DOING DRUGS FROM AN IVORY TOWER:

Reflections on Twenty years of Addiction Studies at Trinity College Dublin

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The invitation to contribute to a special issue of *Studies* on the theme of addictions is timely, coinciding as it does with the twentieth anniversary of the establishment of the Diploma in Addiction Studies at Trinity College Dublin. I have accepted the invitation gratefully, and will use it, perhaps a little self-indulgently, as an opportunity to reflect on the Addiction Studies experience in the context of related developments in policy and practice in Ireland over this period. The Diploma in addiction Studies, which was started in 1983, is a full-time, one-year programme aimed at enhancing the knowledge and skills of those human service professionals (nurses, social workers, counsellors, Gardai, community workers and others) who deal directly with alcohol and other drug problems. The M. Sc. in Drug and Alcohol Policy, which has been in existence since 1998, is a part-time programme, run over two academic years and aimed primarily at those in policy and management positions across a range of relevant human service organisations.

My use of the phrase 'ivory tower' in the title is intended as a comment on the ambivalent relationship which exists between academics with an interest in addictions and those who see themselves as being 'in the field', 'at the coal-face', or however they choose to describe their practical involvement with these matters. When Trinity College presented its proposal for Addiction Studies to the Department of Health in 1983, it did so largely on the basis that a university- based programme could deal with these controversial and contentious topics in an evidence-based way and without becoming too entangled in ideological or interest group conflict. This positive view of Addiction Studies continues to be reflected in the ongoing financial support provided by what is now the Department of Health and Children, as well as in the popularity of the two programmes with a range of students, including those who are seconded by statutory and voluntary employers in the health, social service and criminal justice fields. This is not to say, however, that ideas emanating from Addiction Studies have ever been accepted with deference, as representing a neutral or objective perspective on these matters. My own experience, which I suspect is a common experience for academics who comment on matters of public policy, in that my utterances, whether in lectures, public meetings, media events or in print, have been welcomed and cited as authoritative endorsement for whatever views they reflected only to the extent that they coincide with the existing views of the audience at which

they were directed. When I have challenged or criticised the conventional wisdom of policy makers or practitioners, I have been told frequently, and with varying degrees of politeness and civility, that my views were invalid, impractical and reflective of an ivory tower mentality. I am neither complaining about this lack of deference nor assuming that I have always been right, but merely pointing out that debate about addiction issues tends to be highly emotive and that academic perspectives are not routinely privileged in this debate.

Research has challenged the position of in-patient treatment as the preferred rehabilitation-model for alcoholism.

Addiction Studies has been fortunate to draw on the wider research and teaching expertise of Trinity (including inputs from academics in pharmacy, law, microbiology, psychology, education and other disciplines) but it is based in the Department of Social Studies, and its ethos is grounded in a critical sociological and social policy perspective. Philosophically, this social science perspective is sceptical of the positivistic view that science and technology have, or will ever have, the capacity to provide full and final solutions to societal problems associated with psychoactive drug use; any more than science and technology can realistically be expected to bring an end to marital breakdown or offer a final resolution to policy dilemmas associated with abortion. Our aim, therefore, is not to give students the 'correct' answers to the difficult questions, which arise in relation to such drug use, but to educate them to adapt to and cope with the value conflicts, the relativism and the moral ambiguity that seem inevitable in this sphere.

One obvious example of this educational approach may be discerned in relation to *definitions* of issues with which Addiction Studies is concerned. While students sometimes say that there is nothing more boring than being taught definitions, they also have a tendency, when confronted with uncertainty, to seek and cling to definitions as to comfort blankets; in the context of Addiction Studies this often manifests itself in a quest for definitions of what might be considered the core topics, such as 'drug abuse', 'drug misuse *, 'alcoholism', 'alcoholic', 'harm reduction', 'disease', 'treatment', and other similar subjects. Our policy has been to deflect students away from this preoccupation with definitions, on the basis that very few of the definitions to be found in textbooks, policy documents or elsewhere are quite as absolute and scientific as they appear to be; usually they contain a mix of fact and value judgement, and are highly reflective of the time and place in which they were drawn up. Every few years, for instance, a student writing an essay on alcohol problems will triumphantly unearth and present us with the World Health Organisation (WHO) definition which starts 'Alcoholics are those excessive drinkers...' only to be asked when WHO defined alcoholics in this way (the answer, incidentally, is 1951) and whether

this definition is consistent with what WHO has said in more recent times(it's certainly not!). Staying with this theme of alcoholism and alcoholics, we try to persuade students that it is more educational to explore and understand the shifting policy process, whereby WHO and indeed our own Department of Health and Children, have abandoned the notion of alcoholism as a discrete disease in favour of a disaggregated or a spectrum of problems approach, than it is to learn definitions '. If, at the end of a course, students are still fretting about the definition of 'drug abuse', then we realise that we have made little impact on them.

The treatment landscape underwent two upheavals in thirty years : the explosion of intravenous drug use; and the risk to the whole sexually-active population posed by illicit drug-users who had HIV/AIDS.

The topic of treatment and rehabilitation for addicts is one which, on the face of it, ought to be quite straightforward in the wider Addiction Studies syllabus. Has it not been generally agreed that addictions are diseases and that healthcare systems should treat these diseases with the minimum of moralism and the maximum of technical efficiency? The answer to these questions is, at best, a definite maybe, and even a superficial glance at the literature or a few moments reflection make it clear that treatment and rehabilitation matters are complex and certainly not consensus issues. In recent years, when the relative influence of American and European ideas on Irish public policy has been discussed, it has been summarily suggested that the choice is either 'Boston or Berlin[1]. Debate on the more specific topic of treatment policy in relation to alcohol problems in Ireland over the past years or so might well be summarised alliteratively in terms of a tension between Minnesota and Maudsley: the eponymous Minnesota Model being a somewhat evangelical approach to addiction treatment which has had much influence here since the mid-1970s [2], and the Maudsley being the teaching and research centre of British psychiatry which advocated a more cautions and research-based approach to addiction treatment \ Advocates of the Minnesota Model retain a fundamental belief in the disease concept of alcoholism, and regard inpatient rehabilitation, usually in specialist and highly-structured programmes which derive their philosophy from Alcoholics Anonymous (AA), followed by lengthy periods of aftercare as best practice in this field. British research, on the other hand, is a good deal more equivocal about the notion of alcoholism as a specific disease, is sceptical of the value of inpatient rehabilitation and points out that well-planned brief interventions at community level are as successful and more cost-effective than inpatient rehabilitation. In 1984, when Addiction Studies at Trinity was in its second year, a major mental health planning document *The Psychiatric Services: Planning for the Future* [4] came down firmly on the British side in this debate as to how Irish health services should respond to drinking problems. *Planning for the Future* recommended that psychiatric inpatient admission for drinking problems should be confined to a minority of cases for which there were

specific clinical indicators, and that outpatient addiction counselling within the broader mental health system should be the norm. Implementation of this recommendation has, however, proven difficult, due it would appear to a combination of poor health service management and an enduring popular belief in the benefits of inpatient treatment for alcohol-related problems. Although a network of community-based addiction counselling services has been created over the past twenty years, alcohol admissions still account for a substantial proportion of all mental health admissions (the most recent statistics are for the year 2001, when 18% of all mental health admissions had a primary alcohol diagnosis)[5].

Teaching about alcohol counselling and various treatment modalities can, in my experience, be quite a fraught affair. Given that there are .many voluntary agencies which operate on the Minnesota Model here in Ireland and that these agencies are well-known and popular, any attempt to look at this model from a critical academic perspective or to dwell on the disappointing findings of outcome studies can be interpreted as gratuitously insulting to those who are regarded as selflessly committed to this form of addiction treatment. An additional complication arises from the fact that Roman Catholic priests or nuns have founded all of these Minnesota-style agencies so that, at times, criticism of the model from a TCD source has been treated with suspicion almost as though it represented an irreligious attack on these agencies, if not indeed a Protestant plot! It was fortunate that in 1983, just as Addiction Studies was beginning, the first paper describing a new approach to addiction counselling, known as Motivational Interviewing (MI), was» published [6]. MI, which is in many ways the antithesis of the Minnesota approach, has emerged favourably from the evaluative research; it can be adapted to all kinds of settings, not just inpatient or other specialist addiction treatment settings [7], and has now become popular within Irish healthcare systems. It was also helpful, given the religious aspect of the debate alluded to above, that William Miller, the originator of MI, is not only a first-class research scientist but is particularly interested in spirituality.

While discussion about alcohol treatment systems can generate considerable heat, it is nothing in comparison with the controversy which surrounds the whole topic of treatment and rehabilitation for illicit drug dependence. When Addiction Studies began in 1983, a major concern of the Irish health service was to organise a treatment response to what was then a new problem: intravenous heroin use [8]; in fact, it is unlikely that the Department of Health would have funded Addiction Studies were it not for the sense of crisis surrounding this explosion of heroin use. There were, at this time, two main treatment services catering for heroin users in the Dublin area: a medical unit, known as the National Drug Advisory and Treatment Centre, which had been established in 1969 at Jervis St. Hospital, and a voluntary non-medical agency Coolmine Therapeutic Community (TC) which

had been established in 1973. Each of these services was philosophically committed to abstinence models of care for heroin users; that is to models which assumed that the only valid health service function in this sphere was to detoxify heroin addicts and to support them subsequently in their pursuit of lifelong abstinence from illicit drugs, if not indeed from all psychoactive substances. The two services collaborated closely with one another.

...So "harmreduction" became a mainstream treatment even in statutory settings: methadone maintenance; and also needle-exchange programmes

To those with only a passing interest in drug problems, it might appear self-evident that treatment services should have abstinence as their *goal,* is there not a consensus that drugs are evil, and would not it undermine the societal 'war on drugs' if healthcare systems appear to facilitate continued drug use at the same time as criminal justice systems are striving for a drug-free society? Again, however, the academic literature on drug treatment systems and on drug policy generally has never been supportive of this black and white view of the subject. By the early 1980's, there was a substantial literature, which indicated *inter alia* that the rhetoric of the war on drugs greatly exaggerated the ill effects of illicit drug use, as well as having unrealistic expectations of the outcomes of abstinence-based treatment systems [9]. Even though it was American policy influences that were most dominant internationally, it was virtually impossible to come across any reputable American policy analysts who had reached favourable conclusions about their own country's drug policy or who thought it likely that the so-called 'war on drugs' could be won. Instead, there was an almost obsessive interest amongst American scholars in what was referred to as the 'British System', which was the name given to the British drug policy regime initiated in 1926 by the Rolleston Report and lasting until the late 1960s [10]. This regime had given dominance to the healthcare, as opposed to the criminal justice, system in societal management of drug problems, and was noteworthy for allowing doctors almost total discretion in prescribing addictive drugs to their patients on an indefinite or maintenance basis. This meant that for forty years the British approach to the treatment of drug dependency had been based on an acceptance that if, having been detoxified and encouraged to remain drug-free, addicts repeatedly relapsed, their doctors could then opt to maintain them medically by prescribing their drug of choice. In comparing the harshness of the criminal justice approach of their own country with what was seen to be the pragmatism and humanity of the British System, American policy analysts tended to paint an idealised version of the latter, while also failing to deal fully with the fact the British policy since the late 1960s had now switched to a more restrictive style, with greater emphasis on specialist and centralised medical provision and a renewed belief in abstinence.

From the perspective of the newly created Addiction Studies, however, it seemed important that students should be introduced to this comparative

debate on drug treatment policy, rather than encouraged to regard the goal of abstinence as a God-given and inevitable feature of healthcare interventions. By this time, the debate was certainly not just of historic or academic interest, as many European countries were struggling to adapt to the same wave of heroin use as was afflicting Ireland. The British had begun to rethink the value of the centralised 'clinic' system established during the late 1950s ", and the pragmatic reforms introduced into Dutch drug policy since 1976 were also attracting much comment [12]. As the 1980s progressed, there was a gradual shift internationally towards treatment policy which was based on a willingness to work therapeutically with drug users who either could not or would not commit themselves to abstinence; this became known as 'harm reduction', and some of the better known harm reduction strategics were methadone maintenance for opiate users and needle and syringe exchange schemes for drug users who continued to inject as part of a continuing street drug scene. My memory of teaching this comparative policy material and of introducing students to harm reduction concepts during the first couple of years of Addiction Studies is that, in the broader context of Irish drug treatment systems at this time, these ideas seemed farfetched and irrelevant in the extreme. A Jesuit priest, Frank Brady, had opened a small voluntary agency known as the Ana Liffey Project for drug users in the city centre during 1982, which I had visited and found interesting because it was the first Irish agency that was openly based on a harm reduction philosophy. I have a particularly vivid memory of discussing the Ana Liffey Project with a senior civil servant from the Department of Health, who listened politely and then asked with disbelief whether this new agency was really prepared to keep on seeing and offering some kind of service to people who were still using drugs. When I confirmed that this was the case, he said 'Well that's certainly a novel idea'. I knew that 'novel' was not a term of approbation in this man's vocabulary.

Major social policy change tends to occur in response to what is perceived to be a crisis rather than as a result of research or some other rational policy process, and certainly the introduction of harm reduction into Irish drug treatment systems from the mid-1980's onwards can only be understood in this way. Abstinence as the main aim of healthcare intervention into the addiction process is an ideal with which few would quibble and, for as long as it had no dramatically negative impact on the wider society, there was no particular societal concern with the ineffectiveness of abstinence models of treatment. The crisis came in the form of HIV/AIDS and the speedy recognition that the practice of needle sharing amongst intravenous drug users was an ideal mode for transmitting this newly identified and frightening virus. There had always been a highly symbolic element to public and policy discourse on illicit drug use in Ireland; for many drug use symbolised all that was evil and degrading, and abstinence-based treatment represented not just a

technical aim but also a re-establishment of the moral order. Now, however, both the public and its policy makers were compelled to question and move beyond these simple truths. If drug users only infected one another, it is probable that harm reduction would not have been considered; however, it was clear that drug users were not a deviant group hermetically sealed off from the rest of society, but that through sexual activity they constituted a bridge for the transmission of HIV into the general population incrementally from the mid-1980's onwards: services were decentralised and outreach systems set in place; methadone maintenance became the most common form of treatment for heroin users, and the involvement of family doctors in methadone prescribing was legally regulated [n]; needle and syringe exchange schemes were created in both statutory and voluntary settings, and the idea of providing safe injecting facilities for those who continue to inject illicit drugs has been floated periodically. The philosophy of the Ana Liffey Project moved from being 'novel' to being mainstream, and the project itself became the recipient of considerable statutory funding. These radical changes in treatment policy and practice have not, in the main, been publicly debated or officially announced, and there is some evidence that the public is still quite intolerant of drug users and unconvinced of the validity of harm reduction [14].

With regard to Ireland's present problem with alcoholism, by contrast, it is increased regulation and controls which are needed.

Comparing drug and alcohol policy making in Ireland over this twenty-year period, an interesting paradox emerges: it could be said that in relation to illicit drugs we have been struggling to accept the limitations of controls and regulations, while in relation to alcohol we have been struggling to accept that controls and regulations can play a greater part in reducing the prevalence of alcohol-related problems. On the drugs side, we have been moving to a reluctant acceptance of the fact that we now have available to us a greater volume and variety of illicit psychoactive drugs than was ever the case previously, and that regardless of tougher legislation, longer jail sentences and smarter sniffer dogs, this situation is unlikely to change. Newer approaches to drug policy making [15] reflect this acceptance of a complexity which it seems futile to tackle any longer in traditional cliches: 'war on drugs', 'just say no', 'zero tolerance' and so on. On the alcohol side, however, the struggle by public health advocates has been to shift policy in the direction of greater controls, on the basis that increased access to and commercial promotion of alcohol leads to increased consumption, which in turn leads to an increased prevalence of a range of problems. This has been a difficult task for many reasons. Due to some extent to the popularity of the disease concept of alcoholism, we have a diminished sense of the risk that alcohol poses for all its consumers - and not just those who are genetically predisposed to dependence. Because alcohol is a legal product, many

members of the public, who would be fully supportive of quite draconian sanctions on illicit drugs, regard any suggestion of tighter controls on alcohol as an unwarranted and paternalistic interference with their basic civil liberties. And, of course, the wealth and influence of the drinks industry means that it continues to be an effective lobbyist and counterbalance to the public health voice in this ongoing debate [16]. There has been an unprecedented level of media interest in alcohol issues over the past year, which has undoubtedly influenced the recently announced legislative proposals from the Minister for Justice, Equality and Law Reform.

My colleague Marguerite Woods, who has coordinated the Diploma in Addiction Studies since 1997 when the class size was increased to 24, has been gathering data over these six years on the impact of the course on individual students both during their time here and on their return to work, and hopes to publish her findings in due course. As suggested at the outset, our overall aim is to educate, which we see as assisting human service professionals to accept and cope with uncertainty and complexity where to do otherwise is to embrace rigidity or dogmatism. We are aware that for our students this can be difficult both intellectually and emotionally but we are satisfied that to do other than this would be inappropriate for a university programme, and it is gratifying to note that graduates of the Addiction Studies programme now occupy senior positions in many relevant human service organisations. Our contribution to the evolution of policy and practice in the addictions sphere over the past twenty years is difficult to assess but it is certainly not negligible.

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1 National Alcohol Policy - Ireland (1996). (Dublin: Stationery Office, Interim Report of the Strategic Task Force on Alcohol (2002). (Dublin: Department of Health & Children).

2 Anderson, D.J., (19981), Perspectives on Treatment: The Minnesota Experience, (Center City, Minnesota: Hezeldem).

3 Griffith Edwards, now Emeritus Professor at the Maudsley's National Addiction Centre in London, has summarised his approach to alcohol problems and their treatment in: Alcohol: The Ambiguous Molecule. (Penguin Books, 2000)

4 The Psychiatric Services: Planning for the Future (1984). (Dublin: Stationery Office).

5 Daly, A. and Walsh, D., (2003) Activities of Irish Psychiatric Services 2001. (Dublin: Health Research Board).

6 Miller, W.R., (1983) 'Motivational interviewing with problem drinkers'. Behavioural Psychotherapy, 11, 147-152

7 Miller, W.R. and Rollnick, S., (2002) Motivational Interviewing: Preparing People for Change (2nd ed.). (London: Guilford Press).

8 For a detailed study of the evolution of treatment policy in relation to heroin in Ireland see: Butler, S., (2002) Alcohol, Drugs and Health Promotion in Modern Ireland. (Dublin: Institute of Public Administration).

9 For an example of an authoritative American report of this period which is highly critical of conventional drug policy, see: The Drug Abuse Council, (1980) The Facts about "Drug Abuse". (New York: The Free Press).

10 For example: Trebach, A.S., (1982) The Heroin Solution. (New Haven: Yale University Press).

11 Advisory Council on the Misuse of Drugs (1982), Treatment and Rehabilitation. (London: HMSO).

12 For a succinct discussion of Dutch policy and its historical evolution see: Boekhout van Solinge, T., (1999) 'Dutch Drug Policy in a European Context', Journal of Drug Issues, 29, 511-528.

13 Butler, S., (2002) The Making of the Methadone Protocol: the Irish system?', Drugs: education, prevention and policy, 9, 311-324.

14 Bryan, A. et al, (2000) Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Study. (Dublin: Health Research Board).

15 Building on Experience: National Drugs Strategy 2001-2008 (2002). (Dublin: Stationery Office).

16 See, for instance, the industry's minority report (Note 1) in Interim Report on the Strategic Task Force on Alcohol (2002). (Dublin: Department of Health and Children).