Community Drug Treatment – An Untried Response to Drug Problems in Dublin

by Barry Cullen

There are essential differences between drug problems and community drug problems. Individual's drug problems relate to the social, financial and psychological consequences, for them, of their use, misuse and, indeed, non-use of psychoactive drugs which have addictive or habitual effects. In many instances and indeed, prior to the first Irish opiate epidemic in the early 1980s, such drug problems, although not evenly spread in the population were not concentrated in any particular section of the community. Since the 1980s this situation has changed quite dramatically and newer community drug problems have emerged and have been quantified. Community drug problems arise when there are concentrations of individual drug problems in particular communities. Although the evidence for this concentration has, by now, been well researched and documented, (Dean et al., 1983; O'Kelly et al., 1988; O'Hare and O'Brien, 1992; McKeown et al., 1993), its wider community effects and impact tend to be more difficult to identify and understand. Some effects are obvious: increases in local crime; greater demands on local health and social services; a heightening of local fears particularly among the elderly and parents of growing children; and the relatively large numbers of local young people who have AIDS related illnesses and who have died. Some of the more debilitating effects however relate to the loss of community morale, the acceptance of the inevitability of young deaths, the internalisation and denial of grief, and a sense, in many communities, that their social predicament has little public interest other than that of media sensationalism and political sound-bites. Issues in relation to the community dimension of drug problems in Dublin, including causes, effects, treatment problems and conflicts are discussed and elaborated on in Cullen (1991).

The context in which these community drug problems are currently experienced in Dublin is one of increasing community alienation and a very strong community perception of institutional failure. The communities where drug problems persist in large numbers are characterised by multi-dimensional indicators of poverty. They are the older, least desirable local authority flat complexes in the inner city and the newer, sprawling and socially segregated housing estates in the suburbs. They are areas where there is a concentration of low income and unemployment, where there are persistent inter-generational educational disadvantages, a high level of welfare dependency and a high incidence of other social problems. They are areas whose local economy has either declined and failed – in the case of inner city communities – or never existed – in the case of new housing estates. They are areas that have been badly neglected in the share out of institutional resources for social and economic development.

In the context of the above short outline of community drug problems, it is an arduous task to elaborate on the most appropriate community responses. Clearly a political response to the wider social and economic needs of these communities is a fundamental priority and it is possible to speculate that a greater impact on the drug problems in these communities can, in the coming years, come about, not by setting up new drug services, but by successful implementation of the government's long overdue proposals for local development in disadvantaged communities as outlined in the National Development Plan, 1993 (Ireland 1993,69-75). There is also, an important role for primary community prevention initiatives. Community Response, a health board funded network of voluntary, statutory and community personnel in south inner city of Dublin has begun to develop important community prevention activities and in particular, is

This article is a reproduction of that published in: *Irish Social Worker*, Summer 1994, 12(2), pp. 16-18. Pagination may not match that of the original.

having an impact in local schools. Similar prevention work has been successfully developed by the Youth Action Project, Ballymun over the last twelve years. In relation to more direct community actions, many Concerned Parents Against Drugs groups have proven, to their own communities, at least, that they can have an impact in terms of limiting the local illicit supplies of drugs and in making drug-taking taboo for youngsters.

Community forms of drug treatment

At the outset of the opiate epidemic in the 1970s and up to the late 1980s Irish drug services were dominated by a specialist, centralist model. At the heart of this model was the Drug Treatment Centre Board, Trinity Court (previously known as Jervis Street). This was an institutional clinical and social work service which emphasised that client commitment to abstinence was an essential condition for treatment. This abstinence approach was also held by the Coolmine Therapeutic Community. Up to the late 1980s Irish drug policies were highly influenced by these two services. In practical terms, what such policies meant for generic workers, who operated in the community, was that persons with drug problems were referred to these specialist services for treatment and counselling. The fact that these specialist services provided only one form of treatment contributed to a widespread view among care workers that there was in fact only one form of treatment. In many instances the specialist services' assessments and review reports on individual drug users were accepted, without a great deal of questioning and discussion, by generic, community based workers. In fact, this latter group during this period became quite de-skilled and lacking in confidence in relation to drug problems.

What is quite surprising and unusual about the manner in which drug services consolidated this specialist, centralised approach, is that the Eastern Health Board's Community Care Programme, which was set up in the 1970s, was devised in order to provide a much more community-oriented response to new social and health problems. Indeed the emerging drug problems constituted an ideal test for the efficacy and potential of community care. It proved to be a missed opportunity. Although community care workers were the first to identify, quantify and, prepare local service proposals in response to, the growing opiate problem 1979 – '83, the Eastern Health Board insisted on managing drug problems under its Special Hospitals (psychiatric) Care Programme and in deferring to the Drug Treatment Centre Board in relation to the development of drug services. Thus, the abstinence-only specialist services thrived and community-oriented approaches were, at best marginalised within overall service development, and at worst, completely undermined even at times by their own funders. (Cullen, 1991, Butler 1991.) For anybody who worked in community care in the inner-city during the 1980s the evidence of failure of the abstinence-only approach was palpable. Drug users who persistently failed to satisfy the commitment-to-abstinence condition for treatment became even more disorganised and marginalised within their communities and many have since become ill and died. In some instances the failure of the abstinence-only approach was quite ludicrous. Many drug users interpreted the pre-condition to abstinence as an "empty formula" for gaining access to treatment and so instead of getting a place on methadone maintenance programmes – which they wanted but which, in theory, at least, were not available – they participated repeatedly, and with little success in both short-term and prolonged detoxification programmes. One particularly undesirable effect of the dominance of this specialist model during this period was the complete absence of dialogue and public discussion in relation to drug problems. Because of the scale and magnitude of the problems which were unfolding, the period 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 is characterised by a suspicion of debate - always a most unwelcome trend in any society. Indeed the first significant public debate in relation to new drug treatment policies was initiated not by the statutory services but from

within the voluntary sector (Ana Liffey Drug Project, 1990). The serious dearth of research and published papers on Irish drug problems is itself a testimony to the secrecy and closed mindedness of the time.

In the context of growing HIV problems in Dublin in the mid to late 1980s, it was inevitable that change in relation to drug treatment policies would come about. The first changes came about in the late 1980s, when needle exchange and HIV outreach services were established by the health board. These services' user-friendly and harm-reduction approach to drug treatment were borrowed from the voluntary sector, particularly from the Ana Liffey Drug Project. This project which was set up in 1982 had, despite the sometimes loud opposition from institutional services, operated low threshold approaches to drug users in the city centre and advocated the development of new comprehensive policies. In typical health board fashion there was no clear policy dimension to its new services. It was not until the publication a new government policy on drug problems (Department of Health, 1991) that a clear indication of changing government attitudes became evident. In acknowledging that there was a place for both abstinence-only and harm-reduction approaches to drug treatment, this policy document also set out a new role for community drug teams. It was envisaged that these teams, consisting of community based doctors, nurses, social workers and counsellors would effectively coordinate the inputs of both specialist and non-specialist personnel to individual drug users. This policy shift was consistent with that advocated in the UK nine years earlier. The new approach reflected a growing view that drug users were not, after all, that different from other users of social services, and that their problems did not necessitate separate, specialist services. As Strang (1989, 148) pointed out in his review of changes which were brought about in the North West Regional Health Authority area of England.

Psychological problems may require intervention from a psychologist or social worker or may at best be helped by a 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 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 (Ibid.)

There have been important developments following the publication of the government's new policy. The appointment by the health board of a new AIDS and Drugs Co-ordinator has improved the provision of harm-reduction programmes, particularly through the provision of three new methadone- clinics. However, progress in relation to the development of community-based teams is much slower. Although two community drug teams are being piloted in Ballymun and Rialto, the fundamental obstacle to the development of community-oriented approaches is that the Government in its 1991 report and since, failed to spell out clearly the role of the Drug Treatment Centre Board in the development of community based treatment of its involvement in non- abstinent methadone programmes. Consequently, the Drug Treatment Centre Board has continued to operate virtually unchanged and with a dominant commitment to abstinence- based treatment programmes. Furthermore, although a Department of Health convened expert group has reported on a protocol for the prescribing of methadone by GPs, there has been no departmental agreement in relation to GP involvement in community treatment. In the absence of specialist back-up to community based personnel and policies on these issues, GPs have tended to adopt the status quo, to avoid getting involved with methadone programmes – which are an essential component of community treatment – and to refer-on specialist services. Other generic workers, such as social workers and nurses, have little motivation in becoming more directly involved in dealing with drug problems, and they too are inclined to refer-on.

The slow progress in relation to developing community drug teams reinforces the picture of drugs as the dominant problem. Community drug problems should not be separate from the social and economic context in which they occur and for this reason the most important local responses are those designed to tackle issues of local structures, representation and development. A greater amount of our energies needs to be focused on these issues. The more energies are focused on ideological issues in relation to methadone availability and universal drug-free societies, the less attention will be given to the underlying political issues and the more sustenance will be given to a self-perpetuating and increasingly irrelevant specialist drug treatment industry. In the main, community drug problems arise as seemingly rational individual responses to the harsh social conditions which prevail in many parts of Irish society. There is, at this stage, particularly because of the absence of individual evaluation studies, no evidence that specialist, centralised services have made any real impact on the treatment of those who have been affected. The untried, community treatment response is, for this reason, at least, and for many more reasons also, worth developing and trying.

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