ADDICTION:
COMPLEXITY AND CONFUSION;
Challenges for translating rhetoric into practice.
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The terminology for discussing drug taking and its effects on society presents us with a "terminological minefield" (Gossop 1996). The term "addiction" is often commonly used. Many dislike this term because it can convey physical forces that compel the individual to be out of control, and can imply a pre-determined individual condition, divorced from the environment. Images of alcohol, with decisions about what to do about this drug, are "profoundly coloured by value-laden perceptions of many kinds." (Edwards 2000 Preface) An agreed, succinct definition of what constitutes "an alcoholic" still eludes us. Such labels, it is argued, marginalise and stigmatise some people who drink, separating them from the rest of society, thus removing any need for examination of what is deemed acceptable drinking patterns.

However, such exploration of values and concepts is not the focus here. This article aims to explore issues in the gap between the rhetoric of current policy, and the reality of practice, from two angles. The first is from the viewpoint of the need for theoretical coherence, and the second from that of lay involvement in policy making in Ireland. It is claimed that attempts to bridge that gap are hindered by a lack of any truly integrated theory, and by the wider relationships between civil society and the political structures.

Ireland's level of national consumption of alcohol increased by almost 41% in the ten years between 1989 and 1999. Ten other Europe Union Member States showed a decrease and three others a modest increase during the same period. The estimated cost runs at €2,366m per year (Department of Health & Children 2002). Drinking is an aspect of life in all parts of Ireland. In contrast, opiate use has been mainly concentrated in Dublin, in areas already struggling with high unemployment, high numbers of young people, lack of facilities, and high early school leaving rates (Government of Ireland 2001). Recent estimates put the figure of opiate users at 14,452, 5.6/1000 of the population. In Dublin, this estimate rises to 16/1000, while in the rest of Ireland it stands at 0.9/1000 (Kelly, Caravalho, Teljeur 2003).

Communities have experienced major disruption to traditional ways of life, community conflict and grief as many of their young people die as a result of drug use. In some communities, it is not uncommon to find grandparents rearing children, whose parents have both died. Residents in parts of Dublin feel that they have lost a whole generation of young people, and are now on the third generation of drug users. Concern is also expressed about poly drug use, including opiates, benzodiazepines, alcohol, and cocaine.

"Addiction: Complexity and Confusion"

How we respond to the issues presented is important. Does our intervention improve things, or make them worse? Traditional ways of responding to problems caused by our use of alcohol and drugs saw the issues as individual, being characterised by personality traits, moral bankruptcy, deviancy, and mental illness. Environmental and social factors are now recognised as playing an important role in relation to alcohol and drug use (AMCD 1998). Another explanation explores the idea that "addicts" fulfil a social function, adapting to fit the stereotype, and endorsing the social construct that is "the addict". Problem drug and alcohol use does not occur in a vacuum, and what constitutes "problems" is by no means universally agreed, being influenced by values, cultural norms, attitudes, and social conditions.

The groundswell of local-community support for official measures regarding illegal drugs, has been lacking regarding alcohol-abuse: here, social myths ,rites, attitudes hold sway - the culture creates a climate of vulnerability.

Irish national policy is only in the last decade catching up with this more comprehensive analysis. The complexity of this process has been traced by Butler (2002). Policy traditionally favoured individual strategies, with little understanding of collective strategies. Since the implementation of Local Drugs Task Forces in 1997, and emphasised in Building *on Experience National Drug Strategy 2001-2008,* drugs policy is situated firmly within a social inclusion framework, with the major approach being one of partnership involving all sectors, including the communities most affected by drugs.

With alcohol policies, the favoured approach was also individual, particularly the disease model, until the 1996 *National Alcohol Policy.* This document favoured a health promotion approach, recognising the connections between levels of consumption, public health, and the levels of related problems in our society. Implementation, however, does not automatically follow policy documents.

Responses to drug and alcohol problems draw from a wide range of expertise. Knowledge is required from various fields: Medicine, Psychology, Pharmacy, Sociology, Education, Economics and Political Science are among the foremost. Different professional perspectives and conceptual frameworks imply different interventions, and consequently different policy emphases. Adherents from different disciplines rigorously defend the perception of the profession they belong to. Some of the influences are outlined here'.

Facilitating change in individual drug and alcohol use has occupied the minds of those in the medical profession, in psychology, in psychotherapy, in counselling, and to a large extent those in social work. An enduring lack of consensus has led to confusion (Keene 1997).

Early understandings of problems analysed them as moral issues. Individuals were seen as "sinful", or "lacking in will power". Attempts to change these individuals meant punishing them, or converting them to a

'right[1] way of living. Disease and biomedical models have been a major influence in the alcohol field, and subsequently in the drug field. According to Gossop (1996), methadone maintenance is the epitome of the medical approach to heroin addiction. Methadone maintenance can play a role in the management of drug problems, when provided as part of a comprehensive programme including psycho-social counselling, and emphasising rehabilitation (Ball and Ross 1991). Reduction in injecting practices makes this intervention especially important in preventing the transmission of HIV and Hepatitis among IV drug users.

The 1996 National Alcohol Policy favoured a Public Health-promotion model : consumption levels as a function of public health - public health as a function of social-problems reduction.

Another interpretation of the disease model is practised in the self-help programmes of Alcoholics Anonymous and Narcotics Anonymous. This view sees the disease as one of the "whole person" physical, mental, emotional and spiritual (AA Big B ook; N A R ecovery T ext). It i s s een e ssentially a s a s piritual d isease. The Minnesota Model, very prevalent in the treatment of alcoholism in Ireland, and to a lesser extent treatment of drug addiction, also follows this definition of disease. Claims have been made that this model "represents a blending of behavioural science and AA" (Laundergan 1993).

The disease concept was roundly rejected in some quarters as having any validity (Szasz 1972) and its extension to cover many other human problems in America has been denounced as attacks on *"our self- ami societal regard and our individual and collective competencies..."* (Peele 1995:286) Many individuals however attribute their success in living drug free lives to the twelve step programmes.

Work on developing coherence in the psychology field has produced other ways of understanding addiction. Addictive habits are seen as challenges, learned habits that can be changed, so the person can move on, leaving the addiction behind (Marlatt 1990). A wide range of strategies to prevent relapse developed (Wanigaratne et al 1990).

Social woi'.t is concerned more with the understanding of social factors involved in people's problems, and has used general systems theory to place those with drug problems in social systems (Barber 1995; Hunt & Harwin 1979). While a sensible strategy for making use of all resources, and creating some coherence for the individual, general systems theory has been criticised as being weak on the incorporation of social, economic and cultural systems into the model (Tucker 1997).

Whether we take the medical, psychological, or psycho-social view of addiction, these are still essentially seen as clinical concepts. They are individual interventions, designed to correct behaviour. They do not address the wider socio-economic relationships. Indeed, it has been claimed that much

of the debate about what addiction is "comes down to a struggle between medicine and psychology for dominance in the field[1] (Barber 1995).

The self-help programmes, which have been described as transtheoretical (Brown 1993), do provide mechanisms for the individual to cope with emotions, relationships and social norms, and provide alternative social groups from the drinking and drug using ones. However, they are not social movements in the traditional sense, seeking only personal change among their members and specifically renouncing any ambition to change the surrounding society in which they operate (Room 1993).

A Public Health model has been seen as offering hope of integration (Hester & Miller 1995), contributing to the development of coherence through the bridging of clinical and environmental strategies (Tucker, Donovan, Marlatt 1999).

A health promotion approach not only has as its focus the individual, but also the structural elements of health. A major strategy is community involvement in determining health needs, prioritising action, and working intersectorally to implement actions (WHO 1987). However, this strategy can be interpreted in different ways (McCann 1998). Actions on the collective side often boil down to attempts to control supply or demand through legislation. Lay involvement is canvassed to support the authorities in their attempts to pass and implement control measures. In Ireland, this is fairly easy to achieve in responses to illegal drugs, but very difficult to achieve in the alcohol field. Society values drinking, it is ritualised and enmeshed in many aspects of life. It is easier to interpret problems as due to individual traits. Indeed, the Drinks Industry Group of Ireland produced its own position on the *Report of the Strategic Task Force on Alcohol,* analysing alcohol problems as solely in the realm of individual responsibility.

There are other factors on the collective side which legislation alone will not challenge. These are the issues of the myths, social rites, attitudes, cultural, economic and political factors which create a climate of vulnerability to problems. These require a more "bottom up" negotiated approach. Achieving the level of debate necessary for this is not straightforward in Ireland. Large *groups* of people have been left out of the growth that has happened in the country, initially during the 1960s, and in more recent times during the era of the "Celtic Tiger[1]*. These very same groups of people are those who have been worst affected by the increase in heroin use. They are also severely affected, in common with many other communities, by abuse of alcohol.

Alcohol problems have not led to a groundswell of popular support for reorientation from local community groups, such as happened in the drugs issue (Butler 2002).

Among the ten strategy areas for alcohol action outlined in the WHO European Charter on Alcohol, which Ireland has endorsed, are:

- Enhance society's capacity to respond to alcohol related harm; and
- Support non-governmental organisations (Department of Health and Children 2002:18).

The influences relevant in these interventions are explored further here.

The involvement of lay people in issues that affect them is often mediated through the voluntary and community sector(s). In spite of long involvement of voluntary activity in the development of social services in Ireland, there was historically an underdeveloped legal and policy framework for the support of voluntary work and the contexts in which it takes place. Claims have been made that social, cultural and political structures militated against participation (Powell and Guerin 1997). It took the Irish State until the year 2000 to produce a White Paper *Supporting Voluntary Activity,* laying out the framework for a relationship between the state and the voluntary sector with the vision of promoting active citizenship, equality of opportunity, respect for individual freedom in the pursuit of social goals, and strengthening social dialogue.

Recognition of the important role of the sector also came through the addition of a Community and Voluntary Pillar in Social Partnership, at a level which is unusual in European terms. However the infrastructure that supports it is relatively immature by European standards (Harvey 2002). Supports for volunteering and citizenship remain limited. The major part of voluntary work involves the delivery of services to individuals. This can include an advocacy role on behalf of groups of people. In the most recent national agreement *Sustaining Progress,* there was serious conflict between the members of the Community and Voluntary Pillar, and the government. The Community Platform [2] did not sign the agreement, and now risks its place in the formal process.

Ireland has very few 'think tanks', which in other countries are important stimuli for new democratic ideas. While there are many groups working in the area of social inclusion, there are few working in the areas of political accountability and new democratic ideas. Traditional bureaucratic structures can be remarkably resistant to the changes heralded by the White Paper. Levels of funding to voluntary organisations to engage in reflective policy work or critical commentary are very small (Harvey 2002:99).

Education of young people in civic and community responsibility is minimal in a crowded curriculum. Government in Ireland has been notoriously centralised (Lee 1989). Local government has historically been ineffective in dealing with social issues (Ferriter 2001). There are signs of disengagement of the people from the political process. Reforms of the local government system are underway, but funding remains an issue.

Research has shown that many voluntary groups are increasingly adopting the philosophies of community development and empowerment and mutating into democratically based bottom-up communitarian organisations (Powell & Guerin 1997:174). However, confounding the lack of support for citizen involvement from government is the "contested space" in the sector (Collins 2002). Community work has been split into two traditions. One approach, influenced by sociology, often does not involve itself directly in the work with individuals, concerned more with analysis of economic and political systems. Others, working at community level concerned with ndividuals and the building of caring communities, and coming from various backgrounds, have not engaged with the wider analysis. This "fundamental fracture" (Collins 2002) in the community/voluntary sector in Ireland weakens the capacity of civil society to reflect on the complex myths, rituals, attitudes, economic and political factors which are central to the role of alcohol and drug taking in the state.

Even counselling systems-theory stands in need of the critical edge offered by the socio-logical study of environ-mental, political and cultural "systems "

Community workers have in the past displayed a lack of confidence in handling health issues (Black 1985). The Community Development Projects, set up and funded by government since 1990, only collectively considered their role in the drugs issue in February 1997. A more recent welcome change in this has been the involvement of the CWC [3] in health work, setting up a sub group to consider a community development approach to health, and develop tools to help community workers analyse and engage in health issues in their work. Community development, both as an idea and an area of work, is more vigorous now in Ireland than ever, but is also much more complex. Throughout the 1990s and into the new millennium, there has been rapid expansion in community development activity (Lee 2003).

A strength of community work can be that it calls attention to the wider economic, social and political context, encouraging values clarification and social analysis. However, its weakness is that it promises more than it can deliver. Realisable objectives of enhancing local democracy, encouraging collective action, building community identity and structures, keep open the wider political options, and relieve the occupation of several self-inflicted burdens and expectations (O'Cinnéide & Walsh 1990).

Community work does not necessarily practice an 'either/or' situation. Many community groups perform dual roles (Duggan & Ronayne 1991). Being involved in interventions that can help with specific problems, and, at the same time, contributing to collective action is a big challenge (Thomas 1983). For effectiveness at local level, some consistency across approaches needs to be sought.

It is clear that theories and practice for promoting change in addiction behaviours straddle a wide spectrum of concepts and perspectives. The danger for community groups is that any one of the perspectives could be taken in isolation, leading to a distortion of the picture. Efforts by traditional professionals to work at community level can result in attempts being made to convince "the laity" of the efficacy of the favoured approach. This can lead, for example, to reproducing the specialist at local level.

Paradigm changes do not occur overnight, or even in any planned and systematic way. Academic literature and policy documents alike can be short on practical guidance or solutions to the wide range of everyday problems encountered by those working at community level. Workers have to deal with everyday problems in the absence of cohesive guidelines. Practice needs pragmatism, as people struggle to meet the needs of communities. Theorists, however, find this difficult. While many of the contradictions are survived through pragmatism, others could be resolved more effectively, and more strategically, through the application of well-articulated, relevant theory.

Community Drugs Work has been identified as a 'new discipline', (Ballymun Youth Action Project Annual Report 1994). The range of skills necessary for this work does not exist in any of the single tradition professions.

[y] Traditionally trained addiction counsellors may pride themselves on being eclectic across individual theories, but few are prepared for the paradigm shift required to adapt their perspectives to be consistent with community theories and practice. The combination of systems theory, with the critical edge offered by the sociological study of social, political and environmental factors, can form the basis of an expanded and more integrated alternative to the present fragmentation.

In Dublin particularly, from the involvement of communities with other sectors in the response to drugs, there is the opportunity to develop new theories from practice. Priority in the *Strategic Task Force on Alcohol Interim Report* was given to a limited number of areas for action. These involve regulatory and control measures. It can be seen from this short discussion that actions to implement the remaining areas will require investment in structure, and grounded research, if they are to have any hope of leading to significant change in the level of problems experienced through alcohol and drugs in our society.

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Notes:

[1] **For** a useful account **of theories** and models, see Peterson 2002.

[2] The Community **Platform** acts as a mechanism for participant organisations to engage in social partnership arenas, and to strengthen the individual and collective impact **of member** groups in decision making processes.

[3] Community Workers Coop.

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