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ALCOHOL AND DRUG EDUCATION IN IRELAND: AIMS, METHODS AND: DIFFICULTIES

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Introduction

In 1968 the Minister for Health set up a Working Party on Drug Abuse to which he gave responsibility for drawing up the broad outlines of a future Irish drug policy. The terms of reference of this committee contained a specific request that the Minister be advised on the subject of 'measures to discourage young persons from starting the use of drugs (e.g. publicity, education, etc.) (Report of the Working Party on Drug Abuse, 1971, p.9). In his introductory address to the committee as it began its work, the Minister expressed his personal belief in the value of education as a means of prevention. He said:

> … many of the people taking drugs are young persons with no evil intent, taking them occasionally 'for kicks' or to be 'with it', who would, I should think, have nothing to do with drugs if they were properly advised and informed of the harmful consequences of continuing to take them. (Ibid., p.59)

An earlier Department of Health report, that of the *Commission of Inquiry on Mental Illness,* had welcomed the establishment of the *Irish National Council on Alcoholism* (INCA) in 1966, a body which was primarily concerned to 'educate the public about alcoholism as a disease and the needs of alcoholics' (Report of the Commission of Inquiry on Mental Illness, 1966, p.82).

It is, I think, fair to say that the official view of alcohol and drug education at that time – approximately a quarter of a century ago – was that such education offered society an obvious and uncomplicated means to achieve the socially desired end of the prevention of problems related to drug and alcohol consumption. It was assumed that this was an area characterised by consensus: consensus, that is, about the problems to be avoided or prevented and consensus about the methods which were most likely to achieve this end.

It was also implicit in much of this early discussion that the issues involved in the prevention of these particular social problems were well-defined and discrete. I have failed to

find any reference to or acknowledgement of the fact that health education in this area had the potential to become *political,* that is to become embroiled in wider conflicts concerning the distribution of power, wealth and moral/cultural influences in Irish society. It was as though these early proponents of alcohol and drug education regarded admonitions to the public – and particularly to the young – on the subject of drug and alcohol consumption as being of the same order as injunctions concerning basic hygiene. 'Don't abuse drugs' and 'Beware of alcoholism' were being prepared to take their place alongside 'Brush your teeth before going to bed', and 'Wash your hands after going to the toilet'.

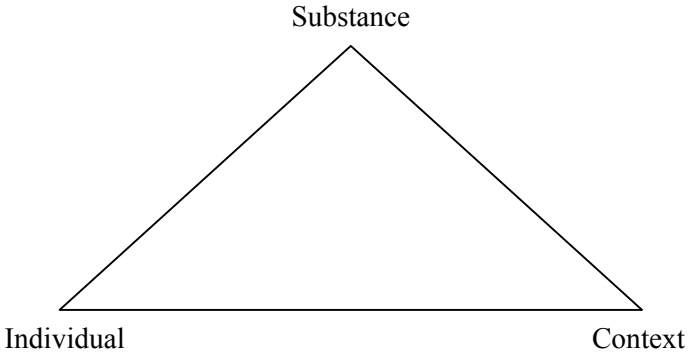
The aim of this article is to review subsequent developments in the field of alcohol and drug education in Ireland, primarily to' illustrate how unfounded these early perceptions have proved to be. It will generally be argued that these preventive endeavours have been both more complex and more conflictual than anticipated, that there have been difficulties in agreeing basic aims as well as methods, and, in particular, that this enterprise has not turned out to be the discrete, apolitical affair which was originally promised. The fundamental aim of this article is not to advise educators how to go about their business *the right way,* but rather to encourage them to face up to and acknowledge the cultural and political complexities and ambiguities which are inherent in this field: Many Irish health educators have already done this and some have been

heavily criticised for doing so, but it is understandable that others have clung to the comfort of the old formulae despite compelling evidence as to their lack of effectiveness and general illogicality.

Theoretical Perspectives

Before considering in a detailed manner the experience of drug and alcohol educators in Ireland, it is useful to discuss some abstract or theoretical frameworks which may be of help in gaining an understanding of the various ways in which alcohol and drug problems – and their prevention – may be viewed.

Figure 1: The Public Health Triangle



The first of these frameworks, the Public Health Triangle which is shown in Figure 1, is based on a traditional public health or epidemiological model which refers to the relationships between *Agent, Host* and *Environment;* a similar framework based on the relationships between *Drug, Set* and *Setting* has been popularised by Zinberg (1984), largely with reference to heroin use.

This is a relatively simple but quite useful framework which may be applied to the study of the *content* of alcohol and drug educational programmes. All that it does is alert the observer, to the range of causal models which may plausibly be proposed in explaining alcohol and drug problems. The main questions raised in this way are:-

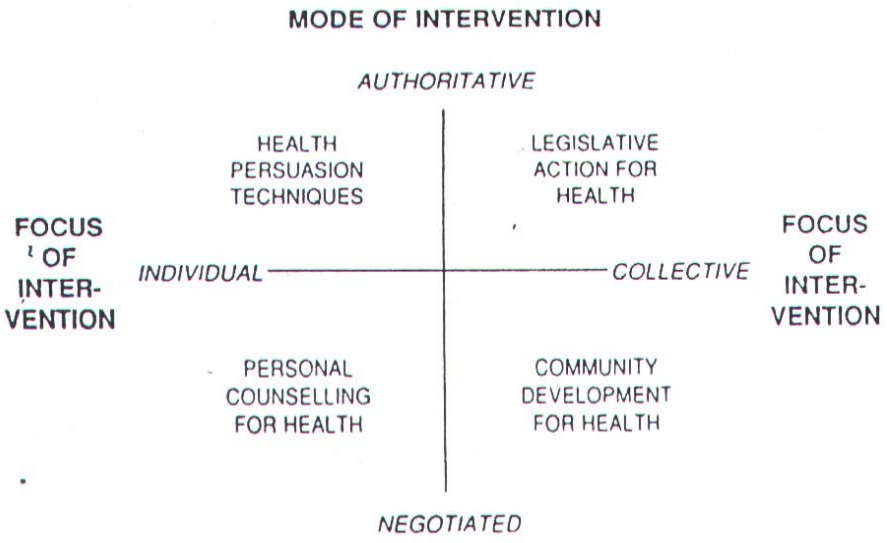
– does the educational programme attribute primary responsibility for these problems to the *substance* itself -suggesting that because of its addictive properties, its toxic effects or its potential to bring about behavioural change it should be avoided?

– does the programme explain addiction or other substance-related problems in terms of the defects or deficits -genetic, biochemical or psychological – of *individual* users?

– does the programme suggest that *context* or environment plays a major role in the causation of drug problems, either in terms of more enduring structural features such as poverty and social disadvantage – which may create a general vulnerability – or in terms of the specifically risky location or situation of the consumer – drinking while driving, using drugs while responsible for children, 'sniffing', volatile substances on a canal bank?

– does the educational programme accept that the interaction of two or three factors must be considered – with the equation showing a high degree of variability – in any preventive activity?

Figure 2: Overall Health Education Strategy



Source: Beattie, 1991

The second framework, which is presented in Figure 2, is more concerned with the overall *strategy* of health education than with programme content, and the two dimensions which are cross-classified in this framework are commonly used in social policy analysis. The authoritative/negotiated dimension is familiar to those who are aware of the debate which goes on concerning the relative merits of policy which is 'top-down' as opposed to policy which develops in a 'bottom-up' style. Proponents of the bottom-up or negotiated approach to social policy, particularly in the health area, tend to criticise the authoritative approach on the grounds that the authority is spurious and that this entire process is paternalistic and non-participative

Traditional health education has had as its focus the individual, and has attempted to influence individuals to make healthier decisions by providing them with information concerning the health implications of the behavioural alternatives open to them. However, there has been an increasing acceptance of the idea that improvements in general health in industrial societies over the past century have been due mainly to changes and reforms at the *collective* level, involving environmental measures, such as improved housing and public sanitation, and that relatively little significance is to be attached to the role of medical and surgical treatment of individual 'patients' (McKeown, 1976). The acceptance of this logic by health authorities has led, over the past fifteen years, to the emergence of *health promotion* (WHO. 1984; Kelleher. 1992), a conceptual approach which restates the importance of collective or environmental measures in improving the quality and extending the length of our lives. It is debatable, however, whether health promotion in Ireland or elsewhere has moved much beyond the level of rhetoric and it is clear that the kind of health education – which is depicted in the two quadrants on the left of Figure 2 – is still flourishing.

Education Which Focuses on the Substance

If we move back to the position which was commonly held in the late 1960s, it appears that the expectation of the Minister for Health was that the Working Party on Drug Abuse would propose the introduction of drug education programmes for Irish young people which would (a) be authoritative, (b) focus on the individual, and (c) largely consist, in terms of content, of the presentation of information on the negative aspects of drugs.

What occurred, however, was quite different: the Working Party resisted the idea that drug education should emphasise information-giving; it moved tentatively towards a negotiated (personal counselling for health) mode of intervention, and suggested that a separate group or committee should consider the detailed issues of drug education in Ireland. This second group, known as the *Committee on Drug Education,* was established in 1972 and reported in 1974, when it basically reaffirmed the views of its predecessor and recommended the establishment of a permanent Health Education Authority, which would include drug education in its broader remit. The Minister for Health accepted this recommendation and promptly established the Health Education Bureau (HEB). The chronological sequence of these events was as follows:

1968-1971: Working Party on Drug Abuse.
1972-1974: Committee on Drug Education.
1974: Establishment of Health Education Bureau (HEB).

What we must try to understand is how the relatively simple and specific task of informing young people about the negative features of drugs became transformed into the establishment of a national Health Education Bureau. At its simplest, what occurred was that the members of these two committees discovered the virtual impossibility of creating drug education programmes which could credibly be built around substance-based information giving. It is instructive to read what the two committees had to say about alcohol; this is a brief exercise because, apart from a passing reference, both committees studiously avoided any discussion of alcohol. This in itself - like the Sherlock Holmes story which involved the dog that did not bark – is significant and will now be briefly considered.

One of the most obvious difficulties which would-be drug educators experienced in Ireland at this period may be explained by reference to the Public Health Triangle. They were expected to create programmes which attributed responsibility for drug problems to the substance itself: the substances concerned were perceived to be, as the legal framework of this period defined them, 'dangerous drugs'. By contrast, the content of the health education message which was being disseminated by INCA at this time attributed causal responsibility for alcoholism to the vulnerabilities of individual drinkers; this suggested that alcohol was not a dangerous drug and that 90 per cent of drinkers could consume it with impunity,

while only 10 per cent would go on to develop the disease of alcoholism. To confirm this point, it is perhaps sufficient to note that in its written constitution INCA set out its main aims, which were entirely related to alcoholism and which were to be pursued 'without making any judgement on the consumption of alcohol per se[1] (Irish National Council on Alcoholism: Memorandum and Articles of Association, 1966).

What this meant was that alcohol – a drug which was increasingly popular with adults – was being authoritatively depicted in favourable or at least neutral terms, while the illicit drugs which were used almost exclusively by young people were portrayed in unremittingly negative terms. There was an obvious risk that young people would see information-based programmes of this type as hypocritical and illogical and that as a consequence they would be dismissive of all forms of drug education. The Working Party on Drug Abuse also became aware of the finding, which was emerging at this time from research into the outcome of drug education programmes, that information-based programmes could sometimes be counterproductive:

> evidence from some recent surveys suggests that direct communication to young people of information about drugs, even though aimed at alerting them to dangers, is likely to cause experimentation (Report of the Working Party on Drug Abuse. 1971. p.38).

This theme was also taken up by the Committee on Drug Education which was clearly and explicitly concerned lest drug education in Ireland should become counterproductive; it issued an interim report to the Minister for Health, calling for a moratorium on all drug education until it finally reported and laid down guidelines. This was in response to its awareness that schools were beginning to provide 'one-off drug education lectures, frequently given by outside 'experts' – including former addicts – who came in and presented a rather sensational picture of the drug scene. It would have been embarrassing, although valid, had the "Interim Report of the Committee on Drug Education pointed out that the style of education of which it was so explicitly critical was also that favoured by INCA at this time. Tactfully, the Committee refrained from any such comment.

Finally, before leaving the topic of information-based or substanced-based education, it is worth pointing to the practical difficulties involved for educators who (in terms of Figure 2) wish to be authoritative. The first difficulty is that the authorities

may disagree with one another, in which case prospective educators must decide which set of authorities to follow or how to present information in a situation where there is no consensus. A good example of this is to be found in relation to cannabis, a drug about which there are such obviously conflicting views, as the following two quotes suggest:

> The widely held belief that cannabis is a harmless, non-addictive drug and the widespread ignorance of the dangers to youngsters is alarming in our society. Parents report that counsellors and other adults in advisory positions have been telling them that cannabis is harmless and not to worry about it. The effects of marijuana are not as dramatic, nor is it addictive like heroin, but marijuana is all the more deceptive and insidious because of this. (Comberton. 1982).
>
> The single biggest cannabis problem is the risk of being caught with it by the police. While there is no cast iron evidence that cannabis does serious physical or psychological damage, a police record can ruin career prospects overnight (Lifeline. Manchester. 1992)

The Comberton quote represents the view of Coolemine Therapeutic Community, a long-established voluntary drug agency in Dublin which has consistently adopted a drug-free philosophy. The second quote represents the views of Lifeline, a British drugs agency which espouses a harm reduction as opposed to a total abstinence philosophy. From a social science perspective the only conclusion we can reach is that each point of view reflects a value position rather than a value-free *scientific* position. The research evidence on the consequences of using cannabis may be interpreted, depending on the attitudinal starting-point or bias of the observer, as indicating either that cannabis is dangerous or that it is relatively harmless. Educators who espouse the former view are likely to be greeted with disbelief by students who are aware of the alternative perspective; educators who are bold enough to favour the latter are likely to be accused of irresponsibility, ignorance and subversion.

The second difficulty arises where there is a radical change in the content of an authoritative pronouncement. The most obvious example of this is the *volte face* of the World Health Organisation and many authoritative medical bodies on the subject of alcohol. Briefly, what has happened is that since the early 1970s there has been a consistent move away from the disease concept of alcoholism as propounded in Ireland by INCA. The major points of conflict between the two models are described in Figure 3.

Figure 3: The Disease Concept v The Public Health Perspective

Disease Concept	Public Health Perspective
• Alcohol is a relatively sale drug	• Alcohol is a dangerous drug
• The only serious problem associated with alcohol is alcoholism/alcohol dependence	• There is a wide range of alcohol-related problems – health, behavioural, accident, occupational – of which dependence is just one element
• The provision of treatment (or alcoholics should be the main concern of health authorities	• The provision of treatment is expensive, of little efficacy and of relatively little importance – health authorities should strive to introduce comprehensive alcohol control policies at national level

Proof of this conceptual shift may be found in an Irish context in Chapter 9 of *The Psychiatric Services: Planning for the Future* (1984), or in the dramatically-titled report of the British Royal College of Physicians, *A Great and Growing Evil: The Medical Consequences of Alcohol Abuse* (1986). The point at issue here is not the relative validity of these conflicting perspectives, but rather that this dramatic U-turn by the 'authorities' creates major difficulties for teachers, youth

workers and others for whom the disease concept of alcoholism was an article of faith. I am unaware of any empirical research into the knowledge or attitudes of Irish drug and alcohol educators but, impressionistically, it seems to me that there is a great deal of confusion on their part concerning the current alcohol orthodoxy. What this suggests perhaps is that it would be better if educators became critically engaged with the issues rather than acting as passive recipients of authoritative wisdom.

Education Which Focuses on the Individual and on Individual Choice

Because of the difficulties involved in basing drug education on the presentation of information about the negative properties of the drugs in question, the official policy line pursued in Ireland was one which favoured education concentrating on individual decision-making or choice. The Report of the Committee on Drug Education (1974) was, as already mentioned, acutely aware that certain forms of drug education might make matters worse, particularly 'where education is confused with

propaganda' (p.12). It therefore recommended that drug education should not be provided as a separate or isolated topic but that it should become part of a broader health education curriculum and that it should be conducted mainly by teachers rather than by specialist drug workers. Following the establishment of the HEB in 1974, but particularly following its first major conference on 'Education Against Addiction' in 1979, the main thrust of its activities was towards training teachers so that they might go back to their schools and establish Lifeskills programmes. There were, of course, local or regional bodies, including, for instance, 6gra Chorcai, who also followed this line.

If we refer back to the framework set out in Figure 2, the Lifeskills curriculum was negotiated rather than authoritative and individualistic rather than collective or public. This curriculum looked at a range of human behaviours which could be broadly viewed as having health implications – diet, exercise, interpersonal relationships and sexuality are examples of these behaviours. Alcohol and drug consumption were part of this range and, as with the other behaviours, they were dealt with in a way that was nondirective and relativistic. In other words, the teachers or facilitators of the Lifeskills programmes avoided any absolutist denunciation of drug use and hoped that by improving the overall decision-making skills of their charges they would gently direct them away from harmful drug use.

It ought not to have come as a surprise, given the conservative nature of Irish culture and the dominant influence of religious values on the Irish educational system, that the Lifeskills approach was attacked in the mid-1980s on the grounds that it was secular, humanist and fundamentally antithetical to traditional Christian methods of social and moral education (Manly et al, 1986; McCarroll, 1987). The HEB was \he object of much of this criticism, and while it would be wrong to suggest that ideological conflict about Lifeskills was the sole or even the main factor which prompted the Minister for Health to close the HEB in 1987, it would equally be wrong to overlook the significance of this conflict. As one of the Bureau's staunchest critics, Doris Manly, wrote at this time:

- Why did the Government axe the HEB? I don't know. Did our criticism play much of a part in the decision? Again, I don't know. I think it reasonable enough to think it may have played some part, but how large a one it's impossible even to speculate. The one sale conclusion, I suppose, is that our criticism didn't do the HEB any good. (Manly. 1987)

This did not mark the end of Lifeskills programmes in Ireland, but it demonstrated clearly that, while health educationalists might favour a strategy which allowed students to develop a sense of relativism and to sharpen their critical faculties, there were influential forces within Irish culture which favoured the retention of more traditional, authoritative and didactic educational strategies.

Education which Focuses on the Context/Environment

Empirical studies of young people who experience drug or alcohol problems generally confirm the causal importance of environmental factors and one of the most obvious of such factors is socio-economic status. Studies of the prevalence of drug problems in Dublin, for example, have shown with almost monotonous regularity that such problems are not randomly distributed in the population but are to be found to a disproportionate extent in socially deprived areas (Stevenson and Carney, 1971; Dean et al, 1985; O'Hare and O'Brien, 1992). What this suggests is that, in terms of the Public Health Triangle, drug education should recognise that context is causally important. Vulnerability to drug problems is quite heavily influenced by adverse social circumstances, as is health generally, and health education strategies which focus on individual choice and ignore public or communal vulnerabilities are likely to be criticised on the grounds that they are, at best, inadequate. A more serious criticism is that such individualistic strategies constitute a form of 'victim blaming', an ideological approach which ignores the environmental constraints on individual choice and suggests that people who have drug problems are themselves entirely responsible for these problems (Naidoo. 1986).

There are, of course, many philosophical and practical complexities involved in this debate on the influence of environment on individual choice. However, those who would dogmatically argue that drug users have free choice and that the difficulties they experience are the result of exercising this capacity to choose are also logically committing themselves to the view that poor people experience more illness and die sooner than their wealthier fellow-citizens because they opt for a less healthy lifestyle.

Evolving health promotion concepts have tended to favour strategies which are negotiated and collective; this simply means that authorities – such as the World Health Organisation

(WHO, 1991) and other international collaborative groupings (Robinson, 1993) – now suggest that local communities ought to play a much greater role in defining and responding to the health problems which exist in their own areas. 'Bottom-up' activity of this kind in relation to drug problems in working-class areas of Dublin has not always been acceptable to the statutory health authorities, as Cullen (1992) has demonstrated in a detailed study of community development in one south inner-city area, but McCann (1992) has recorded how one agency, the Ballymun Youth Action Project, has managed to work for more than a decade on local preventive activities.

Whether national centralised bodies, principally, of course, the Health Promotion Unit, have the will and the capacity to foster and encourage genuine grassroots activity in the alcohol and drug sphere remains to be seen. The HEB was frequently accused during its time of having a bland, apolitical view of these issues: for example, Dr John Bradshaw, who had been the author

of the first prevalence study of drug use in the north inner-city, criticised the HEB's booklet on drugs, 'Open Your Mind to the Facts', on the grounds that it was 'totally unsuited in length and tone to the parents of central Dublin and other deprived districts where drug abuse is certainly or probably rampant' *(Irish Times,* 25/7/83). The HEB was admittedly hindered from working with local community groups, had it been so inclined, by virtue of the fact that it could only undertake activity of this kind when requested to do so by the local health board. During these years of the so-called 'opiate epidemic' in Dublin probably the most obvious sign of central government's discomfort with a community development approach to drug problems was the decision to ignore the recommendations on community and youth development in the unpublished but widely leaked Report of the Special Governmental Task Force on Drug Abuse (1983). In more recent times the Health Promotion Unit has published and circulated the *Drug Questions – Local Answers* pack, but, in overall terms, it is hard to envisage this unit of the Department of Health breaking with the caution and the controlling tendencies of the civil service by promoting radical community activity.

Conclusion

It ought to be clear by now that drug and alcohol education is a complex, politically-fraught activity rather than the straight-

forward procedure envisaged in the 1960s. There are one or two points to be made in conclusion. Perhaps the most important of these concerns the results of the studies which have been done internationally of the outcome of such preventive effort. In the main/the research indicates that drug and alcohol education, even when it has not proved counter-productive, has failed to slow down or prevent initiation of alcohol consumption or illicit drug use by teenagers and young adults (Dorn and Murji, 1992; Plant, Peck and Samuel, 1985). Despite this, there is still a conviction amongst educationalists and social scientists that preventive efforts should be persevered with and improved, largely on the basis of a lifeskills strategy – albeit one which also takes cognisance of public, communal factors rather than individual factors alone (Dryfoos, 1990).

What is also noteworthy, however, is that the use of education as a means of prevention appears to have become institutionalised in Ireland, as elsewhere, so that it is carried on almost as though it were an end in itself, with little or no reference to the evidence of the outcome studies. Prevention packs seem to proliferate, but the energy and enthusiasm which is put into producing and disseminating these packs is rarely matched by a concern for assessing their efficacy. This suggests that preventive activity of this type may be primarily symbolic rather than instrumental: in other words, one could surmise that adult society is less concerned with whether or not educational programmes achieve their specified aims and objectives than it is with the ritualistic and emphatic affirmation of its belief concerning the undesirability of drug use.

This brings us back to the fundamental problem of alcohol and drug education, which is, that preventive work of this kind cannot be entirely rational or characterised by logical consistency if national and international policies on these matters generally lack these characteristics. Alcohol and drug policies, like other social policies, have evolved over time, influenced as much, if not more, by interest group confict than by scientific developments; it may be tempting, however, for educators to attribute more rationality to these policies than they are capable of sustaining. There is an interesting example of this difficulty in early editions of the HEB's *Facts About Drug Abuse*

in Ireland, in the booklet's first section which attempts to provide definitions of some commonly-used terms. Before defining 'abuse' and 'misuse' – a task which most social scientists would baulk at on the grounds that such concepts are value-laden rather than capable of objective definition – the booklet suggests that: The proper use of drugs is to

prevent or treat disease in humans and animals' *(Facts About Drug Abuse in Ireland,* p.1). Any educator who attempted to justify this statement and use it as a base for developing more complex arguments concerning abuse and misuse would run the risk of having this whole enterprise questioned by students, who might point out that such a definition of 'proper use' consigned all consumption of alcohol and tobacco, as well as tea and coffee, to the realms of abuse or misuse. It is virtually impossible to find an example of any society at any time which prohibited all psychoactive drug use: it is probably best then that educators accept and recognise this historical and cultural relativism, rather than proceed on the basis that there is a cultural consensus in favour of a drug-free society.

Finally, it is worth commenting on the possibility that the basic aims of alcohol and drug education could be radically reconsidered. In their review of the English language literature on drug prevention, Dorn and Murji (1992) suggest that 'aims may be more realistic where they focus on reduction in levels of consumption rather than on prevention of initiation' (p.4). If we apply this, for example, to the question of teenage drinking in Ireland, which appears to be initiated nowadays at a much earlier age than previously (Barry, 1993), it might be considered that a legitimate aim would be to keep consumption at a modest level or to reduce the harm associated with such alcohol consumption. A similar suggestion to that of Dorn and Murji was contained in the Prevention Report (1984) published in the UK by the Advisory Council on the Misuse of Drugs. This review of the whole area of prevention started from the premise that preventive activity could legitimately aim to reduce the risk that an individual would start to misuse drugs or, alternatively, it could aim to reduce the harm associated with drug misuse.

In Ireland we have, since the advent of HIV, introduced harm reduction policies such as methadone maintenance and needle exchange for established drug users. These policies have, of course, been the subject of some dispute and controversy and, if there were to be educational programmes advocating safer drug use – rather than abstinence – one could expect more controversy. It would almost certainly be argued, for instance, that educational programmes of this kind were condoning or advocating illicit drug use. We should at least debate these issues, since there is a case to be made for a harm reduction perspective in education at least for some high-risk subgroups of young people, if not for the entire population. .

I started by referring to the early expectations of drug and alcohol education in the 1960s. Obviously, this area has proved to be more complex than anticipated. For everybody who has an interest in the prevention of drug and alcohol problems the options are clear: either we engage with and accept complexity or we pretend that the issues are simple and straightforward. My own preference is for the former.

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