chairman and the author had already visited the Talbot Centre and met its staff. Their perception was that while the centre was located close to a community with a major drug problem, that apart from this physical location the centre's community label existed in name only. A report on this visit emphasised that of the few young people who attended the centre only one was from the immediate community, that members of the local community had no real involvement in the management of the centre and that the staff did not consider the active involvement of community members as being of significance. The report also pointed out that the centre had no advice/information or outreach focus to allow community members to drop-in on a casual basis. It also suggested that the primary function of the Talbot Centre appeared to be one of receiving referrals from the NDATC of young persons who because of their age were not suited for attendance at this latter centre. Finally, the report questioned the feasibility of operating daily attenders programmes in the confined space of the Talbot Centre (Cullen, 1984b).

board's new proposal. The committee's main fear was that the health board's new proposal would constitute the sole health board response in the area and that once it was up and running the YDP programme for Weaver Square would be forgotten about (YDP Committee, 1981/85a - 7/9/83).

Despite the committee's reservations which were expressed to the health board in a letter from its chairman, the health board continued to indicate that the way forward was to set up a Talbot-type day centre in the Dublin 8 area. There was one practical argument in support of the health board position: - it was now recognised by all concerned, including the YDP committee, that the Weaver Square premises was unlikely to be available for at least eighteen months, and that if the YDP was to commence operations - of whatever type - some kind of temporary premises was required. The health board made it clear that it would support the provision of a temporary premises for the purposes of operating a Talbot Centre type of programme and no other. Funds were available for the refurbishment of a suitable centre for these purposes.

This situation posed a dilemma for the YDP committee and the author. The committee clearly did not support a Talbot Centre model for the YDP. Yet, it seemed the only way the YDP could get off the ground with premises was by agreeing with the health board's suggestions. The committee was anxious that any commitment by it to support a new Talbot Centre type of project must be related to the more comprehensive YDP programme being developed in the long term. At meetings between the YDP committee and the health board in both August and September 1983, the committee insisted that its support for the interim situation as proposed by health board management was related to the health board making progress in acquiring and developing the Weaver Square building (YDP Committee, 1981/85a - 7/8/83; 22/9/83)[30]. While the health board was

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[30]In preparation for the September meeting the YDP committee prepared a single page document headed: *Amending of Project as planned to provide an immediate Outreach (advice and Counselling)*

not prepared to provide a definite commitment to the Weaver Square premises, it pointed out that its commitment to the temporary phase of the YDP could be interpreted as commitment to a process which might lead to Weaver Square.

In these discussions, health board management also pointed out that they envisaged that a "mini-day attendance programme" for drug users should take place in the temporary premises. There was considerable dispute on this aspect of the programme between the YDP committee and the health board. Committee members pointed out that drugs counselling had to be developed in a broad manner with an emphasis on building up links and contacts with community members and developing inducements to attract drug users into a centre. If they approached it from a perspective of insisting that drug users with whom the project came into contact had to attend a programme in the centre, on a daily basis, without having first built up a broader programme of youth development activities within that centre, then the whole approach could be counterproductive.

It appeared to some committee members that the health board's understanding of a daily attenders' programme was that drug users should in some way be compelled to attend it.[31] Committee members were at pains to point out that it was this approach which

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service. This document outlined the YDP committee's support for the interim arrangements being proposed by the health board, along the following lines:

i The immediate recruiting and training of a second whole-time worker to undertake the counselling of drug users and their families. The immediate provision of good temporary accommodation for project workers.

ii Agreement on a timetable for the opening of the YDP premises and day programme in Weaver Square, and the allocation of the project leader to the work of developing and organising this innovative programme. The outreach counselling service to be offered within the catchment areas of the project, in keeping with the project's proposal to pilot an approach in the south city area.

iii The determination of a September 1984 opening date for the day attendance programme. The work of the project leader to include discussions with non-health departments and agencies, to bring about a broad involvement in the project

iv Initial discussions to take place to determine baselines for the evaluation of the project and the community approach to drug prevention, education and treatment. Interim report to be prepared after 18 months.

v The responsibility of the YDC for and to the project to be specified." (YDP Committee, 1983)

[31]There was another aspect of this matter which also concerned committee members and which renewed fears that health board management seemed to be dealing with the committee on a political basis.

they understood to have failed elsewhere and that if a new response was to have any real meaning then it would have to depart from this overall compulsory approach. In response health board management insisted that the programme of work for the centre must demonstrate some form of daily attendance. This particular disagreement appeared to be sorted out at the September meeting, when it was suggested that the new centre could begin the process of developing small scale youth programmes and that this particular aspect of the centre's work could satisfy the health board's requirement that there be some form of daily attendance. The daily attendance programmes referred to by the committee were of a broad youth development type which would include drug users, but would not exclusively consist of drug users.

At the end of September 1983, therefore, it appeared that at last the YDP could operate on the basis of some form of agreement between its committee and health board management. The committee was generally satisfied that the health board considered the temporary phase of the project as being linked into the Weaver Square development and that the focus of activities in this temporary phase would be around outreach counselling and youth development contacts as envisaged by the project leader in his report to the committee at its July 1983 meeting[32]. Progress in relation to these

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Questions were raised as to whether the health board was game-playing and not being honest with regard its intentions for the YDP. Committee members expressed concerns both openly to health board senior management and in private discussions that the board was not seriously interested in the Weaver Square proposals but at the time - August/September 1983 - it was not yet prepared to admit this. It appeared to some that the health board's primary concern was to set up a centre (at minimum cost), call it a drug project, and by providing information on numbers of persons who attended this project, to then inform the general public and politicians, that this drug project was truly in existence - irrespective of the quality of the work it did on the ground (Humphrey, 1991, King, 1991, O'Kelly, 1991, Smyth, 1991).

[32]One factor which was particularly crucial to the committee's agreement to continue to support the health board's proposals was that the health board had agreed to use part of the STGDC's Small Club premises on Donore Avenue as a suitable location for a temporary premises. These premises were owned by Dublin Corporation and consisted of a number of small rooms in what previously were shops on the groundfloor of the first block of flats at the entrance to St. Teresas Gardens. While the STGDC had the full use of the Small Club, they had not, at the time, signed on as legal tenants. In agreeing to refurbish the Small Club, health board management believed that a direct tenancy (or licensing) arrangement between *it* and Dublin Corporation could be arranged. It was only when the refurbishment was near completion that health board management realised that the STGDC were the legal tenants. The confusion in this was caused by the fact that the STGDC did not sign on as tenants until November 1983. The committee had not previously signed a tenancy for the reason that this would have meant taking responsibility for electricity supplies also. In November 1983 it was prepared to take this responsibility in the knowledge that the health board would have to pay a fair share of the

activities has already been outlined in the previous chapter 6, and generally, these were considered to be positive by the committee. However, before long the apparent health board-YDP agreement was directly put to the test in relation to both the project's drugs-focused programme and progress in relation to the Weaver Square building.

As pointed out in the previous chapter 6, the author had since August 1983, undertaken preliminary outreach work with drug users in St. Teresas Gardens with a view to this work being developed by a project worker - when appointed. The health board had been requested to advertise for such a worker. In response the health board replied that it would take up to four months for such an appointment to take place and, rather than delay for such a length of time it offered to give a temporary assignment to an addiction counsellor, Catherine Lillis, who was known to the Board[33]. In January 1984, Lillis was appointed to the post of addiction counsellor with the YDP on a temporary basis. The author initially opposed this appointment on the basis that what the project needed was an outreach worker and not an addiction counsellor. He also objected to the manner in which the appointment was made without competition. However, he subsequently acquiesced on the basis that it was temporary, and that if it did not work out, alternative arrangements could be made[34].

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bills. Health board management, however, was displeased when it realised that the Small Club which it was refurbishing was legally occupied by the STGDC, that a negotiation of health board tenancy from Dublin Corporation was not feasible, and that future negotiations in relation to the use of the Small Club had to involve the STGDC. However, it was because it was assured of this tenancy that the STGDC first proposed the use of the Small Club for the YDP and the fact that they had guaranteed tenancy was never deliberately hidden from anybody. The committee assumed this fact to be understood by health board officials. STGDC members believed that their own activities would benefit from locating the health board project in these premises; the premises would benefit from the refurbishment and it would put the committee into a bargaining position with the health board in relation to securing funds for the premises's upkeep. If the YDP was to be based in the Small Club premises there was some likelihood that it could be developed alongside objectives already envisaged by the STGDC and the YDP committee. As *de facto* tenants of the Small Club the STGDC, therefore, was likely to continue insisting with the health board that the YDP develop towards securing the Weaver Square building. The refurbishment of the Small Club commenced in October 1983 and was completed in January 1984.

[33]According to the health board this addiction counsellor was highly recommended by the director of the NDATC, Dr. Michael Kelly. This recommendation was considered by senior health board personnel as almost sufficient for Lillis's appointment.

[34]The project leader's acquiescence came about as the result of a direct plea by the Director of Community Care, Dr. Kevin Murphy, who assured the project leader that if the arrangement did not work out, other options would be considered.

What was not made clear to either the author or the YDP Committee at the time of Lillis's appointment however, was that the health board envisaged Lillis's role as similar to that of a number of counsellors/tracers who had also been employed in other community care areas. In effect, these counsellors, while employed by the health board, worked to the NDATC. Prior to Lillis's commencement of employment she was informed by the health board that the NDATC had clinical responsibility for her work[35]. Thus, when Lillis commenced employment with the health board, in the Small Club premises, there was considerable confusion in relation to accountability and reporting arrangements. The author's understanding was that she was accountable to him. Her understanding was that she was accountable to the NDATC. While the official health board position was that for drug-related purposes, she was clinically accountable to the NDATC - as other counsellors/tracers - this was not made clear to the author or to the YDP Committee until the following August 1984.

Catherine Lillis's main background was as a missionary sister in the Far East but she had trained as an addiction counsellor in Chicago for two years. She was - and continued to be - very committed to an abstinence, disease model of addiction treatment[36]. As a strong supporter of the AA philosophy, she believed that once a person becomes addicted to a substance (alcohol, drugs) that it is necessary for this person to foreswear such substances totally. If a young person is addicted to heroin

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[35]Like the project leader and the YDP committee, the Director of Community Care, was also seemingly unaware of these arrangements. At the time Lillis claimed to have been separately briefed about her role by both the director of the NDATC and the health board's Senior Administrative Officer, Aine Flanagan.

[36]Lillis is particularly committed to what is known as the Minnesota Model, an approach to the treatment of alcoholism and drug use which was developed in the US state from which it takes its name. Anderson (1981,9) explains the alcoholism-is-a-disease hypothesis as follows: "What impressed us most about our alcoholic patients was that, despite the repeated occurrence of drinking-related problems or disabilities, they continued to use alcohol. This behaviour, it was felt, probably resulted because alcoholics had both a pathological dependence upon alcohol and a loss of control over their ability to regulate the ingestion of the drug. It was this chronically dysfunctional behaviour associated with drinking that was initially viewed as the illness of alcoholism. Further, since this behaviour appeared to be highly stereotyped, repetitive and maladaptive, we felt it could best be thought of as an involuntary response which lacks the characteristic adaptive flexibility of voluntary behaviour. Thus, then as well as now, the loss of control of the drinking behaviour plus the continued pathological dependence upon alcohol, despite its negative effects, was the essence of the hypothesis that alcoholism is in fact an illness."

then this person must foreswear all mood-altering drugs, including alcohol, for the remainder of their lives. She believed that drug users need to be totally drug free before any work can commence with them and that once treatment has begun it is necessary for them to see themselves in a lifetime of recovery. Furthermore, she attributed the large amount of drug use in the community *primarily* to what she saw as unacceptably high levels of alcohol consumption. Within her approach to drug problems, 'chemical dependency'[37] was considered the primary problem to be dealt with.

From the outset, there was a clash between the author's community-oriented approach to the drug problem and the counsellor's clinical, disease approach. The author's approach was problem-focused and emphasised supporting the drug user on a number of levels within the family and community. From within the author's social work and community work training and work experiences, he found it impossible to accept Lillis's contentions that those community members who used heroin did so primarily because of individual, chemical predispositions or because their learned habitual behaviour resulted from some form of community pathology. He associated heroin-use with the impact of social and economic change and with the consequences of unemployment, deprivation and poverty[38]. He saw the Small Club as a centre within which activities could be developed to which drug users might be attracted. In time, their involvement with these activities could provide a basis for them to deal more

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[37]'Chemical dependency is a term which is used to refer to "harmful dependency on any mood-altering substance' (Anderson, 1981, 14). The implications of the use of this term is that the common factor in both 'alcoholism' and 'drug addiction' is a dependence on chemicals and also that there exist "addiction-prone people" who "are vulnerable to many different mood-altering substances and must be on guard against almost all forms of self-medication involving such substances" *(Ibid).*

[38]The author agreed with the observation of Finigarette and Hasse (quoted in Jamieson *et al*, 1984, 11) that "young people who are disadvantaged and alienated may find the foundation of a socially authenticated identity in addiction. For such person, drug use provides at last a 'constructive' focal activity in life, generating its own occupational responsibilities, opportunities for success and achievement, social status and ideological, philosophical or religious meaning." The author (project leader) believed that the implication of this approach to drug problems was to explore new social identities and reference points both for those young people who had already used drugs and for their younger counterparts who were seeking role models. This approach involved focusing attention away from drugs intake and into social realities (and their causes) which surrounded drug-using behaviour.

effectively with major issues in their personal lives, including drugs[39]. But the priority in the meantime was to make the Small Club an active, supportive and encouraging environment[40].

The addiction counsellor, in contrast, adopted a more directive approach. She envisaged the Small Club as a drug treatment centre similar in objectives to the Rutland Centre[41] where she had recently worked and the only real difference between both, was that one was residential and the other wasn't. The Small Club she believed *must* be a place which had a drug-free, alcohol-free ethos. Those who attended it *must* demonstrate both a commitment to and evidence of abstinence. Attenders' commitment to abstinence could, in her view, be demonstrated by regular urine-testing in the Small Club. Within this model of counselling which Lillis espoused, to offer succour to any of these young people while they were still using drugs would constitute "enabling[42]"; a form of intervention which removes all incentive to become abstinent. The label "enabler" was one that Lillis freely ascribed to those health and social care workers whom she perceived as not supporting her views of addiction.

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[39]The author's approach in relation to direct work with drug users was similar to that of the proponents of motivational change (Bolton and Watt, 1989;Miller *et al*, 1986; Prochaska and DiClemente, 1984). These authors de-emphasise addiction as a disease and shift the focus on individuals-as-having-choices. The goal of intervention is to assist the drug user in reaching a level of understanding and/or control over their drug-use such that associated problems are minimised. The outcome may be that drug-user stops using drugs but this is not an essential optimal goal. An elaboration of this author's practical application of this approach is available in relevant sections of Ana Liffey Drug Project Annual Report, 1990.

[40]The author advocated a form of "social rehabilitation" (Vollers, 1987) which focused on providing counterweights to an addict's lifestyle in areas such as vocational training, education, housing, recreational activity and the development of relationships *(Ibid)*. This approach is similar to that of "social integration" (Blakeborough, 1977, 10) as advocated by the Kaleidescope project in Kingston-on-Thames, one of the projects which the author had visited as part of his induction into the position of project leader in 1983. This project had both a caring and pragmatic approach to drug problems: "There is no simple and immediate way of preventing some people from trying to destroy themselves, but in the longer term it is possible to improve the social experience of a group so that they become more interested in fulfiling themselves than in destroying themselves. It is necessary that a community gives all its members hope for a reasonably happy life. Communities of all kinds can be dynamic or apathetic, just or unjust, kind or cruel, exciting or dull. Whenever individuals or groups in a community are dropping out and being self-destructive, the community needs to be involved in the process of rehabilitation" (*Ibid.*, 1)

[41]The Rutland Centre is a privately-run, fee-paying, drug-free therapeutic community which specialises in the treatment of alcoholism and drug addiction in Dublin

[42]The concept of "enabling" refers to community ignorance, denial and resistance which contributes to an unacceptable toleration of addiction which in turn inhibits the addict's decision to seek treatment (Anderson 1981, 12-13).

The author while supportive of the idea that, when a daily attenders addiction programme became feasible in the Weaver Square premises, a no-drugs, no-alcohol condition could be applied to those who voluntarily attended this programme, was not prepared to apply this condition to everybody who came into contact with the YDP, and neither was he prepared to introduce urine-testing into a community based centre. Even, if he supported such conditions and testing, the STGDC, which managed the Small Club, did not. The author suggested to the addiction counsellor that the abstinence condition could be applied voluntarily to drug users who wished to avail of her counselling, provided this arrangement did not interfere with other programmes and activities which were being operated from the centre[43].

In the narrow confines of the Small Club premises, however, such interference seemed almost inevitable and it first manifested in relation to work with the youth group with which the author was involved. The addiction counsellor suggested that she provide a counselling service to members of the youth programme who had previously used drugs. The author agreed that the counsellor could counsel these young people and he encouraged it on condition that it was totally voluntary. However, during counselling, the counsellor insisted that the young people provide evidence that they were no longer using drugs or alcohol. In effect this meant going for urine-testing to the NDATC, a place which would inevitably bring the young people concerned back into contact with former drug-using peers. The young people refused to provide the requested evidence and declined the counselling service. The addiction counsellor requested that they be refused an involvement with the youth programme. The author, who was effectively coordinating this programme, refused pointing out that if a daily attenders' addiction programme had been operating and if the people concerned were willingly attending

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[43]The concept of voluntary participation in treatment is, to a large extent, a misnomer within the disease model. Working from a definition of addiction-as-disease, proponents of the model argue that denial and resistance are symptomatic of the illness and therefore, that, a form of social coercion is justified in order to make the addict understand that they are, indeed, suffering from an illness (Anderson,1981, 11-12).

this programme then this particular sanction could apply, but it could not apply in the context of youth programmes, which were not specifically drug-focused.

The conflicting positions adopted by the author and the addiction counsellor in this affair mirrored those which earlier emerged in discussions between health board management and the YDP committee. At a more micro level however, they contributed to tensions within the Small Club premises. These tensions gathered momentum in relation to a residential activity which was organised with the youth group in June 1984. The addiction counsellor held the view that such activities should have an alcohol-free, drug-free, participation condition. The author believed that such conditions for participation were restrictive, contrary to the project's normalisation ethos and that they were impossible to effectively monitor. As a result of this residential activity, which was jointly organised by the YDP and the STGDC (Cullen, 1984c), the addiction counsellor[44] initiated a process whereby complaints[45] were made against the author by the health board's senior administrative officer, Aine Flanagan[46]. In a letter to the author, Flanagan detailed these complaints and pointed out that they could result in "disciplinary action". The author rejected the complaints and demanded they be "either substantiated or withdrawn." The complaints were never substantiated by the health board[47].

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[44]The addiction counsellor had been invited to participate in the residential activity primarily for the purposes of easing some of the tensions surrounding her in the Small Club. It was hoped that through an involvement with young people in a residential setting that she would acquire a better understanding of their situation and needs.

[45]Essentially these complaints concerned allegations of intoxication by two members of the youth group - who were under the age of 18 years - during the residential activity (Eastern Health Board, 1984). The health board did not provide any information as to the origins of the complaints, nor did it make clear how the allegations against the two young people constituted a complaint against the project leader. At a meeting with health board management personnel the complaints were rejected by the author (Cullen, 1984d).

[46]The Senior Administrative Officer increasingly bypassed the Director of Community Care in relation to issues involving the author. In the previous month, July 1984 she "summoned" the author to her office and admonished him for an article - published in the June issue of *The Gardens* - which derided the response of health administrators - and by her implication, of herself - to drug problems. She demanded that the author acknowledge that the article's criticisms were aimed at her and that he should apologise. The author refused. The incident highlighted growing tensions between the author and health board management.

[47]The author received no further written communication from the health board in relation to these allegations. Eighteen months later in 1986, his trade union contacted the author who was, at the time,

This incident had a serious, demoralising impact on the work in progress in the Small Club and particularly undermined and destabilised the joint efforts of STGDC and YDP in relation to youth programmes and other developmental work. The incident highlighted the health board's preference for the institutional, abstinence-focused model as espoused by a newly-appointed and temporary addiction counsellor as compared to that which was supported by the more well-established YDP committee and operated by the author who was the project leader and who, at the time, had four years work experience with the health board in St. Teresas Gardens. It also raised serious questions about the health board's commitment to the YDP. If the health board allegations could have been substantiated, they at least demanded the use of a proper procedure; the use of improper procedures in pursuing allegations that were not substantiated always had the potential to cause irreparable damage to the health board's own project. In the event, this is what happened[48].

Indeed, the health board's developing attitude to both the YDP committee and the author became increasingly apparent during 1984. Despite the health board having received a letter of sanction for the expenditure of £80,000 from the Minister for Health in relation to the Weaver Square premises in March 1984, there was no progress with this premises. As a result of the Minister's letter and at the direct request of health board management, the YDP committee, in April 1984, submitted a detailed programme design for the Weaver Square premises which emphasised the necessity for both Youth Development Programmes and Addiction Programmes (YDP Committee, 1984). This submission in relation to the Weaver Square building was in effect the committee's last contribution to the development of that particular centre. There was no further

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in other employment, and informed him that the health board had finally agreed to withdraw the allegations. However, they intended doing this by destroying both his and their copies of the letter which made the allegations. The procedure therefore was for the original copy of the letter to be brought to the health board so they could both be destroyed. This request was refused by the author on the basis that it did not constitute a withdrawal. As a result, nothing further on this matter happened. The health board has acknowledged to the author that the procedure it used in making these complaints was both erroneous and embarrassing (Flanagan, 1991).

[48]In subsequent discussions which the author had with Lillis, it was apparent that she felt she had been used by health board management in this whole affair.

consultation between the health board and the committee in relation to its plans for Weaver Square or any other centre.

In January 1985, the project leader wrote to the health board expressing concern with the destabilising effects of health board management decisions on the progress of the YDP (Cullen, 1985b). In listing what he considered to be important YDP achievements[49] he argued that the health board as a result of its actions, rather than being seen as "instrumental in these achievements" would be seen as "antagonists". He suggested that the health board express its policy, "unambiguously", in relation to the YDP. Meanwhile, the health board had already decided its attitude to Weaver Square premises and decided that it was not suitable for the expenditure of £80,000 on renovation and openly abandoned all plans for this particular building.[50] It did consider the possibility of setting up a purpose-built premises on the grounds of Bru Caoimhghin, off Cork Street, but this never came to fruition. The Committee's advisory function in relation to the work in progress in the Small Club was also diminished. A meeting held in the Programme Manager's office in April 1984 had made it clear that the committee was seen as an advisory one and that no direct management responsibilities were now envisaged.

A number of other developments also continued to affect the author's role and functioning in the YDP and in his work with the STGDC. In August 1984, health board management delayed payment of an annual increment for the purposes of

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49In subsequent correspondence (Cullen, 1985c) reiterated these points and listed the following as indicators that the combined social work, STGDC and YDP approach over the years had been successful:

"(1) The area social work team report a radically reduced level of client intake from St. Teresas gardens over the past two years.
(2) The Probation and Welfare service probation officer reports a similar reduction in intake.
(3) The local Gardaí have reported a huge reduction in crime levels in the community.
(4) The local VEC school has reported an increased intake from St. Teresas Gardens.
(5) St. Teresas Gardens has moved from being a 'low demand' area to being a 'high demand' area in Dublin Corporation allocation system."

50In interview for this thesis, Aine Flanagan, Senior Administrative Officer, for the health board pointed out that it had been her view ever since 1981 that the Weaver Square premises was not suitable for the YDP. This view however, was never expressed to the YDP committee.

considering a report into the author's performance of duties as project leader. Subsequently, correspondence from the health board, in March 1985, made clear that the author was expected to "give the Board his absolute loyalty" and that there was a view that the author "sees his loyalty as being to organisations other than this Board and that this has created hostility which has not helped working relationships" (Eastern Health Board, 1985a). While the author was fully aware of the hostilities, he believed that the health board by allowing itself to make unsubstantiated allegations the previous August, had greater responsibility for creating this hostility than himself, and therefore greater power in resolving it, if indeed it sought a resolution. The discordant relationship between health board management and the author resurfaced in relation to the latter's participation in an RTE radio interview on March 7th 1985. The interview itself was non-controversial and innocuous but the author was reprimanded for participating without first obtaining management permission[51]. During April 1985 the author also found himself in dispute with the health board in relation to changes in his conditions of employment which the health board had unilaterally made[52].

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[51]The radio interview arose in relation to an Open Day which had been organised for the YDP. The interview was on the morning news programme *Morning Ireland*, and during it, the author outlined the purpose of the open day and the achievements of the programme's participants over the previous six months. As this radio programme has a key agenda-setting function for other media, the interview attracted further positive media coverage of the open-day event, which itself was not attended - despite invitations - by health board management personnel. In response to a request that he explain why he appeared on a radio programme without obtaining permission the author pointed out that the request for him to appear on the radio had come quite late the night before - as was quite normal with morning radio programmes - and that he had decided to do the interview knowing that it was likely to be in a positive vein and unlikely to be dealing with issues which were either contentious or controversial. He believed that in the circumstances his decision to go ahead with the interview was justified. A letter from the Eastern Health Board Programme Manager, while congratulating the author for the way in which he conveyed a message about the project on the radio pointed out that "all officers who are invited to appear on the media must get clearance either from myself, if it is within my jurisdiction" and that "no officer is entitled to make his own decision on these matters" (Eastern Health Board, 1985b). In the previous three years the author had been requested on several occasions by journalists who were covering events in St. Teresas Gardens to agree to be interviewed. On each occasion he had declined primarily on the basis that he believed such comment on his part was likely to cause confusion in relation to the work he was involved in the community. He found it surprising that on this one occasion when he had participated - and only after being requested at the last minute - in a programme which all agreed was very positive, that this should further reinforce negative relationships with health board management.

[52]At the time of his appointment the author's remuneration was, according to his letter of appointment, a salary scale, which at the time was a senior social worker scale (Eastern Health Board, 1983). From July 1983, the author was duly paid according to this scale. In the nine month period July 1984-March 1985 the author's increment payments were delayed, and he accumulated a credit with the health board. However, in April 1985, at the time that the health board awarded the author his increment, it also decided, unilaterally, to reverse the salary scale decision which had been taken in July

While the rapidly deteriorating relationship between the author and health board management was known in St. Teresas Gardens to only a few key members of the STGDC, on a wider level, the effects of the negative relationship between health board management and the YDP were more publicly apparent. The lack of progress in relation to the Weaver Square premises was obviously evident to all. The addiction counsellor's drugs-focused programme had little measurable effect in relation to current drug users most of whom refused to see her unless such contact was made a condition of either their attendance in the NDATC or the probation and welfare service[53]. In effect, during 1984-5, there was no outreach counselling - of the type originally envisaged by the YDP committee and initiated by the project leader during August-December 1983 - taking place in St. Teresas Gardens. Therefore, during this period 1984-5, despite the activities of the CPAD, the community- and youth-focused efforts of the STGDC and YDP and, the presence in the Small Club of a health board addiction counsellor, services for drug users remained much the same as before.

Most of the vital ingredients for initiating and developing an outreach, drugs service were, during 1983-4, available to the health board. There was a broadly-based, active, and committed committee - members of which were capable of drawing resources from other sources[54]. There was what seemed to be a suitable premises which was available for nominal rent. There was adequate Department of Health sanction to spend money.

1983 and to pay the author according to the social work salary scale which he had been paid up to this point. In paying the author the backpayment which he was due as a result of his increment being awarded, the health board deducted an amount equivalent to its estimation of overpayment as a result of him being paid a senior social worker salary (Eastern Health Board, 1985c). The author protested these changes and later when he had left the employment of the health board - despite documentary evidence of his entitlement to the original senior social work salary scale - was refused backpayments due as a result of increases in senior social worker salary scales (Cullen, 1986; Eastern Health Board, 1986).

[53]In August 1984 the author was eventually informed that he had no responsibility for supervising the drug counselling programme and that this programme was under the clinical direction of the NDATC. The author expressed written concerns that this arrangement separated the health board's involvement with youth development activities from its intention to provide a local response to the drug problem. He was also concerned that the new supervision arrangement effectively meant that the counsellor would have no local supervision and that this raised serious questions in relation to accountability (Cullen, 1985b).

[54]The chairperson of the YDP committee, Michael King, had secured the equivalent of 800 teaching hours per annum for the project; the STGDC representatives, along with the author had secured additional financial commitments from AnCO, Youth Employment Agency, Department of Labour and also from some voluntary sources.

There was a supportive community and there were young people willing to participate in project activities. There was no shortage of ideas. Yet, despite all these positives, the YDP and its central health board management moved from one conflict and crisis to the next.

STGDC sponsored youth programmes - of the type outlined in the previous chapter - continued in the Small Club but eventually these ceased due to the lack of interest of statutory agencies. A report on one youth programme in 1986 made the point that the project "might have been sending lollypop sticks on journeys down the Liffey and called it Youth Development" (STGDC, 1986) for all the interest and care funding agencies had in the work itself. By this stage the health board had removed itself from an involvement with youth development in St. Teresas Gardens altogether and had transferred the one post concerned with youth development into a second addiction counsellor position. From 1986 until the time of writing, this new counsellor[55] and Lillis operated from offices in health board area headquarters in Lord Edward Street/Castle Street[56].

Conclusion

The activities which are detailed in the previous chapter 6, indicate that localised responses can have an important impact on serious social and community problems. Community social work has been an important dimension to these activities and in

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[55]This counsellor was instrumental, in 1990, in forming Community Response a partnership group of community, voluntary and statutory interests who work jointly on drug problems in the south inner city area (Community Response, 1991).

[56]Apart from its involvement with the Talbot Centre health board provision of direct services for drug users during the years 1984-91 consisted almost entirely of employing individual addiction counsellors in different parts of the city. These counsellors have effectively operated without any stated objectives, guidelines, or structures for supervision or consultation, and without any clear form of accountability. Butler (1990, 11) commented as follows in relation to this counselling programme: "New services were created, or at least new posts were created; it's an exaggeration to call them services.....Unfortunately these were created without any reference to the network of services which already existed within the Community Care Programme. Very often it appeared that no thought had been put into the way in which addiction counsellors were going to liaise with all the other professionals with whom they shared the same team. Many counsellors worked in isolation as a result".

particular the localised health board support which was given to both the STGDC and CPAD contributed to their effectiveness. Essentially, community social work, contributed to the emergence of potential partnership relationships between local community organisations and statutory bodies. In this chapter 7, it is apparent that while localised supports to community efforts in St. Teresas Gardens were in place, that at a higher institutional level, there was a lack of commitment to the local dimension.

At a political level, institutional responses to the drug problem lacked attention to its local community dimension. Thus drugs policies - for the control of both supply and demand - continued to be formulated without reference to the communities which were directly affected[57]. Whereas, the STGDC and CPAD had expected that as a result of their activities a more determined institutional response - in which they would be involved - would be put in place, the institutional criticism which their activities eventually engendered was quite the opposite and was for them surprising. The situation was exacerbated by the virulence of the criticism implied in the treatment of the CPAD by RTE's *Today Tonight*. In many respects, this RTE programme exhibited many of the features of what has been described as the 'moral panic'[58]. The primary consequences of institutional criticisms of the CPAD were the undermining of it's organisational base in St. Teresas Gardens and particularly of the STGDC, the deeper entrenchment of a number of key CPAD activists and, the nurturing of relationships with the one semi-institutional organisation - Sinn Féin - which was openly and warmly supportive to what had happened[59].

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[57]References to Community Priority Areas in the report of the Government Task Force On Drug Abuse - which could have provided a basis for greater community input into policy-making - were omitted from the published statement on this report (Department of Health, 1983) - the report itself was never published.

[58]An editorial in the Irish Times, (March 1, 1984) captures this feeling of moral outrage very well: "The hideous cancer which is heroin addiction had not yet manifested itself in its more diabolical form....the sight of young people lying in doorways trying to experience life through the filter of a hypodermic needle."

[59]At least two of the leading activists who subsequently became most supportive of the CCCPAD and the Sinn Féin role were, at the outset of the formation of the CPAD, most vociferous in resisting such involvements. Indeed, one of these activists, at a meeting held in St. Teresas Gardens in July 1983,

For the most part, developments in St. Teresas Gardens during 1983-5 took place in a wider policy vacuum wherein the issues which the community was confronting on a local level, were not adequately addressed. The consequent concentration of local energies on the local dimension contributed - at this level - to tension and conflict which ultimately divided the community and brought it close to the state of fear and demoralisation it had experienced prior to the formation of the CPAD. In the midst of these developments, the one local organisation - STGDC - which, over the years - good times and bad - had provided a focus for community efforts, disintegrated and subsequently - at a local level - an organisational vacuum was created.

The lack of commitment to the community dimension was particularly evident in the health board's favouring of clinical, individual-focused responses. It is apparent that the health board lacked real commitment to the YDP's essential ethos and sought to redirect it from its originally intended youth development focus to a more institutional, drugs-focused programme. The activities of health board management undermined the achievements of successive community efforts and where once a partnership relationship seemed possible, a destructive chasm was created. Thus, although there were significant local developments resulting from community activities during 1983-5, these constituted a respite more than a solution for the community and its problems. Years of community social work effort it seemed were to no avail.

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questioned whether Sinn Féin could be trusted because of the dubious drug dealings of some of its own former members.

Chapter 8 - Summary and Conclusion

The focus of this study has been one community's experience of drug problems. There is great difficulty in applying the term community - in both an analytical and practical sense - to the study of drug problems. Historically, studies of drug problems are generally more concerned with their pharmacological, behavioural and psychosocial aspects than with those concerned with community. Chapter 1 of this study has identified, and elaborated on, a developmental approach for exploring the community experience of drug problems, utilising qualitative research methods and techniques. This study has been conducted in retrospect and the inherent limitations of this approach have been outlined. Despite its limitations, which need to be seen in the context of a general lack of Irish studies of drug problems, the community case study presented here can improve our understanding of drug problems and contribute to developing coherent policies for responding to same.

Social policy definitions and public attitudes in relation to drug problems have not, in an historical sense, remained static. Rather, they shift from time to time through notions of bad habit, criminality, disease and social problems. Chapter 2 has described the emergence of the term "problem drug-taker" in the UK from the early 1980s (ACMD, 1982), at a time when, in the Irish situation, there was a policy bias towards clinical, disease concepts of addiction. The interchangability of terms such as "drug abuser", "drug addict" and "problem drug taker" according to swings and changes in public perceptions and knowledge, does not make the task of the policy-maker or practitioner easy; it must surely bewilder those unfortunate enough to find themselves attending services because of their use of drugs.

Changes in public perceptions highlight that there is no simple definition or single solution to the drug problem. The consequences of drug use are too serious for their responses to be dependent on the outcomes of competition between different and

conflicting models. Its seriousness demands the application of scientific logic and political pragmatism. This author has recently applied the term "problem drug-user" in his attempt to provide a working description of persons who present to drugs services seeking help[1]. This approach emphasises that concern be directed at wider problems than an individual's use of, or addiction to, a particular drug. If a small group of individuals within a social system use drugs in such manner that most others within the same system find this behaviour problematic, it is appropriate that the unique psychological factors which contributed to this behaviour, are explored, in order to provide satisfactory explanations as to why it occurred. It is furthermore, appropriate, to respond to the individuals concerned in such manner that their rehabilitation to the system is sought. However, if a large and significant number of individuals within the same social system exhibit similar behaviours, it is more appropriate to seek explanations outside of the individuals concerned. C. Wright Mills (1967, 9) has argued that the "essential tool of the sociological imagination is to distinguish" between personal troubles - which are to do with the self - and issues which transcend the self and become public matters. Problem drug use - as described in this study - transcends individual concerns. As O'Kelly *et al* (1988) have highlighted, not merely one, or two, or three but rather, almost 30% of the male age cohort, 15-24, who were living in St. Teresas Gardens during 1981, were involved in heroin use. The public dimension to this problem requires attention to the circumstances and difficulties which gave rise to such a large incidence of individual drug-taking.

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[1]This description is taken from Ana Liffey Drug Project (1991, 10): "Problem drug users are persons for whom the continued use of psychoactive drugs creates profound difficulties. These difficulties include: addiction, in relation to drugs which create a psychological craving; withdrawal symptoms in relation to drugs which create a physiological dependence; financial hardship and an involvement with crime in relation to drugs which cannot be bought at a price which the user can afford; court appearances and imprisonment in relation to drugs which are illegal; isolation from family and community in relation to drugs which are not socially approved; serious illness and the risk of HIV infection in relation to drugs which have been adulterated with impurities or administered intravenously with unclean syringes and needles; and, the prospect of being permanently labelled as 'junkie', 'alcoholic', 'unemployable', 'outcast' and' deviant' in relation to drugs which have caused problems over a prolonged period."

Explanations and solutions in relation to the particular experience of drug problems focused on in this study cannot be explored purely in personal terms. Yet, as outlined in chapter 2, at the time that this group of young people became involved in drug use, such treatment and rehabilitation services as were available, were centralised, medically orientated, and quite removed from the communities in which the problem had become most manifest. They were furthermore, both punitive and clinical in their focus. They reinforced the picture of "drugs" as problem, and they approached drug treatment with abstinence-for-life models. In effect they succeeded, certainly for the first half of the 1980s, in removing themselves from the position of having a dynamic, interactive relationship with the problem with which they were most concerned. Yet, for this same period, these same services succeeded in occupying a central, dominant position in relation to influencing broader policy and practice responses, and in confining these to the single abstinent approach[2].

Because of the scale and magnitude of the problems which were unfolding, the period 1978-85 should have been one which generated a debate about drug policies, treatments and practice approaches in order that informed political decisions could have been taken. In contrast, the period was characterised by the absence of dialogue, and the serious dearth of research and published papers on Irish drug problems is itself a testimony to the lack of both public and specialised debate[3].

This study has been concerned with the community factors which have contributed to drug problems. In chapter 3, the emerging drug problems in St. Teresas Gardens have been outlined in the context of generalised deprivation resulting from modern social and economic changes. This community during the 1970s and 1980s became increasingly marginalised and incapable of dealing with the new problems which were developing in

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[2]See National Coordinating Committee on Drug Abuse (1986).

[3]The first Irish seminar to consider a wider than abstinent-only range of drug treatment policies was organised and reported on by the Ana Liffey Drug Project (1990).

its midst. The effects have been particularly felt by a significant number of young people for whom the changing situation provided neither employment nor the opportunity to acquire education or develop new skills. The rapidity with which local youth embraced heroin use and its accompanying lifestyle has had a devastating impact on the community, resulting in an undermining of its delicate social fabric and its sense of cohesion.

This study has unavoidably focused on conflict, a conflict which first manifested in an all pervasive fear which engulfed St. Teresas Gardens for a number of years, and prevented many people from talking about the problem let alone do something about it. In a small, built-up community of 1,250 persons the existence of such a major drug problem could not but leave an indelible mark. The effects of widespread heroin-use on non-using community members was devastating. Quite apart from the effects of increased criminal activities, the drug problem generated widespread fear and suspicion. Many community members who had once valued their sense of community and closeness, hid from their neighbours and retreated from community involvement. For quite a considerable time, the elderly in the community lived in genuine fear of being attacked or burgled. The not-so-elderly - fathers and mothers of growing children - experienced a deep fear of the unknown. Many residents decided to leave the community and seek new work opportunities and lifestyles in the expanding housing estates in Dublin's western suburbs. They were replaced by new tenants many of whom had no local roots and no desire to stay in the community on a long term basis. Indeed some new residents were drug-using or drug-dealing squatters who moved into the community in order to be located close to regular heroin supplies, a development which further accelerated the community's rapid decline

The needs which were encountered in St. Teresas Gardens during the early 1980s did not lend themselves to individualised or centralised responses. The Community Care Programme of the Eastern Health Board, given its overall aim of reaching out into the

community, was, in theory at least, the ideal vehicle whereby new emerging needs could have been identified, quantified, elaborated on and responded to within new non-institutional and more community-oriented frameworks. However, as has been outlined in chapter 3, the practice of community care in relation to social needs did not correspond to its rhetoric. Personal social services occupied a subordinate position to the more dominant community health services. Social workers found it extremely difficult to access management, decision-making and resources, in relation to planning and development; a key problem was the absence of social work managers. By the early 1980s, social workers were highly critical of the community care structures and advocated that the personal and social services be administered separately under a new programme.

The history of community work in the Eastern Health Board is even more fraught with problems and conflicts. The practice approach of community work is a collective one which involves the worker in bringing people together so that they may participate in changing their own situation and contributing to change in their locality. Health board management envisaged community workers as having an administrative, liaison brief with voluntary organisations who were providing a range of social services. There was inevitable conflict between the different perceptions of health board management and community workers in relation to, both their different interpretations of the role of the community worker and, also, their reporting relationships. Some community workers who were predisposed to explore the community dimension to social need, were marginalised within the health board's structures as a result.

Not surprisingly therefore, that attempts to develop community social work responses to needs in St. Teresas Gardens encountered numerous obstacles. In chapter 5, this study shows that from the early 1970s, there was, through the community care social work service, a number of attempts to develop responses to the predicament of St. Teresas Gardens. A succession of community based social workers assessed need in

St. Teresas Gardens and concluded that traditional casework responses would have limited effect. Community oriented approaches were developed and a local development committee - the STGDC - was set up. Through the efforts of this committee and the support of community social work personnel, a variety of community activities were initiated and the emerging drug problem was identified. Although, information in relation to this drug problem was presented to the appropriate authorities, the statutory response to the local problem in St. Teresas Gardens is generally perceived locally, as being slow and long drawn out. Initially, during 1978-81, when informed of the extent of the local drug problem statutory health officials were sceptical and non-responsive.

Eventually, with the encouragement of political and local public pressure, the Eastern Health Board in 1982 set up a community project to respond to the drug problem in the form of an experimental and innovative youth development programme. This project had a difficult history. From the outset, the first project leader encountered obstacles in accessing resources and getting clear, specific commitments from the health board in relation to project premises, staffing arrangements and budgets. A committee consisting of a broad range of representative local and professional interests which was ostensibly set up for the purposes of managing the project, had major difficulties in establishing a working relationship with health board management - letters were not replied to and telephone calls were not returned. Committee perceptions were that health board management was incapable of engaging in a development exchange with the community in relation to the YDP. The project was plunged into a deep crisis in early 1983 when its project leader, deeply concerned at the project's lack of progress, resigned and the YDP committee concerned that they were being dealt with politically by the health board contemplated disbandment.

While the overall focus of this study has been the decline of community in the midst of dramatic social and economic changes, there were, as chapter 6 has outlined, quite a number of local developments and activities which contributed to a greater sense of

community and a regeneration of community spirit in St. Teresas Gardens. Included in these were the various activities operated by the St. Teresas Gardens Development Committee (STGDC) such as summer projects, children's clubs and holiday schemes. There was also a Community Workers Training Course operated by the committee with funding and assistance from a number of statutory agencies in 1982/83 and which contributed to the development of local leaders. In all these developments, community social workers, working with the health board played an important role[4].

The widespread perception that statutory authorities had failed in their responses to the drug problem contributed to the formation of the Concerned Parents Against Drugs (CPAD) and the taking of local, collective action in St. Teresas Gardens, in June, 1983. When the CPAD was first set up its main features were its mass participation, democratic and non-violent action. In its first year, 1983-4, it was generally seen as successful in controlling the local supply of heroin. The initial media coverage of the CPAD was favourable and this coverage was instrumental in the formation of other groups throughout the city. The CPAD actions spurred on a whole range of social activities within the community and the development of new friendships and alliances. It also united the community in a manner it had never previously experienced. In its early days the CPAD manifested many of the features of a social movement and demonstrated a capacity to unite in collective action members of some of Dublin's most disaffected communities.

The success of the CPAD provided a unique opportunity for youth and general drug-prevention activities to be developed in the community. Through the operation of the Youth Development Project (YDP) and the cooperation of the St. Teresas Gardens Development Committee (STGDC), a number of youth development programmes

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[4]The community social work approach in St. Teresas Gardens may be likened to that described by Twelvetrees (1984). In this account of social intervention on a stigmatised council housing estate, Twelvetrees emphasises that social intervention must involve more than casework and include the following: residents' involvement in assessing local needs; pressure on authorities to provide better services; and, create partnerships whereby residents can collaborate with the authorities.

which explored innovative methods of working with young people at risk, were initiated and developed. These programmes had a further spin-off effect with young people becoming more directly involved in local community activity. Taken together these activities constitute an important record of local community effort.

Despite, the success of the above developments, the community experiences of St. Teresas Gardens during the period of this study were overshadowed by conflict. In the community, conflict became most acute when decisions were made to take collective action against persons who were alleged to be involved in drug dealing. Initially this conflict involved members of the community accusing drug dealers and later requesting and insisting they leave the community. When action was taken to remove alleged drug dealers from the community it was embroiled in conflict with law and authority. Furthermore, as outlined in chapter 7, the CPAD became quite isolated following the coverage given it by an RTE *Today Tonight* programme which concentrated on the local involvement of Sinn Féin and on allegations of vigilantism. While initial media - and political - suggestions that the CPAD was being manipulated by Sinn Fein were quite unfounded, there is little doubt that Sinn Féin, in time, grasped the political opportunity that was presented to it. In effect this contributed to further uncertainty and confusion among local people in St. Teresas Gardens, who while unaware of the deeper implication's of Sinn Féin's involvement, were still nonetheless supportive of CPAD's objectives and activities.

Other conflicts evolved from local leadership struggles, and in particular the role of the STGDC in trying to sustain the CPAD's original objectives and methods in the face of quite firm opposition from those members who had adopted a very hardline attitude especially against drug users. Further activities described by this latter group as anti-drugs actions, but which bore little resemblance to the kind of peaceful, democratic actions characteristic of the CPAD at its outset, split the community and returned it to the situation of widespread fear which existed a few years previously. In the midst of

these tensions, conflicts and fears, the CPAD in St. Teresas Gardens eventually disintegrated, and with this disintegration the movement as a whole lost its direction and impetus. The STGDC also lost impetus: it became quite entrenched and incapable of engaging in broader community developments.

Chapter 7 also considered the progress of YDP's relationships with the health board following the appointment of this author as its second project leader in July 1983. The YDP committee made greater efforts at highlighting both the youth development and community features of the developing project. However, the health board had apparently made a significant decision that its efforts in St. Teresas Gardens should be less concerned with the originally specified broad objectives of youth and community development and more specifically with drug-focused counselling. Tensions within the YDP focused on the objectives as understood by the author and community supporters which were apparently quite distinct from the expectations held for it by health board management and by other mainstream services. The conflict was further compounded because the health board did not fully clarify its drugs policy; in fact it had no coherent policy. There were inevitable staff-management clashes contributing to bitter exchanges in the midst of which the proposed local drug service never fully materialised. When the author resigned in 1985, the YDP became run down and eventually, less than two years later, the health board transferred the project leader's post into a drugs counselling position in the area.

The period 1978-85 therefore, was quite a traumatic time for St. Teresas Gardens. Despite the positive community experiences during this period it was dominated by the conflicts referred to above. These conflicts have had a serious impact not only on the community in a general sense but they have had an even greater impact on many of the individuals who were directly involved.

In May 1991, thirteen years after heroin-use first escalated in St. Teresas Gardens, the Irish Government published a report setting out a new strategy for dealing with the drug problem. This report - paralleling earlier developments in the UK and elsewhere - pointed out that "the provision of services aimed at the achievement of drug free society only or harm reduction programmes solely are inappropriate" and that services needed to be decentralised through the involvement of "Community Drug Teams" in a "small number of known areas which have been most directly affected by the drug problem" (Department of Health, 1991, 18). These policies represented a significant shift in the direction of a community-focused response that was so patently avoided 6-10 years earlier. While the administrative structures and resources required to deliver on these new services have not, as of yet, been fully elaborated on, there have been some indications that practical changes and resource allocations to accompany policy developments, are in train (O'Connell, 1992).

A lot more yet needs to be learned from the communities in which these problems have manifested before cohesive responses will fully develop. Heroin-use remains a choice for young people in St. Teresas Gardens and surrounding communities, who leave school at an early age and, who face the prospect of long term unemployment. Indeed, the author has been informed by a number of residents of south inner city communities that once again, in 1991-2, opiate-use has become a choice for young people. It seems unlikely that a fundamental change in such choices will come about as a result of the activities of social services unless the managers of these services develop a greater capacity to understand the local dimension of such problems, make a commitment to local consultation, and acquire some fundamental, skills in working with community groups on a local level.

There is furthermore, a political dimension to this problem which underlines the social division and segregation of modern Dublin. Political problems demand political solutions, and in the absence of focused policies to deal effectively with such issues, it

is difficult to see how young people in St. Teresas Gardens, in the next decade, no matter what drug treatment and preventive services are available, will avoid the prospect of using drugs, or avoid living in a family where the parents are also drug users. It is a pessimistic prospect, but hopefully its realistic potential will help to focus minds at a political level and contribute to the development of policies and actions which prove capable of averting it.

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