Soc Indic Res (2011) 102:229–244
DOI 10.1007/s11205-010-9672-x

A Case for Developing Community Drug Indicators

Hilda Loughran · Mary Ellen McCann

Accepted: 30 May 2010 / Published online: 12 June 2010

Abstract The EU Action Plan on Drugs (2005–2008) calls for member states of the European Union to provide information on five key epidemiological indicators. These are: general population surveys, prevalence and patterns of problem drug use, drug related infectious diseases, drug related deaths and mortality of drug users, and demand for drug treatment. The goal is to improve the comparability of data across the Member States, which is a central task of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction). Ireland has made progress on a national level in meeting this obligation. Currently the core information systems used to monitor the drugs problem in Ireland and to inform policy making are in the health and law enforcement areas including treatment, mortality and crime data. The dominance of such objective indicators and treatment outcome measures has contributed to obscuring the view of communities experiencing drugs problems on a day to day basis. The data are summations of the individual experience of drug problems and contribute little to understanding the broader question of how drug problem effect communities. This article draws on a community drugs study to review the contribution of traditional indicators of drug problems and consider some of the limitations of this data. It then presents an analysis of community data to identify possible community indicators of drug problems.

Keywords Community indicators · Social indicators · Drugs · Mixed methods research

1 Introduction

The European Union Action Plan on Drugs 2005–2008 (EMCDDA 2005) calls for member states of the EU to provide information on five key epidemiological indicators. These are:

H. Loughran (✉) · M. E. McCann
School of Applied Social Science, University College Dublin, Skeffington Building, Dublin 4, Ireland
e-mail: hilda.loughran@ucd.ie

M. E. McCann
e-mail: mary.mccann@ucd.ie

general population surveys, prevalence and patterns of problem drug use, drug related infectious diseases, drug related deaths and mortality of drug users, and demand for drug treatment. The goal is to improve the comparability of data across the Member States, which is a central task of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

Ireland has made progress on a national level in meeting this obligation. (NACD 2002/2003; NACD 2006/2007; Kelly et al. 2003; Long et al. 2005). Treatment statistics are also an important part of the picture. As in most European countries, service provision has grown dramatically in Ireland (Government of Ireland 2005: 34). The programme of expansion embarked on by the then Eastern Health Board (EHB) during the 1990s, was described as "probably one of the more innovative community drug service programmes in Europe" (Farrell et al. 2000). Objective indicators show part of the picture. However, they may not have much meaning for the people living and coping with the issues every day in their communities. Increases in drug treatment numbers, for example, do not say anything about changes in the everyday life of a community. Existing surveys are unable to provide an adequate impression of the way in which crime can impact on different areas or sectors of society (Connolly 2002). To capture the experiences of communities of the drug problem since 1996, a study involving three communities was carried out in Ireland. An innovative methodology of community participation was used. The 1996 was chosen as the baseline for the study, since that year marked a significant shift in national drug policy, with new structures and resources (Government of Ireland 1996).

2 Sources of Information for Indicators of Drug Misuse In Ireland

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

Treatment Data is obtained from The *National Drug Treatment Reporting System* (NDTRS), which provides data on treatment given by statutory and voluntary agencies on a nationwide basis.

Health Data provides information from three main sources:

- National Psychiatric In-patient Reporting System:

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

- The Hospital In-patient Enquiry (HIPE) scheme:

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

- The Department of Health and Children:

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

Mortality data is obtained from the Registrar Generals Office. Registrars of Births and Deaths are collected from a number of sources (medical practitioners, police, and coroners) and returned centrally to this office. These data are reported upon (Report on Vital Statistics) by the Central Statistics Office (CSO). Significant progress has been made in

collecting more accurate data on drug related deaths in Ireland through the development of a National Drug Related Deaths Index (Long et al. 2005).

Law enforcement systems provide data on the number of charges (arrests) for drug offences. The data are event-based, individuals cannot be identified so the number of individual persons involved is not known. Collection of drug seizure data is carried out by the Gardai and the Customs Service.

Information from these systems tells us something of the changes which have happened over time at a national level. However, drugs problems are more directly experienced at a local level. These systems may not be appropriate for accurately monitoring the benefits, for people living in the areas most affected by serious problem drug use, of action around drugs.

3 Community Indicators

The notion of developing community indicators for drugs is informed by an acknowledgement that drug use is not just an individual issue but has an impact on families and communities (Loughran and McCann 2006a). Chanan (2002: 9) argues that assisting communities to flourish is one of the most enlightened things a Government can do, which helps to assist a deepening and internalising of democracy. If Government is to assist communities to flourish, then Government and communities alike need authentic ways of judging whether this is happening. The most practical way of specifying the people whose quality of community life we are focussing on is by locality. Chanan therefore suggests that it makes most sense to measure community involvement at ward, aggregate ward and local authority (district) level as these could be correlated with Government statistics on local deprivation. Electoral divisions (EDs) were used in this study as these are the units which are used in Irish national data collection.

Community Indicators provide a vehicle to understand and address community issues from a holistic and outcomes-oriented perspective (Swain and Hollar 2003: 1). The impetus towards community improvement originates with how a community values itself and what vision it has for its future. Community indicators tell graphic stories about specific aspects of life and wellbeing in the community. If tracked over time, they offer a moving picture of community trends in the recent past. These trends can be followed for understanding. They can also be compared with the community's vision.

Attempting to develop indicators from the themes emerging in such data is a very recent focus of enquiry in Europe. The UK Drug Harm Index, for example, does include community harms (MacDonald et al. 2005). The indicators used are community perceptions of drug use/dealing as a problem, using data from the British Crime Survey, and drug dealing offences, using data from the Recorded Crime Statistics. While these instruments yield valuable information, they are limited for capturing local stories in a timely fashion (MacDonald et al. 2005). Ritter (2009) emphasises the importance of focussing on consequences, rather than on drug use per se. She categorises these into health related, crime related, community related, labour market and productivity, and pain and suffering.

The current study took the position that communities themselves should have a say in what constitutes an indicator of drug related harm. The study was designed to inform the development of a set of community indicators of a community drug problem. The attempt in the study was to tell these graphic stories about three communities' experience of drugs from 1996 to 2004.

Through the inductive process outlined in the methodology, issues of importance to local people were identified, and it is proposed that these become the basis for a set of community indicators. These issues should be able to be measured. A next step for effective monitoring of drugs policy needs to ensure that these issues are included in data collection. Collaboration is required with the various data collection agencies, and community groups, so that more effective instruments can be developed.

4 Methodology

The study had three phases. The preliminary steps were to investigate the information from traditional indicators and discover what they can tell us about communities dealing with drugs issues. From there, the task was to explore how communities view that information. Finally the data gathered from both current indicators and qualitative data from community sources would be aliased in an integrative way to address the question of the need for community indicators of drug problems.

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

The areas chosen for this research were seen also as important social and political units. From the outset there was a perception that they share common experiences which were outlined in Irish drug policy documents particularly since 1996. One of these shared experiences is drug problems. These drug problems did not develop in a vacuum. The conditions for fostering the growth are to be found in the socio-economic situation of many communities. These conditions form the backdrop for the personal relationships, the group networks, and developing patterns of behaviour (Flecknoe and McLellan 1994).

The first phase of the study involved developing community profiles of each of the three communities drawn from available traditional indicator data. The data were analysed and evaluated in terms of their contribution to providing a picture of drug problems in these communities.

The second phase related to the collection of qualitative data. This was done through conducting three focus groups in each community as well as in depth interviews with key informants in each community. The selection process for the participants in this phase was complex. Three community drugs agencies worked in partnership with university researchers to identify and select possible participants. The goal of representing a 'community' perspective was made difficult by the limitations in defining community and even more importantly the diversity of views, experiences and concerns within any community. Hence the task of a community participative research approach is to attempt to reach a broad spectrum of views but also to account for the representativeness of those included in the study. To enhance the validity of the findings an overall structure of levels of community participation was devised to inform the participant selection process.

The framework conceptualised four levels of community involvement and specified criteria for the selection of participants from each of the four levels. This framework offers an instrument for identifying a wide range of views within a community and could be used

in future studies in these or other communities. What is important in future studies is to reach this diversity of opinion, not necessarily to return to the same individual participants. The sampling frame would provide methodological consistency. The final sample in this research had representation from all four levels. The criteria for each level are as follows:

Level 1: People involved with the community agency partners who were the initial starting point of a community mapping process.
Level 2: People involved with groups, agencies, organisations connected to the partners because of (a) drug issues and (b) for other than drug related issues.
Level 3: People involved with groups, organisations, services in the wider community identified by but not directly involved with the local partners.
Level 4: People who are not engaged directly in organised community groups.

Participants from each level of community involvement were included in the focus groups and interviews. Thirty-nine people were recruited who fitted the criteria for Level 1, 25 for Level 2, 21 for Level 3 and 12 for Level 4. As anticipated it was more difficult to access Level 4 participants as by definition they were not engaged in already established community links. A total of 97 participants were involved in the study across three communities as well as the input from 6 community based researchers.

5 Findings

Much of the available data on treated drug misuse, mortality, education, health and crime for the communities could not be disaggregated from national or regional data to inform the community specific requirements of the profile. Data sets used different area definitions for the purposes of collection and reporting of data so that it was impossible to extract information specific to the three communities. In spite of these limitations it was clear from the profiles that all three communities did have drug related problems. Some of the unique aspects of the nature of the problems in each community became more evident through the qualitative data gathered.

A number of themes emerged from the qualitative data which suggest areas for further study. Four key themes will be discussed to illustrate some of the concerns related to dependence on traditional indicators to inform drug policy and services. The four themes are the range of drugs used, alcohol, drug related mortality, and crime and local drugs markets. These themes will be discussed drawing on quotations from the qualitative data referenced to each of the communities involved.

5.1 Theme 1: The Range of Drugs Being Used

An important source of data on drugs being used is treatment statistics (HRB 2003). These were examined for the period of the research. The following table shows that the predominant drug being used by those who sought treatment in one of the communities is heroin. Cocaine and benzodiazepines barely appear, and cannabis numbers are also small (Table 1).

The situation is similar for the other two communities (Tables 2, 3).

These statistics represent only those who present for treatment and hence do not accurately reflect the true extent of the drug problem since presenting for treatment presupposes both the existence of a treatment option for your drug of choice and the willingness to attend such treatment. As seen in each of the areas these statistics resulted in

Table 1 Main types of drugs used by those who sought treatment in Community A from 1996 to 2002

Year	Main type of drug used							Total
	Other Opiates	Heroin	E[a]	Cocaine	Benzodiazepines	Hallucinogens	Cannabis	
1996	1	19	1				1	22
1997		37					1	38
1998		16	1		1		4	22
1999		19				1	1	21
2000		63		1	1		1	66
2001	2	138		1	1		2	144
2002	3	122		0	1		5	131
Total	6 (1.4%)	414 (93.2%)	2 (.45%)	2 (.45%)	4 (.90%)	1 (.22%)	15 (3.4%)	444 (100%)

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

[a] And other MDMA

some clear data regarding heroin but were not sensitive to poly drug use. Treatment data also depends on drug users actually accessing treatment. In Community B the data shows that 159 people presented for treatment in 2002. The Local Drugs Task Force believed that the statistical information did not accurately reflect the extent of the drug problem and an unofficial estimate suggested that there could be over 600 heroin users in that one area alone (http://www.kwcd.ie).

Participants reported that use of hash was common place. It has become an accepted drug. Links with organised crime served to highlight the heroin problem as regular newspaper articles reported drug seizures and dealing in the area.

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

For example, one of the groups pointed to a 1994 report. An outreach worker gave a rundown of drugs being used in Community C on the occasion of the launch of the report, 1st July 1994. He talked about them in the order of those that were the most abused 'Alcohol, cannabis, ecstasy, tranquillisers (Valium had become routine), heroin, naps, physeptone, rohypnol, temgesics, acid, sniffing' (Ballymun Youth Action Project 1994).

The findings on poly drug use in this research are supported by reports from other sources (Rourke 2005: 31; NACD 2003). The Mid-term Review of the National Drugs Strategy 2001–2008 also recognised the changing patterns of drug use (Government of Ireland 2005: 35–39).

5.2 Theme 2: Alcohol

It was not possible to get community data on alcohol consumption patterns, under-age drinking or the consequences of alcohol use for the communities from indicators. The qualitative data revealed that the issue of alcohol use was seen as a serious concern in all three communities. This related to high-risk, under-age drinking and disturbances created

Table 2 Main types of drugs used by those who sought treatment in Community B from 1996 to 2002

Year	Main type of drug used											Total
	Other Opiate	Opiate sub stitute	Heroin	E and other mdma	Cocaine	Amphetamines	Benzodiazepines	Hallucinogens	Inhalant	CANNabis	Unspecified drug	
1996	5		113	3						2		123
1997	9	1	90				1	1		6		108
1998	7	5	132	1	5					2	1	153
1999	6		104	1			2					113
2000	20		143	1	1		1			3		169
2001	4	N/A	154	2	1	N/A	N/A	N/A	N/A	1	1	163
2002	2	N/A	159	0	0	N/A	N/A	N/A	N/A	1	1	163
Total	53 (5.3%)	6 (.6%)	895 (9.2%)	8 (.81%)	7 (.71%)	0	4 (.4%)	1 (.1%)	0	15 (1.5%)	3 (.30%)	992 (100%)

Source of data NDTRS email 19/03/03 and 28/07/04

Table 3 Main types of drugs used by those who sought treatment in Community C from 1996 to 2002

Year	Main type of drug used								
	Other opiates	Opiate subs	Heroin	Ecstasy and MDMA	Cocaine	Hypnotics and Sedatives[a]	Benzodiazepines	Hallucinogens	Volatile Inhalants
1996	52		224	1	1	1	7		
1997	14		185		2				
1998	30	1	334		3				
1999	45		256						
2000	21		360		1		1		
2001	16	3	377	1	0	N/A	1	N/A	N/A
2002	10	0	275	1	4	N/A	1	N/A	N/A
Total	188 (8.4%)	4 (.18%)	2011 (90.3%)	3 (.13%)	11 (.49%)	1 (.04%)	10 (.45%)	0	0

Source of data NDTRS email 19/03/03 and 28/07/04

[a] Excluding benzodiazepine

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

> The first-choice drug here in this community is alcohol,…… Alcohol plays a major part in the problems of this community (Community B).

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

There was some concern at the increased availability of off-licences. One of the local partners in the research had drawn attention to the increase in alcohol off-licence outlets, directly as a result of the retail plan of the area regeneration company. Where there were two off-licences before, there were a total of seven at the time of the research. National data shows that the numbers of the latter increased substantially in Ireland at the time of this study (STFA 2004: 11).

5.3 Theme 3: Drug Related Mortality

Drug-related deaths and deaths among drug users is one of the five key indicators of drugs misuse in Europe. All three of the communities in this study had experienced drug-related deaths. In the development of the community profiles it was noted that drug related statistics were seen to be flawed due to a number of recording issues. These include an under-reporting of deaths when not recorded as drug related. Byrne (2001) cited in Long et al. (2005) conducted a study which showed that 332 opiate-related deaths in Dublin were investigated in that time. Byrne's analysis of this data showed that 90% (300/332) of the coroners' cases lived in Local Drugs Task Force Areas (which included two of the communities in the current study). Community C in our study and two other communities in task force areas had the highest rates of opiate-related deaths for the reporting period and this was approximately 16 times the rate experienced in areas of Dublin not designated as task force areas (Long et al. 2005: 43).

Byrne (2001 cited in Long et al. 2005: 44) found that two-thirds of the opiate users who died tested positive for three or more drugs with just over 11% testing positive for only one drug.

These statistics support the views of the people in this study that drug-related death is a significant part of life in their communities, that polydrug use is involved, and that the impact is considerable. 'Two distinct patterns were observed among the eight drugs most commonly implicated in drug-related deaths: benzodiazepines, opiates (heroin and methadone) and alcohol were by far the most common substances implicated in these deaths, while cannabis antidepressants, and stimulants (ecstasy and cocaine) were less commonly implicated'(Loughran and McCann 2006c).

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

People dying, a few young deaths (Community B)

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

In Community B, the impact was described very graphically. This participant remembered

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

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

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

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

5.4 Theme 4: Local Drug Markets

The issue of local drugs markets was raised through the qualitative data. There was limited data available for the communities in the traditional indicator data sets. The statistics available from the Gardaí (the Irish police force) tell us very little about the consequences for people living with the kinds of activity described above. For example, statistics for drug offences where proceedings commenced show us that the Gardaí have information on some different kinds of drugs—cannabis, heroin, LSD, ecstasy, amphetamines and cocaine. 2719 proceedings in total were taken in the Dublin Metropolitan Region in 1999, and 2757 in 2002. For Wexford/Wicklow (which would include Community A activity) the numbers are 201 for 1999, and 212 in 2002. The year 2001 has most proceedings taken in both the Dublin Metropolitan Region and Wexford/Wicklow.

Police data for two of the communities during the time of the research show the great discrepancies in trying to build a picture of an area. Information was made available, by request, from two local stations. The information from both stations is very different (Tables 4, 5).

As will be obvious, such data is not an accurate indicator of the levels of drug use in an area. They are more an indicator of garda activity, and priorities. Compounding this for the purposes of tracking change over time is the fact that data is gathered from different sources many of which employ different geographic criteria for defining the area from which data is gathered. For example the crime statistics from the Gardaí are gathered in different administrative districts than health or even from areas defined by electoral districts.

Table 4 Police data on drug detections for Community C 1996–2003

Year	Garda searches[a]	Drug seizures	Value of drugs seized in Euro
1996	33	161	N/A
1997	58	250	N/A
1998	60	192	N/A
1999	65	140	N/A
2000	87	239	N/A
2001	42	185	N/A
2002	40	79	N/A
2003 (May)	27	101	N/A

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

Table 5 Police data on drug detections for Community B 1996–2003

Year	Garda searches	Drug seizures	Value of drugs seized
1996	1,173	N/A	755,850
1997	6,257	N/A	929,088
1998	7,757	N/A	532,750
1999	3,510	140	2,626,915
2000	2,888	219	716,671
2001	2,942	229	1,784,510
2002	3,265	218	743,020

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

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

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

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

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

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

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

In another, it was the local railway station:

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

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

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

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

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

In another community, the same thing was noted:

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

Another described the change like this:

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

Another interviewee was pessimistic about change, saying:

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

A speaker in a focus group agreed with this view:

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

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

6 Discussion

It is clear from this data that traditional, quantitative indicators have serious limitations when it comes to measuring drug problems at local level. While significant progress has been made in Ireland in gathering data, the findings from this community study suggest that they are insufficient for capturing change at a local level, in a timely fashion, and in a way which is useful for informing future policies. Data interpretation involved the integration of traditional indicators and the qualitative data. The discussion of the relationship between traditional indicators and community indicators highlighted some of the community concerns about traditional indicators.

Profiles were drawn up for each of the three communities and were published separately (Loughran and McCann 2006a, b, c). The profiles included available data on treated drug misuse, mortality, education, health and crime for the communities. This was a difficult task as the formulation of data precluded disaggregation of national or regional data to inform the community specific requirements of the profile. Data sets which used different area definitions for the purposes of collection and reporting of data made it impossible to extract information specific to the three communities. In spite of these limitations it was clear from the profiles that all three communities did have drug related problems. Some of the unique aspects of the nature of the problems in each community did not emerge in this data but became evident through the qualitative data gathered.

The emphasis in treatment provision, and in national strategy (Government of Ireland 1996), at this time was responding to heroin and so the data reflects this. Hence the treatment data must be used cautiously as it may inadvertently support a case for more heroin treatment at the expense of the need to diversify the treatment services.

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

The qualitative data from the area supported this criticism of the statistics.

Heroin use was the focus of community and government interventions. This may be explained by the different nature of heroin use including injecting behaviour and of course the illegal activity associated with its procurement and use. The focus was justifiable from a health perspective, given concerns about HIV/AIDS among injecting drug users. However, it is clear that this focus distracted attention from the widespread use of a range of other drugs. While interventions, specifically methadone and community organised responses, appear to have had some impact on the use of heroin, the failure to attend to the other drugs emerged as a serious mistake in the community profile for 2004 (Loughran and McCann 2006d). It is clear that mechanisms need to be found to gather such trends, and monitor them.

Communities' concern about increased availability of alcohol is backed up by international research. This shows that levels of availability, and of per-capita consumption, are directly related to the levels of alcohol-related problems in a society (STFA 2004). When we consider that these communities are also trying to deal with various other major changes, for example the upheaval surrounding the regeneration programme in one of the areas, their frustration at the lack of understanding on the part of those planning their environment is perfectly understandable. It is the people who live in the areas who will directly experience the result of increased availability of alcohol. This concern about alcohol also came through during the consultation process for The Mid-term Review of the National Drugs Strategy (Government of Ireland 2005).

There is a depth of pain felt in communities through the loss of their young people, and of young parents. This pain is compounded by under reporting, and can be perceived as a lack of care from the authorities. Efforts to redress this are being made, with the launch of a National Drug-Related Deaths Index in September, 2005. It is intended that detailed and accurate data be provided to facilitate a reliable decision as to the cause of death and its link with drug misuse (Speech by Mr Sean Power, Minister of State at the Department of Health and Children, at the launch of the National Drug-Related Deaths Index 26th September 2005). It is important to note that the index has been developed with the involvement of CityWide Family Support Network.

The limitations of reliance on traditional indicators could be categorised in a number of areas. Firstly the data gathered in traditional indicators is often inaccessible to local communities. The data are not gathered in a format that can facilitate disaggregation so that communities can use the information to develop appropriate treatment and prevention strategies to address the specific needs of their community. In addition, different sectors have different boundary areas for collection of data.

Secondly the indicators do not reflect some of the central concerns of communities around drug use. This can take the form of indicators such as mortality data which do attempt to record drug related deaths where no account can be taken of the overall impact of such deaths on community life.

Thirdly the process of gathering traditional indicator data is slow and the real time issues of communities have often moved on by the time statistics are collated and published.

The findings of this study also support the importance of developing indicators through people being involved in their own communities, either through volunteer effort, or social interaction, using local services, in paid employment in a community agency, or on management boards of local structures. The use of indicators to track the involvement of people in interventions, assess the strengths of communities, their inclusiveness, level of organization, capacity and influence, would provide evidence for reflection and review of priorities and work practices (Community Development Foundation 1996).

7 Conclusion

The challenge offered by the qualitative data from this study is to translate some of the thematic concerns identified by participants into community indicators of drug problems. This necessitates finding a meaningful method of gathering measurable data on such issues as impact of drug use at community level in terms of community quality of life and engagement in community as well as attempting to broaden the scope of current indicators to embrace some impact factors.

Community Level Indicators are derived from observations of aspects of the community other than those associated with individual community members (www.faculty.washington.edu/cheadle/cli). So the numbers of drug users in a particular community, while valuable information, is not so central to this study as the issues that the drug use raises for those living there.

There is great value to be accrued by communities being involved in establishing indicators for measurement, and subsequently being involved in their collection and refinement. Understanding of the complexities of the problems will deepen, with an appreciation of the difficulties of accurately portraying the area so that it can be compared over time (Join Together 1996). Ireland has the structures (drugs task forces at local and regional level), and the grass roots involvement to pilot such local collection of data, and be leaders in the development of Community Drugs Indicators. For planners, while some of the information on its own may not be statistically relevant, when taken as part of a more comprehensive framework of indicators, a more accurate picture of change will emerge.

Finally communities would benefit from gathering data in a format that could be utilised in real time. Accessing information about changes in drug use patterns and availability is essential if timely responses and prevention strategies are to be implemented on the ground.

Acknowledgments This paper is based on work funded by the National Advisory Committee on Drugs, Ireland. The views expressed in this paper are the authors' own and do not necessarily reflect the views and opinions of the NACD.

References

Ballymun Youth Action Project. (1994). *Annual report.* Dublin.

Byrne, R. (2001). *Opiate-related deaths investigated by the Dublin City and County Coroners 1998 to 2000.* Dublin: University of Dublin, Addiction Research Centre.

Chanan, G. (2002). *Measures of community: A study for the active community unit and research, development and statistics unit of the home office*. London: Development and Statistics Unit of the Home Office.

Community Development Foundation. (1996). *ABCDA Handbook—A framework for evaluating community development*. London: Community Development Foundation.

Connolly, J. (2002). *Drugs crime and community in Dublin monitoring quality of life in the North Inner City*. North Inner City Drugs Task Force: Dublin.

Farrell, M., Gerada, C., & Marsden, J. (2000). *External review of drug services for the Eastern Health Board*. London: National Addiction Centre, Institute of Psychiatry.

Flecknoe, C., & McLellan, N. (1994). *The what, why and how of neighbourhood community development*. London: Community Matters.

Furey, M., & Browne, C. (2004). *Opiate use in Ireland 2000 and 2001*. Garda Siochana Research Unit: Dublin.

Government of Ireland. (1996). *First report of the ministerial task force on measures to reduce the demand for drugs*. Stationary Office: Dublin.

Government of Ireland. (2005). *Mid-term review of the national drugs strategy 2001–2008*. Dublin: Stationary Office.
Health Research Board. (2003). *Drug misuse research division: trends in treated drug misuse in the Republic of Ireland, 1996 to 2000. Occasional paper No. 9/2003*. Dublin: Health Research Board.
Join Together. (1996). *Strategies to fight substance abuse bolster problem solving by communities*. Boston: Join Together.
Kelly, A., Carvalho, M., & Teljeur, C. (2003). *A 3 source capture recapture study of the prevalence of opiate use in Ireland 2000 to 2001*. Dublin: Trinity College, Small Area Health Research Unit, Department of Community Health and General Practice.
Keogh, E. (1997). *Illicit drug use and related criminal activity in the Dublin metropolitan area*. Dublin: Garda Research Unit.
Long, J., Lynn, E., & Keating, J. (2005). *Drug-related deaths in Ireland, 1990–2—2. Overview 1*. Dublin: Health Research Board.
Loughran, H., & McCann, M. (2006a). *A community drugs study: Developing community indicators for problem drug use*. Dublin: NACD.
Loughran, H., & McCann, M. (2006b). *Bray community case study: Experiences and perceptions of problem drug use*. Dublin: NACD.
Loughran, H., & McCann, M. (2006c). *Crumlin community case study: Experiences and perceptions of problem drug use*. Dublin: NACD.
Loughran, H., & McCann, M. (2006d). *Ballymun community case study: Experiences and perceptions of problem drug use*. Dublin: NACD.
Lupton, R., Wilson, A., May, T., Warburton, H., & Turnbull, P. J. (2002). *A rock and a hard place: Drug markets in deprived neighbourhoods*. London: CASE, London School of Economic and the Criminal Policy Research Unit.
MacDonald, Z., Tinsley, L., Collingwood, J., Jamieson, P., Pudney, S. (2005). *Measuring the harm from illegal drugs using the drug harm index.* HMSO, Home Office Online Report 24/05.
NACD (National Advisory Committee on Drugs) & DAIRU. (2003). *Drug use in Ireland & Northern Ireland*. Dublin: NACD/DAIRU.
Powell, F., & Geoghegan, M. (2004). *The politics of community development*. Dublin: A. & A. Farmar.
Ritter, A. (2009). Methods for comparing drug policies—The utility of composite drug harm indexes. *International Journal of Drug Policy, 20*(6), 475–479.
Rourke, S. (2005). *CityWide drugs crisis campaign : A decade of achievement*. Dublin: City Wide Drugs Crisis Campaign.
STFA (Strategic Task Force on Alcohol). (2004). *Second report.* Dublin: Department of Health and Children.
Swain, D., & Hollar, D. (2003). Measuring Progress: Community indicators and the quality of life. *International Journal of Public Administration, 26*(7), 789–814.
The European Union Action Plan on Drugs 2005–2008 Lisbon: EMCDDA.