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**A STUDY OF THE MANAGEMENT AND TREATMENT
OF SUBSTANCE MISUSE PROBLEMS IN A REGIONAL
HEALTH BOARD IN IRELAND**

Kieran Cullen B.S.S. C.Q.S.W. M.Litt

A thesis submitted in fulfillment of the requirements of Ph.D

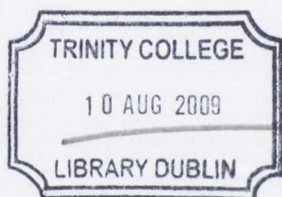
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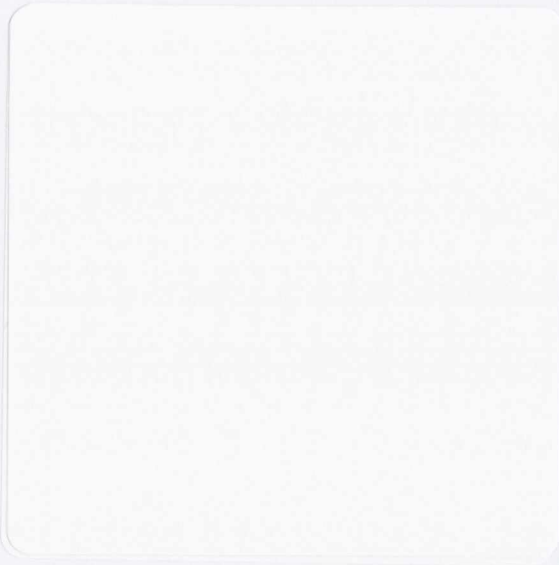


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Declaration

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Summary

This study presents the findings of a research project conducted within a Regional Health Board in Ireland and aimed at evaluating the way in which the public health service responds to alcohol-related problems; the study is also concerned, but in a more limited way, with drug problems. There is an action-research dimension to the study. Its commencement coincided with a renewed attempt by health board management to change the way in which both alcohol and drug services were organized and delivered. The intention of those managers who initiated the project was to base organisational change on the research literature which indicates: 1) that alcohol contributes to a spectrum of health and social problems rather than to a single unitary disease; 2) that inpatient or residential care for alcohol-related problems is neither clinically necessary nor more effective than community-based treatment programmes; and 3) that a wide range of both primary care and mental health professionals can collaborate in the management of drinking problems.

However, the literature review for this project also revealed that there is considerable professional and organisational resistance to the implementation of evidence-based policy and practice for the management of alcohol-related problems, so that the introduction of such practices into this regional service could not be taken for granted. The study includes a new, secondary analysis of annual data on the treatment of alcohol problems in psychiatric hospitals over the period 1965-2006, which reveals that attempts to promote similar changes over the previous two decades were also resisted.

The action research, which took place with the agreement of senior management within this service, consisted of a series of focus groups, meetings and interviews with a range of professionals in which views were elicited and proposals aired for new and more systematic approaches to the care of problem drinkers, and also of drug misusers. Although initial responses were positive, ambivalence to the change process emerged gradually. Mental health professionals who had traditionally played a dominant role in the health service response to drinking problems were particularly reluctant to embrace the changes, while primary and community care personnel were often unwilling to take on new roles. Ultimately there was considerable resistance to the introduction of what promised to be a comprehensive, new approach to this area of healthcare activity.

These findings are discussed in the context of the wider literature on international failures to translate research findings into practice in the alcohol sphere, and on the specific organisational changes which took place in Ireland's public health system during the course of this project. It is concluded that, in the absence of a national 'top-down' commitment to the introduction of a more systematic health service response to drinking problems, organisational change of this type is unlikely to succeed at regional level, irrespective of the commitment of regional and local managers and practitioners to bring this about.

This study is dedicated to the memory of Jean Cullen (1949-2005)

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TABLE OF CONTENTS

Declaration.....	3
Summary.....	5
Dedication.....	7
Acknowledgements.....	9
List of tables, figures and charts.....	13
Note on terminology, acronyms and names.....	14
Chapter 1 – Introduction, background and study outline.....	15
Introduction.....	15
Background.....	17
The dichotomy of the disease model and the public health approach to alcohol.....	22
Author's role.....	28
Chapter outline.....	30
Chapter 2 - Literature review	
Contrasting models for treating alcohol problems	33
Introduction.....	33
The disease model of alcoholism.....	34
Public health model – a broader base for treating alcohol problems	55
Implementing the public health model.....	78
Conclusion	84
Chapter 3: Methodological framework and methods	
of data collection and analysis	87
Introduction.....	87
Paradigmatic differences – positivism and interpretivism	88
Realist evaluation.....	93
Four models of evaluation.....	96
Focus groups.....	106
Individual interviews.....	112
Insider / outsider perspectives.....	115
Study limitations	119
Stages of data collection and analysis	122
Summary.....	130
Chapter 4 - The treatment and management of alcohol	
problems through psychiatric hospital in-patient admissions.....	133
Introduction.....	133
The disease model and inpatient psychiatric admissions.....	135
National data on alcohol admissions.....	146
Regional data on alcohol admissions	154
RHB data on alcohol admissions	162
Summary.....	166

Chapter 5 – Community alcohol services	169
Introduction.....	169
Before <i>Planning for the Future</i>	170
Developing community alcohol services	173
Staff and training.....	177
Team organisation.....	183
Supervision	186
Resource back-up.....	193
Impact of services	197
Summary.....	207
 Chapter 6 – Emerging drug problems and new drug policies providing a focus for changing alcohol and addiction services	 213
Introduction.....	213
Background to new drugs policies.....	214
Regional coordinating committee on drugs.....	220
Internal addiction services review.....	235
Summary.....	248
 Chapter 7 – Action-research process.....	253
Introduction.....	253
Inter-sectoral friction.....	256
A shared vision	262
Primary care and the role of GPs	275
Social workers and child and adolescent addiction issues	280
National Drugs Strategy	291
National Alcohol Policy	294
Integration of alcohol and drugs in policy.....	298
Developing proposals.....	302
Summary	306
 Chapter 8 – Summary and conclusion	311
1. An embedded disease model.....	316
2. Developing alternative community-based treatment.....	321
3. Overview and moving forward	326
 References.....	340
 Appendix 1: Organisational map for action research study	361
Appendix 2: Personnel roles, sex and participation in data events	362
Appendix 3: Focus group question schedule.....	363
Appendix 4: Individual interview schedule.....	366
Appendix 5: An outline of county-level substance misuse teams.....	369
Appendix 6: HSE administrative areas	375

LIST OF TABLES, DIAGRAMS AND CHARTS

- Table 2.1: Summary of evidence of effectiveness based on (n = 10) research reviews
- Table 2. 2: Treatment modalities with evidence of effectiveness
- Table 4.1: Psychiatric Admissions (All and First) with Alcohol Diagnosis, Ireland, 1965-2006, annual number, rate per 100,000 population (16yrs+) and % of total admissions
- Table 4.2: Psychiatric Admissions with Alcohol Diagnosis, Ireland, 1972-2004, rate per 100,000 population (16yrs+), national, regional, and highest and lowest regional
-
- Chart 4.1: National psychiatric in-patient admissions with alcohol diagnosis (all and first admissions), 1965-2006
- Chart 4.2: National psychiatric in-patient admissions with alcohol diagnosis (all and first admissions) per 100,000 population 16 years +, 1965-2006
- Chart 4.3: Alcohol diagnosis as percentage of All and First national psychiatric admissions, 1965-2006
- Chart 4.4: National in-patient admissions with alcohol diagnosis by hospital type (public, private and general hospital units) and All hospitals, 1971-2006
- Chart 4.5: In-patient psychiatric admissions with alcohol diagnosis, per 100,000 population (16 years +), national, highest and lowest regional annual rates, 1972-2004
- Chart 4.6: In-patient psychiatric admissions with alcohol diagnosis as a percentage of all admissions, national, highest and lowest regional annual rates, 1972-2004
- Chart 4.7: In-patient admissions with alcohol diagnosis per 100,000 population (16 years +), national, Regional Health Board and Adjacent Health Board (AHB), 1972-2004
- Chart 4.8: Alcohol diagnosis as percentage of all psychiatric inpatient admissions, national, Regional Health Board , Adjacent Health Board (AHB), 1972-2004
- Chart 4.9: Alcohol diagnosis in-patient admissions in three county areas in the Regional Health Board , 1971-2006
- Chart 4.10: Alcohol diagnosis in-patient admissions in Regional Health Board, and highest and lowest county areas, for each year, 2000-2006
- Chart 4.11: Regional Health Board alcohol and drugs admissions to both psychiatric and non-psychiatric residential facilities, for periods 1981-85 and 2001-05
-
- Figure 1.1: Alcohol problems
- Figure 3.1. Models of Evaluation
- Figure 3.2. Action-research cycle
-
- Box 2.1 AA 12 Steps
- Box 2. 2: Symptoms of drug dependence syndrome

Note on terminology, acronyms and pseudonyms

The health authority studied in this thesis is referred to as Regional Health Board or RHB. The former term is used more in the introduction and conclusion, whereas the latter tends to be used much more frequently in the text on findings.

The RHB has three operational programmes and two of these are regularly referred to in this study – the Community Care Programme, and the Special Hospitals (Psychiatric Care) Programme. For simplicity this latter programme is referred to as Mental Health, while the former is referred to as Community Care.

There is the possibility of some confusion in relation to addiction services set up under these respective programmes. Community Alcohol Services - CASs – were set up under Mental Health, while Substance Misuse Teams – SMTs – were set up under Community Care. The acronyms CAS and SMT are used throughout this study, particularly in sections on findings. An organisational map relating to the study is provided in Appendix 1.

There is reference in this report to RCCD – a Regional Coordinating Committee on Drugs set in the mid 1990s to process proposals for developing substance misuse services in the RHB. Similarly, there is reference to IASR - Internal Addiction Services Review – this review was initiated in the late 1990s also to develop substance misuse services.

The locations of the RHB are not given, nor are names of places, people and so forth. Various other mechanisms are used to retain anonymity. RHB personnel who are quoted in this study were each randomly assigned a gender-neutral pseudonym. While some of these pseudonyms may sound or write more as one gender than the other, this does not necessarily reflect their true gender status.

Chapter 1 – Introduction, background and study outline

INTRODUCTION

This thesis is a case study, which reports the findings of an action research project conducted within one Regional Health Board in Ireland, aimed at changing the way in which this statutory agency managed and treated alcohol problems within its functional area. It has become a truism that, in most societies where it is routinely consumed, cultural attitudes towards alcohol are marked by considerable ambivalence: positive attitudes about alcohol's effects as a personal relaxant and as a contributor to communal celebration are juxtaposed against equally clear beliefs that its consumption is a significant contributor to a range of health and social problems. While healthcare systems have never been entirely clear about the role which they can play in alleviating such problems, it is by now quite firmly established in most developed countries that the healthcare system should play *some* role in this sphere.

The study reported here is best understood in the context of contemporary preoccupations with the implementation of evidence-based policy and the delivery of evidence-based public services. Specifically, it is a study that reports on the difficulties involved in changing policy and practice from a specialist addiction-as-disease model that is not well supported by research evidence, to a community-based, public health model, which is strongly supported by research. To those who believe that public service provision is, or at least should be, a rational process, it would seem

obvious that the Regional Health Board studied here should switch to an evidence-based model: policy-makers and managers should draft policies and service plans which reflect this more rational approach to the management of alcohol-related problems, and professionals employed for this purpose should implement practices in line with these new policies.

However, “the reality of the policymaking process is rarely so simple or straightforward” (Babor et al., 2003, 255) and researchers and policymakers often operate from separate agendas that are framed by different knowledge, political and moral considerations (Johnson et al., 2004). To those who recognise that public policy and service provision is not necessarily so rational, and that the rational model tends to discount the influence of interests in policy decisions (Howlett and Ramesh, 2003), and that professional interests can “generate ‘needs’ as much as respond to them” (Thom, 1999, 9), it would seem obvious that this organizational transition – from specialist ‘alcoholism’ treatment to more broadly based management of alcohol-related problems – is one which is likely to be opposed, resisted and delayed by a variety of factors, within and external to this health service organization.

The internal factors, which will be looked at in depth throughout the findings of this thesis, include professional resistance to changing ideologies and practices which – however lacking in supporting research evidence they may be – are well established – as well as delay and inertia in introducing the administrative reforms necessary to underpin what is effectively a paradigm shift in terms of healthcare management of alcohol-related problems. From the perspective of the external environment, the major obstacle to this transition to a more rational and evidence-based response to alcohol

problems is the existence of societal and cultural expectations, built up for more than a century, that problem drinkers should be admitted to inpatient mental health facilities. The Irish public has come to view psychiatric admission as the usual and appropriate response to 'alcoholism' and it would be naïve to think that views of this kind would be promptly abandoned because they lack an evidence base.

BACKGROUND

The study was conceived during a period, 2001-2 when its author¹, along with colleagues, was involved in reviewing services that provided specialised, residential addiction treatment. These residential services, operated by independent, non-governmental organisations, received substantial statutory funding to both establish and operate their programmes, yet it appeared their intervention models lacked evidential support, were at variance with stated public policy and furthermore lacked connection with many statutory and non-governmental community service providers. Many of these community-based service providers were openly critical of what they perceived as an imbalance between well-funded, residential services and under-resourced, stretched community services.

These criticisms reflect a wider policy debate about alcohol problems, which traditionally, were dealt with through a specialist, mental health care system; newer approaches involve a blend of specialist and public health practices. Variations in

¹ The terms "author" and "researcher" are used interchangeably in this thesis for variation.

treatment have an important historical context and reflect divergent, and at times even conflicting, positions on alcohol misuse as a medical, psychological or social problem (Edwards, 2000). The proliferation, in recent decades, of extensive alcohol research provides a sharper focus to the differences between treatments, thereby challenging service providers to provide more evidence in support of their interventions (Miller and Weisner, 2002).

Arising from an involvement with the above mentioned service reviews, this author became interested, at a regional level, in a more extensive evaluation of policy change and service development, and brought forward proposals for conducting such study which might later be used for a doctoral thesis. The development of the author's interest in this study coincided with a decision by the Regional Health Board, in 2003, to instigate a new drive towards changing the focus of its substance misuse services, building on previous efforts to put more emphasis on a public health and community-based approach, thereby shifting the stress away from specialist, residential and hospital-based models. A number of factors contributed to the Regional Health Board's new drive for change. These will be outlined in more detail in later chapters, but in summary they include:

- 1) A growing awareness of the lack of impact of a psychiatric in-patient model of treatment, frequently referred to by both practitioners and managers as a "revolving-door" system.
- 2) The lack of evidence in support of other, non-psychiatric, specialist residential services.
- 3) Changes in the nature of substance misuse problems, including illicit drugs as well as alcohol.

- 4) The growth in public demands for more community-based responses to substance misuse problems.
- 5) A perennial belief within Regional Health Board management that these various problems needed to be managed outside of their traditional mental health services base.

Also, at the time, the concept of evidence-based policy and practice had acquired considerable currency, amid demands for changing the way in which many services were provided, particularly within the overall context of extensive health service reforms.

Fieldwork for this study commenced in November 2003 and was completed in September 2006. During the period of study the Regional Health Board, along with nine other statutory regional authorities (three in the capital, Dublin, and six in regions outside Dublin), which had responsibility for the overall, regional management of health and social services since they were established under the provisions of the *Health Act* (Ireland, 1970), were abolished, in the context of a protracted health reform process, and were replaced by a single, centralised Health Services Executive, under the *Health Act* (Ireland, 2004).

With the regional structure of ten health boards, services were organised under three separate programmes, each of which had a regional executive management team (Curry, 2003). These programmes were:

- Community Care Programme (community health, general practitioner services, public health nursing, community welfare, child welfare, care of the elderly)

- General Hospital Programme (inpatient hospital services, outpatient consulting services undertaken in hospitals across all categories of medical need other than psychiatric services and mentally handicapped)
- Special Hospitals Programme (all hospital and non-hospital services for persons who are psychiatrically ill or have a mental handicap).

Under the Community Care Programme, community care areas were designated in each region, usually, but not always with populations of 100,000 approx. Some of these are coterminous with established geographic counties, depending on the population and size. In this study reference will be made to the Community Care Programme as indicating the overall regional structure within which relevant services – General Practitioner (GP) services, social work services and Substance Misuse Teams - are based; reference is also made to Community Care Managers, which in each instance refers to an overall county or area manager of these services.

Under the Special Hospitals Programme, psychiatric services are organised from county-based psychiatric hospitals, which in turn are structured into sub-county sectors. The capitalised term “Mental Health” is used below in order to refer specifically to psychiatric services. Reference is made to Mental Health managers who are either county hospital manager or county nursing manager; reference is also made to Community Alcohol Services which are staffed by addiction counsellors who are managed by Mental Health managers.

As a result of re-organisation following the Health Act, 2004, two service programmes were established under the central management of the new Health Services Executive. The first of these, Acute Services, incorporates the General Hospitals Programme and all other acute hospital services; the second combines the

Community Care Programme and all non-acute services in the Special Hospital Programme, including non-acute, psychiatric services. Previous Community Care Areas have been designated Local Health Areas, each of which has an overall Local Health Manager. The transition from the regional structure to the new National-Local structure commenced in January, 2005 during the course of this study.

The Regional Health Board that was the focus of this study is based outside the greater Dublin region and has a current catchment population of just over 460,000, a growth of 8.7% over the period 2002-2006; the region is mixed urban and rural: it has one city (pop. 50,000), four medium sized towns (pop 17,000 – 23,000) and six smaller towns (pop. 5,000 – 11,000) (*Census 2006: Vol 1 - Population classified by area*, 2007). The distance from one end of the region to the furthest is 160km.

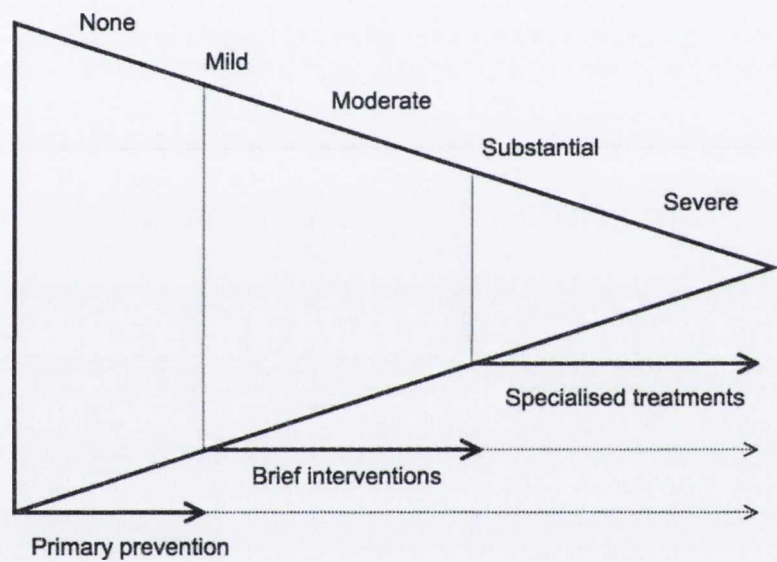
*THE DICHOTOMY OF THE DISEASE MODEL AND THE PUBLIC HEALTH
APPROACH TO ALCOHOL*

An overriding theme in this study is the dichotomy of the disease model and the public health approach to the treatment of alcohol problems. Adherents of the disease model accept the core idea of a clear boundary between those they believe to have a disease, alcoholism – at whom treatment is targeted – and others. In this regard, alcohol specific health and social problems are considered manifestations of a unitary disorder, which is primarily explained by individual vulnerabilities or predispositions in some drinkers. For the health service, the main implication of this model is that service providers should create interventions – mainly of a specialist nature and often in mental health settings – that would resolve to cure or overcome this disease; more treatment is considered better and the optimal is intensive, residential treatment. This model has dominated the treatment of alcohol problems since the 1930s and despite a lack of supporting research evidence, continues to be highly influential in many healthcare systems – including that of the Republic of Ireland.

In contrast to the disease model, public health advocates sidestep the idea of a distinct boundary between normal and problematic drinking and favour the conception of a spectrum of alcohol problems, and the provision of various interventions across this spectrum, which at its most serious might include persons defined by disease advocates as alcoholic, but not exclusively. The main thrust of this public health model is to direct policy at whole populations primarily, and not simply at sub-groups with the most serious apparent problems. This public health approach follows an

ecological perspective that views alcohol-related problems as not simply related to individual behaviour but as interconnected with social, cultural and environmental influences. Arising from these interactions therefore, every individual who drinks alcohol is viewed as having some potential health or social risks. The following diagram represents this public health spectrum of alcohol problems.

FIG 1.1.ALCOHOL PROBLEMS



Source: *Broadening the Base of Treatment for Alcohol Problems* (1990)

Contemporary research reviews of alcohol policies assign greater overall importance to society-wide policy responses which seek to reduce the overall consumption of alcohol through supply regulation and control, as compared to individual-directed treatments, which, apart from brief interventions, are regarded as less important in reducing alcohol-related problems (Sheron et al., 2008; Babor et al., 2003; Edwards,

1994; Chisholm et al., 2006; Anderson and Baumberg, 2006; Chisholm et al., 2004). In this regard therefore, the base and middle sections of the triangle in the above diagram are favoured as the loci of policy interventions rather than the apex, which is more likely to be the place where intensive treatment interventions are concentrated. The balance in favour of population-directed measures is evident in international policy statements (World Health Organization [Europe], 2006) and national policy statements (National Alcohol Policy [Ireland], 1996; Strategic Task Force on Alcohol, 2004), although the Irish Government is often criticised by public health advocates for failing to act in accordance with these policies (Irish Medical Organisation, 2005).

Despite alcohol treatment's general low rating as an overall measure for tackling alcohol problems, its positive benefits are nonetheless emphasised by public policy advocates. These include: providing direct, practical assistance to families, employers and the wider community in dealing with specific alcohol problems, raising public awareness, generating dialogue of alcohol problems within society, and involving health and social service professionals as alcohol policy advocates (Babor et al., 2003).

Contemporary reviews of the research literature on treatment outcomes is, in general, more supportive of the benefits of interventions that have been framed within a public health model than those that rely on a disease conception (Miller et al., 2005; Miller and Wilbourne, 2002; Miller and Hester, 1986b; McCrady, 2000; Finney and Monahan, 1996; Miller et al., 1989). Despite evidence in support of the public health approach however, in practice disease models in Ireland continue to attract medical, practitioner and public support (Carlin, 2006; Farren, 2006; Egan, 2007; Leane et al.,

1994; Rowen, 2003), as they do in the US (Miller and Weisner, 2002; Peele, 1995), where they were first developed. It is this conundrum that initially motivated this author to undertake this study: conscious as he was of the very comprehensive literature that existed in support of the public health approach, he wished to explore, within the context of a reasonably-sized health care system, why practical support for the public health approach seemed at best tentative, in the face of a more sanguine disease model.

Disease models of alcohol treatment rely greatly on the idea of specialist, usually residential, interventions, in which persons defined as alcoholic have an intensive, often cathartic, therapeutic experience, which is designed to make them aware of their lack of control over alcohol and the necessity for them to make a holistic commitment to alcohol abstinence; persons are often encouraged to use the philosophy of Alcoholics Anonymous as a foundation for therapeutic change (Anderson, 1981; Cook, 1988; McNeece and DiNitto, 2005; Farren, 2006). Mental health services have historically played a central role in providing the locations and personnel for alcohol treatment (Edwards et al., 2003). Formal treatments were first developed during the latter half of the nineteenth century, and in keeping with the institutional formula of the time, their main focus was often long-term confinement in psychiatric asylums. While the focus of intervention has changed, reflecting changing ideas about alcoholism as a disease and its causes, the primary location of treatment has remained within mental health settings, either the modern psychiatric hospital or various day centres, day hospitals and mental health counselling clinics, and mental health trained personnel have been the main treatment providers.

While psychiatric settings are broadly considered appropriate locations for the treatment of persons with the disease, alcoholism – although some disease model advocates might disagree with that – they are not so likely to be considered the most appropriate settings for public health based interventions. This latter group of treatments consists of an eclectic mix of direct, intensive therapies and less-intensive, harm-reduction measures; it advocates *both* abstinence *and* controlled or reduced drinking as appropriate treatment aims, and it suggests a wide diversity of interventions, including individualistic models for supporting cognitive change and increasing personal motivation to change, as well as brief counselling, social networking, and systemic and family therapies (Bien et al., 1993; *Broadening the Base of Treatment for Alcohol Problems*, 1990; Meyers and Miller, 2001; Miller et al., 1998; Miller et al., 1995; O'Farrell, 1993). Many of the treatment interventions that fit this public health approach are normally provided not in hospital settings, but in settings that are located either within or close to the natural settings of the people being treated. This approach flows from an ecological understanding of human development, whereby individual problems and stresses are perceived as the result of failed or partial adaptations between individuals and their surrounding social and environmental systems; improved functioning is linked to improved adaptation, brought about through intervening across a number of interactional – inter-personal, person-in-environment – domains: interventions that do not quite fit an institutional context (Van Wormer, 1995; Barber, 2002).

Obviously, variations of both institutional and non-institutional approaches, or compromises between both can be suggested in re-shaping a treatment system from a mental health base to a community base, and two specific variations of these

possibilities are evident within this study. In the first model, which is not studied here, although reference to it is made in the literature review and findings, individual 'alcoholics' would enter a specialist, residential setting – which may or may not be psychiatric-based - and family members and / or friends and colleagues would attend regularly to share in the intensive, therapeutic experience, and afterwards the individual would participate in an aftercare programme – supported by these third parties – and would relate back to the centre on progress in community adaptation, and to get further help, as required, in managing their recovery process.

In the second model, alcohol specialists are regarded as being of less importance but, conceding that they have some role to play, this role is seen as best played in non-residential, community-based settings. What really distinguishes the second model however, is its insistence on the valuable role which generic human service professionals can play in the identification and management of problem drinkers: in many instances it is seen that generic workers can intervene effectively with such clients, but even if it is deemed necessary to refer some clients for more intensive treatment, generic workers can continue to play a role in their long-term management. This second model, or formulations of this second model, were studied during the action research project in this study, and most of the main data is derived from focus groups and interviews with practitioner and management personnel, who in various ways endeavoured to shape the transition from an institutional- treatment system, to a non-institutional system, and simultaneously deal with the multiple, practical and organisational difficulties that this entailed.

AUTHOR'S ROLE

From the outset of his engagement with this study, its author was cast in the role of consultant; methodologically this role is delineated as action-research, a form of organisational enquiry in which the researcher has a continuous, iterative engagement with organisational members, identifying organisational issues for change, and contributing to reflection and evaluation, while generating internal reports and proposals to help move the process of change forward, and where necessary re-engaging and repeating the process.

In addition to this consultant role, the author also sought to generate broader insights into policy change and service evaluation. In this latter role, the author's concern is with knowledge-development; in practical terms this involves the author standing back from the action-research process in order to bring together a synthesis of data developed at different stages of the overall engagement – in this case drawing mainly from focus groups and semi-structured interviews with stakeholders - and integrating this with background and historical knowledge, gained from reviewing relevant documents, theoretical literature and research studies, using both qualitative and quantitative data collection. The author also undertook a secondary analysis of annual published data on inpatient alcohol treatment, 1965-2006, thereby providing a unique epidemiological knowledge background to his assessment of qualitative data; this analysis also provides an important, stand-alone framework for assessing the role of mental health services in alcohol treatment over the period of four decades.

Coghlan and Brannick (2005, 25) describe the second action research process, which is often the focus of academic dissertations, as “an action research cycle about the action research cycle” and they concur with Zuber-Skerritt and Perry’s (2002, 171) distinction between “action research in the field”, which is “aimed at practical improvement” and “independent action research in preparing the thesis” which is aimed at making an original contribution to knowledge”. This study’s contribution to knowledge is framed from within the action-research process, which provides unique insight into the various conceptual, methodological and practical difficulties entailed in a shifting paradigm – from an institutional, disease model of treatment, to a non-institutional, public health approach – within an overall research context of fading confidence in the abilities of health care systems to make this transition.

To reiterate, the study reported here was aimed – in action research mode – at introducing a more rational, evidence-based approach to the management of alcohol problems to one Regional Health Board in Ireland. As will be discussed in more detail in Chapter 2, the research literature supporting this new public health approach is clear and compelling, while the specialist ‘alcoholism treatment’ is not well supported by research evidence. However, the action research was undertaken in the expectation that the process of implementing this evidence-based approach was likely to encounter resistance at many different levels, rather than being automatically accepted within the Regional Health Board or within the wider community served by this agency.

CHAPTER OUTLINE

The literature review for this thesis, **Chapter 2**, provides a comprehensive overview of two dichotomous models of alcohol treatment and these provide focus for the study's evaluations: on the one hand is the addiction-as-disease model, whose advocates are among the strongest proponents of specialised, intensive addiction-focused treatments and which has dominated the main forms of service provision in Ireland for almost five decades; on the other hand is a broader, public health model, which views addiction as one of many alcohol-related problems requiring attention through multi-disciplinary interventions and which has been widely advocated in national and international alcohol policies in recent years and also enjoys considerable support within the research literature

Chapter 3 provides a detailed outline of the study's methodology, which draws from realist thought (Levin and Greenwood, 2001; Shani et al., 2004; Anastas, 1999; Robson, 2002). A general framework and typology of models of evaluation – with particular reference to social policies - is presented, alongside a consideration of their main philosophical tenets. The action-research approach used in this study is identified as *Developmental – Formative* within this typology, and the specific methods of data collection are outlined and summarised.

Chapters 4 & 5, drawing from a *new*, secondary analysis of psychiatric in-patient reports and also from data collected from focus groups and interviews, assesses progress in achieving a re-structuring of alcohol treatment provision within the Regional Health Board, arising from recommendations in the report, *The Psychiatric*

Services – Planning for the Future (1984). This report advocated that mental health services radically scale down the use of inpatient hospital admissions for treating alcohol problems and recommended that, as an alternative, alcohol treatment should be provided on an outpatient basis primarily. It further recommended the establishment of Community Alcohol Services in order to coordinate new, outpatient interventions and provide support to mainstream Primary and Community Care personnel to become involved in the treatment and management of these problems. Essentially, this report signalled the first official policy shift away from the disease model to the public health approach, and is generally considered a watershed in alcohol policy development in Ireland.

Chapter 6 explores the impact of newly emerging problems associated with the use of illicit drugs, and a new drugs policy position, on how the Regional Health Board responded to what could now be generically described as 'substance misuse'. The policy position reflects the growing involvement of community-based services with alcohol and drug problems, an involvement that arose within the context of the *National Drugs Strategy (2001)* and also as a result of psychiatric services, in general, having little, if any, involvement with this care group. The Regional Health Board embarked on two successive processes aimed at restructuring services in response to this changing external environment, arising from these problems and from the *National Drugs Strategy*. Both of these posed significant, internal organizational challenges, particularly as they required a more closer, effective collaboration between the Mental Health programme, who had overall responsibility for managing Community Alcohol Services, and the Community Care Programme, which set up new community-based Substance Misuse Teams in response to these developments.

Chapter 7, is focused specifically on the action research process as used in this study, and provides further insight into issues affecting the Regional Health Board's attempts to achieve organisational change. These issues include continued tensions between two separate Regional Health Board sections, the absence of an agreed overall vision for service development, the general non-engagement of mainstream Primary and Community Care personnel in the treatment of addiction problems, and concerns about the lack of coherence between various national policy documents. The chapter also deals with a number of issues concerning the future prospects of a localised addiction service.

The concluding **Chapter 8** summarises and synthesizes various ideas from the different bottom-up processes, reported on in this study, in which views were elicited and proposals aired for new and more systematic approaches to the care of problem drinkers. It is noteworthy, particularly within the context of an action-research study that was focused on policy implementation, that these ideas remain at proposal or conceptual stage; the recommendations that arose from the action research were not implemented. The chapter summarises the main findings of the study overall and in concluding that the attempt to introduce a coherent public health approach in the main failed, the chapter identifies the main reasons why this was so.

Chapter 2 - Literature Review: Contrasting models for treating alcohol problems

INTRODUCTION

As stated in Chapter 1, the aim of this study is to analyse the way in which a regional health authority in Ireland, referred to as the Regional Health Board (RHB) managed proposals to change policy and practice in treating alcohol problems. The historical and sociological literature, which informs this study, generally tends to view the process whereby alcohol problems are understood and managed as being both socially constructed and contested (Levine, 1978; Gusfield, 1996; Mulford, 1994; Room, 2001). To describe the process as 'socially constructed' means that the basic concepts which underpin societal management of alcohol-related problems may be understood as emerging from social and political processes, which reflect cultural values and interest group conflict, rather than being the result, as is often claimed, of objective scientific research. Alcohol concepts are 'contested' in the sense that more often than not there is disagreement, often of a fundamental nature, about their validity despite the fact that they are presented as arising out of objective scientific research. At the same time, various commentators have expressed concern about the gap between what has emerged as demonstrating effectiveness in the alcohol treatment literature and what continued to be practised (Hodgson, 1994; Miller and Hester, 1989; Miller et al., 2005).

It is possible to discern within the wider literature a range of models which purport to explain alcohol-related problems – for instance, Miller and Hester (1989), identify eleven such models; in the field of drug addiction (Keene, 2001) outlines three. For the purpose of providing a theoretical framework as a backdrop to the present study, the literature is reviewed here in terms of two of the dominant models – the disease model of alcoholism and the public health model of alcohol – which between them have relevance to most, if not all, of the main features of the policy debate as to how health authorities should contribute to the societal management of alcohol and its associated problems.

THE DISEASE MODEL OF ALCOHOLISM

Although, as will be seen, there is ongoing debate and ambiguity about its meaning, the idea that there is a disease called alcoholism has two central implications: one is that alcohol-related problems may validly be conceptualised as symptomatic of an underlying disease, with the clinical manifestations of craving, tolerance and withdrawal, and for which continued abstinence from alcohol, achieved through personal change, is the only route to recovery, while the second is that, as with other diseases, responsibility for its societal management rests legitimately with the medical profession and the healthcare system. The concept of alcoholism-as-disease has existed for about 200 years (Durrant and Thakker, 2003). Early exponents include the physicians Benjamin Rush who described alcohol addiction as a disease (Rush, 1785; Porter, 1985), Thomas Trotter, who in an 1804 essay (Trotter and Porter, 1988, 390) -

considered the first significant medical text on treating alcohol problems - emphasised that “the habit of drunkenness” was “a disease of the mind”, and Magnus Huss who introduced the term “alcoholism” as a “complex of disease manifestations” (Van Wormer, 1995, 30).

Although Keller (1986) identified references to alcohol problems in ancient writings, and Porter (1985) suggests there are implicit alcoholism references in eighteenth century descriptions of drunkenness and drink-related madness, it is generally accepted that the concept of alcoholism-as-disease was, in the nineteenth century, perceived as a novel idea. New disease perspectives contrasted with historical social, moral or religious ideas, which viewed heavy drinking as not “a matter for the doctor, but for the judiciary, the churches or the reformer” (Chalke, 1970, 122). The work of Benjamin Rush and other physicians led to a shift in focus away from issues of law, morality and willpower, towards a consideration of the destructive impact of alcohol *as a commodity* on individuals and society, leading also to a growth in the temperance movement, which grew in the US through an expansion of treatment. However, the temperance movement also gradually became associated with alcohol prohibition, and with the criminalization of opiate possession following the passing of the *Harrison Narcotic Act* in 1914 (Musto, 1999) the demand for alcohol prohibition gathered even further momentum (Durrant and Thakker, 2003); in contrast the Irish experience of organized temperance at the time, though the work of Father Matthew, was relatively short-lived, following the opposition of powerful institutional religious interests who feared its potential, as a social movement, to disrupt established social conventions (Townend, 2002).

As in current, modern discourse, the issue of loss-of-control, or the inability to stop drinking despite the evidence of negative personal, social and health consequences, and despite a desire to stop, characterized the early alcoholism condition. The focus of treatment, therefore, was on achieving long-term and permanent abstinence from alcohol as a way of overcoming the loss-of-control. One famous US temperance organization, the Washingtonians (founded in 1840), advocated public declarations of total abstinence alongside providing personal support to individual drinkers in order to maintain this (Maxwell, 1950). In nineteenth century conceptualizations, loss-of-control was perceived as being derived primarily from alcohol itself and its addicting properties, an analysis that lent to the temperance movement's tilt towards prohibition, and also helped explain the focus in treatment on removing the individual from the direct influence of alcohol and into asylums, where persons with alcohol problems were locked away, and exposed to aversion therapies and various other treatments focused on alcohol substitutes (Berridge, 1990; Edwards, 1987; Lender and Martin, 1987; White, 1998).

By the early twentieth century the temperance movement, as previously mentioned, had shifted towards prohibition in the US, and towards alcohol control laws in Northern European countries, a shift that reflected an emerging corporatist idea that alcohol consumption was incompatible with industrial efficiency; this focus on prohibition and alcohol control underlined a lessening of concern with treatment (Levine, 1984). However, under such controls, illicit supplies of alcohol increased and so too did related problems, although few or no treatment facilities were then, available (Keller, 1986). An important effect therefore of prohibition was the decline

in treatment provision and a shifting in focus, temporarily at least, away from medicalised conceptions of alcoholism.

With the repeal of alcohol prohibition the power and status of temperance bodies was severely diminished. As these bodies had played an important role in the management and treatment of alcohol problems, their denouement created a policy vacuum in this area. Those persons now affected by drunkenness were often socially stigmatized and to fill the policy vacuum a disease conception once again gathered momentum.

Initially, this new disease conception gathered momentum not as a result of the efforts of medical professionals, but because of individual members of lay organizations, such as the self-help fellowship Alcoholics Anonymous (AA) whose ideas have since spread to most areas of the world. A striking difference between the modern conception of alcoholism and earlier ideas is that while it shares a focus on “loss-of-control” and on the need for abstinence, the source of this condition is located, not in the commodity alcohol but in the individual; thus whereas previously temperance movements were concerned with the social and political dimensions of addicting drugs as well as their individual effects, the activities of new alcohol fellowships centred on alcoholics who had the disease, alcoholism. As Levine (1984, 116) outlined:

...it eschewed any political position or activity; the only reason to be in Alcoholics Anonymous was to help oneself stay sober and to improve one's life, and to do so by helping others whose drinking was beyond control.

While the temperance movement's conception of alcohol involved treatments that removed the person from the influence of alcohol, a tendency with the more modern version was to suppress or mitigate those factors within individuals that contributed to their disorders. At an extreme this included during the 1950s and 1960s excessive electroconvulsive therapy, neurosurgery and apnoea aversion (Edwards, 2000, 131-2). This new conception was functional to the post-prohibition era, in which it was accepted that individuals could drink with little restriction and during which "it was no longer possible to convince many people that alcohol was inherently addicting" (Levine, 1984, 116). It reflected nonetheless, a sympathetic understanding for those persons, who because they had the disease, could not drink in the same way as others without major consequence, although some of the treatments that were provided, could, in retrospect, be described as unnecessarily cruel. The following quotes are instructive:

The alcoholism disease concept, having lain nearly dormant for some 150 years, finally found a fertile environment in the mid 1900s. It fitted well with the public's hunger for a simple explanation of chronic drunkenness, its yearning for simple solutions, its faith in science and technology to find a quick fix and its awareness of medical science's dramatic success in conquering many diseases (Mulford, 1994, 518).

The disease concept of alcoholism may be out of tune with the facts and a serious obstacle to rational solutions, but it has the great attraction of embodying assumptions that are convenient to almost everyone concerned. It allows us to drink happily, secure in the belief that normal people like ourselves do not become alcoholics; it allows the alcohol industries to do their best to persuade us to drink more without any suggestion that this is dangerous; and it allows politicians to avoid electorally unpopular decisions. Even alcoholics stand to gain: they are offered treatment for their 'illness' and by implication reassured that it is not their fault that

they have become ill and that it is someone else's job to get them better (Kendell, 1979, 370).

Various factors contributed to the diffusion of the modern disease model. AA did not intentionally organize to promote the disease conception, but many of "its members did have a large role in spreading and popularizing that understanding" (Kurtz, 2002, 6). However, the work of E. M. Jellinek, through the Yale Center on Alcohol and his involvement as an alcohol advisor to the World Health Organisation, brought the disease model scientific credibility and a measure of institutional support that was particularly important in bringing the model to international prominence. Mental health professionals also embraced the modern disease concept, although outside the US, more attention was given to the public health model, particularly in the UK, Europe and Australia. In the US many clinical professionals became involved in developing specialised addiction treatment programmes that were specifically structured around the disease model's main tenets; they incorporated some of the ideas and principles from AA, were generally private in orientation and usually residential in structure.

From the late 1950s, disease model programmes had significant influence on the development of alcohol treatment services in Ireland. Until quite recently the predominant intervention response in the Irish health care system to individual alcohol problems was in-patient treatment in psychiatric hospitals; this form of treatment has roots in both the nineteenth century approach of removing individuals from the source of alcohol as well as the emerging belief within psychiatry at the time

the expansion took place, that the condition was a clinical disorder that could be successfully treated through intensive in-patient admission.

In the continuing discussion below of the disease model, the background and work of AA is described and consideration is also given to the work of Jellinek. This discussion is followed by an analysis of formal disease model programmes with particular reference to the findings of evaluative research.

AA was founded in the city of Akron, Ohio in 1935 by two professional men with serious drink problems, who met and discussed these problems, and through this semi-formal support they achieved and maintained sobriety. AA followed the legacy of the Washingtonians and other earlier temperance groups that emphasised the importance of self-help and individual commitment to change and is made up of recovering alcoholics. Its key founding features, which have continued to date, are self-help, the use of confessional testimonies, social and personal support, and adherence to a set of lifestyle principles, referred to as 12 steps, which are aimed at surrendering to a higher power in order to support permanent abstinence. These are described in Box 2.1 below.

Box 2.1 AA 12 Steps (Anonymous, 2001)

- | | |
|----|---|
| 1 | We admitted we were powerless over alcohol – that our lives had become unmanageable. |
| 2 | Came to believe that a Power greater than ourselves could restore us to sanity. |
| 3 | Made a decision to turn our will and our lives over to the care of God <i>as we understood Him</i> . |
| 4 | Made a searching and fearless inventory of ourselves. |
| 5 | Admitted to God, to ourselves and to another human being the exact nature of our wrongs. |
| 6 | Were entirely ready to have God remove all those defects of character. |
| 7 | Humbly asked Him to remove our shortcomings. |
| 8 | Make a list of all persons we had harmed, and became willing to make amends to them all. |
| 9 | Made direct amends to such people wherever possible, except when to do so would injure them or others. |
| 10 | Continued to take personal inventory, and when we were wrong promptly admitted it. |
| 11 | Sought through prayer and meditation to improve our conscious contact with God <i>as we understand Him</i> praying only for knowledge of His will for us and the power to carry that out. |
| 12 | Having had a spiritual awakening as a result of these steps we tried to carry this message to alcoholics and to practice these principles in all our affairs. |

AA’s basic support structure is meetings, which are held in a wide variety of locations, including hospitals, churches, schools, community centres and treatment centres. Meetings commence with a reading of the “AA preamble”:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problems and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization, or institution; does not wish to engage in any controversy, neither endorses nor proposes any cause. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

There are both open (non-addicts, friends, family members) and closed (members only) meetings. Closed meetings focus on discussing members' experiences of drink and addiction and on creating mutual support for discussing and analyzing progress through recovery. AA meetings end with a collective rendition of the Serenity Prayer, which is an appeal to God for assistance to develop courage to bring about personal change and to develop a calm acceptance of the things that cannot be changed through personal effort.

In addition to meetings, the AA fellowship also encourages a form of mentoring, whereby new members become assigned to a sponsor who offers personal advice and is available through telephone or other contact to assist in difficult relapse moments and other crises. Also, the fellowship encourages ongoing informal contact between members as a way of creating alternative social networks and avoiding previous friendship routines where avoidance of alcohol might prove difficult. Although AA also encourages some formal, non-therapeutic meetings, it is in general a movement bereft of formal, organisational structures; it has no hierarchy and no permanent leaders and its expectation of leadership is that it supports, but does not direct; its groups have autonomy, but are encouraged to own no property; there are no dues and funding is not accepted other than voluntary contribution; members are asked to refrain from identifying themselves to the media as being in AA and to desist from becoming involved in public or political issues as an AA member (Emrick, 2001).

AA is an international fellowship. Other self-help groups with similar structures have also been formed, including: Narcotics Anonymous, dealing with drug problems; Gamblers Anonymous, focused on gambling problems; and Al Anon and Alateen for

partners and family members. There are currently about 120,000 separate AA groups in over 170 countries internationally, with an approximate membership of 1.9m². In general the structure and focus of AA groups in different jurisdictions is standard, although variations exist with respect to whether the “Higher Power” referred to is perceived as a Christian God, “God as we understand Him” or as the collective power of the group; and with respect to whether new members should be assigned a sponsor (Emrick, 2001).

As is clear from its membership size, AA has popular appeal, related perhaps to its emphasis on practicality over theory; it has particular appeal in societies that emphasize a can-do individualism and where a suspicion of authority prevails (Trice and Staudenmeier, 1989; Edwards, 2000). It is important to emphasise that AA is a spiritual fellowship; its meetings’ structure were styled on the Oxford Group, a Christian society that engaged in prayer meetings at which members stood up to “publicly confess their shortcomings” (Edwards, 2000, 104). It is not, and never has been, a professional treatment, and does not claim a clinical theory. Like the temperance movement, it relies on the personal, subjective experiences of members without external, clinical input (Robinson, 1979) and is also highly reliant on spiritual ideas and these, it is contended, have helped sustain self-directed recovery (Miller and Kurtz, 1994)

AA’s informality, its lack of professional structure, and its reliance on members’ religious and subjective experiences have exposed it to the criticism that its proceedings can become dominated by charismatic leaders who, in the absence of

² (http://aa.org/en_information_aa.cfm?PageID=2&SubPage=50 - downloaded June 13, 2008).

rational structures, can both influence some members to make dramatic and positive changes in their lives, but also potentially alienate others, thereby setting back their prospects of dealing with their problems (Nace, 2005; Peele et al., 1991). However such criticisms can attribute to AA claims with respect to treatment that are not being made; as a take-it-or-leave-it voluntary fellowship it makes no claims with respect to treatment, no single AA member intervenes with another, while every member has individual responsibility for personal recovery. Its ideas moreover have remained quite intact for over seven decades, compared to the Washingtonians whose “thunder” was “worn out” within four years (Marsh, 1866) cited in (Maxwell, 1950, 46); also, the Oxford Group from which the AA derived many of their meeting ideas had a much shorter lifespan (Edwards, 2000). Despite initial resistance from professional medical and social bodies, AA’s principles have also permeated formal psychosocial treatment; in various alcohol programmes, participants are encouraged to avail of AA, while in some, treatment is structured around completing AA’s 12 steps; this latter application of AA principles is discussed in a later section below.

The issue of effectiveness of AA in overcoming alcohol problems draws attention to the relative merits of various approaches for assessing research evidence. Issues of research methodology for assessing evidence both generally and more specifically in relation to the research approach undertaken in this thesis, are discussed in the next chapter. For the present it is important to note that within the dominant research literature on treatment effectiveness, the randomized controlled experiment, whereby prospective treatment participants are randomly assigned to alternative treatment programmes, is considered the “gold standard” for conducting such research (Sackett, 2000). As a non-institutional, self-selecting, self-help fellowship however, AA does

not lend itself to such experimental testing of treatment efficacy and its status as a stand-alone, effective treatment therefore, is untested, and unproven in relation to this standard (Babor et al., 2003). In much the same way that randomizing attendance at religious meetings would provide little of scientific value on the impact of separate religions on people's lives, there is no scientific "evidence that AA works" (Edwards, 2000, 116). However, unlike many formal treatments, AA neither makes, nor feels the necessity to make, scientific claims, although there is (non-experimental) survey evidence of a positive relationship between participation in AA and success in achieving abstinence. Vaillant's (1995, 384-5) study of a non-clinical population sample, for example, found that significant numbers of the cohort gradually recover over time, and that this recovery is achieved:

not because we treat them but because they heal themselves(and is) associated with the alcoholic discovering: (1) a substitute dependency; (2) external reminders (such as disulfiram ingestion or a painful ulcer) that drinking is aversive; (3) increased sources of unambivalently offered social support; and (4) a source of inspiration, hope, and enhanced self-esteem (such as religious activity) (and) that Alcoholics Anonymous, or any reasonable facsimile, appears to be an effective means of bringing all these four factors to bear.

In his discussion of these issues Emrick (1987), reports that outcomes for AA members are more favourable for those with more intense involvement, more frequent meetings, more likely to have or be a sponsor, to lead meetings and to have worked through Steps 6-12, after completing formal treatment.

As formal programmes often use AA as an adjunct to their treatment, it has been possible to conduct comparative, experimental studies surveying AA as a factor in

formal treatment outcome. Emrick et al's (1993) analysis of 107 (non-experimental) studies of AA concluded that persons who attend AA during or after other professional treatment do better than persons who do not attend. In their discussion of AA in Project Match, a multi-site randomized controlled trial that was based on matching clients to different treatment types, Tonigan et al., (2002, 204) report "small to modest benefits were associated with frequency of AA attendance after formal treatment". AA participation therefore, can be seen as "a valuable resource" when used in conjunction with formal treatment programmes, including programmes – such as cognitive behaviour therapy with generally low rates of AA attendance (Ibid., 202); the benefits however, are more likely to be present in programmes in which there is a specific focus on supporting attendance at AA (Humphreys, 1999), although it is impossible to predict who, from any formal treatment group, can successfully affiliate to AA (Emrick, 2001).

In general AA is perceived as being successful with persons with more serious alcohol problems and who perceive abstinence as the means for overcoming these, but offers little promise to those who wish to, or could with the right assistance, mitigate alcohol-related problems through controlled or reduced drinking (Zinberg, 1977; Emrick, 1987); an important tenet of public discourse on this issue is that the latter constitute a much larger problem for society, potentially causing greater economic, social and personal harm (*Broadening the Base of Treatment for Alcohol Problems*, 1990).

Given its membership, AA has widespread popularity; it requires no subvention from government and there is no direct cost to society or individual cost to members, apart from the expense and time of getting to meetings and whatever voluntary contributions they choose to make. In addition to some evaluative evidence of its positive benefits, there is some evidence that levels of AA membership in society have further positive impact such as on reductions in population rates of liver cirrhosis (Mann, 1991). These various factors provide a strong basis for encouraging persons who recognize they have serious alcohol problems to avail of AA's support system, particularly if indications of prospective AA affiliation become apparent during the early stages of attendance. However, it is important to draw a distinction between the encouragement of participation in a voluntary fellowship whose ideas are based on the disease model and the incorporation of the disease model into the development of formalized, publicly-funded treatment. The emergence of the Minnesota Model of addiction treatment had particular impact on these latter developments.

Jellinek's text, *The Disease Concept of Alcoholism*, (first published in 1960 and later made available in 1972 through the Christopher D Smithers Foundation) became the "canonical scientific test" for the disease model (Fingarette, 1988), using scholarly language to lend credence to, and support for, the model's key propositions (Van Wormer, 1995), and more specifically supporting the proposal that alcoholics are persons (different to non-alcoholics) who experience an irresistible *physical* craving for alcohol, as a result of which they develop a *loss of control* over drinking and a consequent, inability to stop that can only be overcome through abstinence. Jellinek elaborated loss of control by stating:

Loss of control means that any drinking of alcohol starts a chain reaction which is felt by the drinker as a physical demand for alcohol. This state, possibly a conversion phenomenon, may take hours or weeks for its full development: it lasts until the drinker is too intoxicated or too sick to ingest more alcohol (Jellinek, 1952, 679).

Jellinek also proposed that the disease alcoholism was progressive through a series of stages and he considered the condition irreversible, a view that resonates with the popular axiom – “once an alcoholic, always an alcoholic” (Williams, 1956) cited in (Edwards, 2000) and has also become “the absolute linchpin of the disease theory” (Edwards, 2000, 102).

Jellinek’s primary concern was that society, through health care institutions, adopt a caring as opposed to a punitive attitude towards people with alcohol problems. He was based at the Yale Centre for Alcohol Studies in the late 1930s, which was founded on the back of a medical research study on alcoholism. He was the first editor of *Quarterly Journal of Studies on Alcohol*, which was founded in 1940 and he was also closely involved with the Yale Summer School in Alcohol Studies, which commenced in 1943. According to Levine (Levine, 1984, 117) the “Center, the Journal and the School became the intellectual centre of what has since been called the ‘alcoholism movement’”, which also included AA and the National Council of Alcoholism. Jellinek and his associates regularly affirmed the ideas of AA. AA members participated in Jellinek’s studies thus allowing him to translate “their experiences and views into scientific and medical terminology” (Ibid.). The National Council on Alcoholism, which took on the role of promoting the disease model

through education, training and through agitating “for state alcoholism programmes”, was founded by Marty Mann, who was both a member of AA and an associate of the Yale Centre (Ibid.). It was through his role as alcohol advisor to the World Health Organization during the early 1950s, that Jellinek’s ideas gained international momentum and influence (Thom, 1999). During this period WHO declared alcoholism as a disease; a similar declaration was made by the American Medical Association in 1954. In Ireland the *Report of the Commission of Inquiry on Mental Illness (1967)* based its claim that alcoholism was a disease on WHO’s then stated position.

Jellinek’s seminal work had a positive impact on alcohol research as well as heralding a major expansion in the development of professional treatment as a humanitarian response to persons with alcohol problems, and as a counter to moral and social stigma (Room, 1972). In due course others elaborated on the disease model from a clinical perspective (American Medical Association, 1967; American Psychiatric Association, 1968; Royce, 1981; Sellman, 1994), bringing it to higher levels of sophistication, and it was also extended to substance use problems, pathological gambling and other habitual behaviours and disorders (American Psychiatric Association, 2000).

The disease model’s distinction between alcoholics and normal drinkers became particularly attractive to formal treatment providers with a leaning towards providing specialist treatment services; narrowly defined service clients can more easily demonstrate common needs and respond to prescribed interventions, thus potentially simplifying the task of mobilising treatment personnel, developing specialised

programmes, organising these into professional and administrative structures and raising finance and securing insurance cover (Edwards et al., 2003; Rasmussen, 2000). It is quite common therefore for highly focused bodies such as private hospitals or not-for-profit agencies to develop and structure treatment provision around a disease model, with intensive in-patient services (Fingarette, 1988) public facilities being more likely to operate community-based treatment (McNeece and DiNitto, 2005). This disease approach to treatment was and continues to be popular in the US, but was not emulated in many other Western countries, such as UK, Canada and Australia, where in-patient referral was limited to persons with co-related medical (including psychiatric) problems or where the need for in-patient detoxification was clearly indicated (Goodwin, 1991). The UK's recent experience of alcohol treatment was clearly influenced by the work undertaken by Edwards and his colleagues who developed the concept of alcohol dependency syndrome and drew attention to a broader range of alcohol-related problems (Edwards et al., 1976), and that of Shaw et al., (1978) who set out a rationale for involving primary and community care personnel, and by a broadening of the policy community associated with alcohol issues (Thom, 1999).

Recent Irish experience of alcohol treatment tends to reflect developments in the US more than the UK – this experience is discussed later below but first it is important to discuss the proliferation in the US of formal treatments that are premised on the disease model and support induction into AA principles through intensive facilitated therapies and have become an important component in the alcohol treatment system in Ireland. The most common such treatment, known as the Minnesota Model - it was first formally established in Center City, Minnesota in 1949 - fuses AA with ideas

from therapeutic communities, thereby creating structures and processes to enable alcoholics help each other embrace sobriety and to develop a lifetime commitment to abstinence, and dedication to attendance at AA. The model is underlined by an acceptance that alcoholism exists as a primary condition, disease or involuntary disability, with physical, mental and spiritual effects, all of which need to be taken into account in order for treatment to be effective.

The basic intention in the Minnesota Model is to assist a person's recovery, with alcohol abstinence normally viewed as the essential condition for *full* recovery; the underlying premise is that regular attendance and participation in AA helps a person to change, and to achieve and maintain sobriety. Treatment is commonly organised through an intensive post-detoxification, 4-6 week residential programme (or combined hospital detoxification and residential) and treatment methods include individual and group therapy, educational sessions and active participation in the residential community. The treatment process is to educate persons in basic disease model ideas, to familiarize persons with the AA 12 steps, to assist persons to undertake the first four steps of AA and to link in with a sponsor, and to monitor persons' progress in attending and engaging with AA (Anderson, 1981; Cook, 1988; Stinchfield and Owen, 1998).

Although highly influenced by AA's 12 steps, the Minnesota Model is separate to AA and importantly it has in some formats included the use of confrontation, which is not an AA principle (Miller and Kurtz, 1994). The residential component is usually followed by a long period of AA attendance; although this is often described as

aftercare. In fact AA operates independently of professional treatment providers and while AA often recruits from hospitals and treatment centres, it is available to persons whether or not they participate in professional treatment.

While AA incurs little or no cost, the cost of professional, formal Minnesota Model programmes can be high, particularly if such programmes are based in residential settings – and this is often the case - and in these circumstances it would seem that such costs require some justification on the basis of outcomes. Miller and Wilbourne (2002) building on previous work (Miller and Hester, 1986b; Miller et al., 1989) conducted a meta review of 361 studies where specific treatment modalities were compared to either a control group or alternative treatments. In this review Minnesota Model programmes are poorly rated, due in part to a low number of comparative trials; as with AA, Minnesota Model programmes are difficult to study rigorously (Miller et al., 2005). However, poor results may also be attributed to the confrontational approach to counselling in Minnesota Model programmes. Such results are mitigated by non-experimental research in support of these programmes amid some evidence that their traditional confrontation style has, in many cases, been modified, or even abandoned (Moos et al., 1999; Ouimette et al., 1997; Project Match Research Group, 1998).

This modification notwithstanding, a limitation of Minnesota Model programmes within the context of a system of service provision, is that participation requirements can often deter from recruitment into treatment persons whose alcohol problems are mild or moderate or whose problems are severe but who are not dependent. The

treatment therefore does not suit most persons with alcohol-related problems. This issue arises with respect to AA, as previously discussed; the important distinction is that AA is not a formal treatment and requires no public funding or private investment, whereas formal Minnesota Model treatment programmes operate with considerable costs, and in general their providers actively seek both public and private funding. For this reason, among others, the alternative public health approach, discussed below, has been advocated. Similarly, Minnesota Model programmes do not suit persons who seek to control, reduce or modify their drinking behaviour as an alternative goal to that of total abstinence. In fact Minnesota Model programmes specifically do not work with persons with such goals. Yet this goal is considered both meaningful and achievable for many persons with alcohol problems, including persons whose problems are considered serious. Although formal Minnesota Model programmes have dominated many professional treatment systems, for example in the US and in Ireland, the need for a broader base of treatment dealing with the variable needs and capacities of persons with alcohol problems, suggest that other forms of treatment also be available; in this sense one size does not fit all, and other forms of treatment are indicated (*Broadening the Base of Treatment for Alcohol Problems*, 1990).

The above review has shown that the disease model of alcoholism has mixed origins; historically it can be traced to various temperance movements during the 19th century. The model's various proponents share a number of interrelated ideas: that alcohol problems may validly be seen as diseases; that loss-of-control of alcohol intake is symptomatic of alcoholism; and that lifetime abstinence from alcohol is required for effective recovery; the main focus of treatment interventions therefore is to support

the achievement of a state of abstinence. Through the development and expansion of the voluntary self-help fellowship, AA has helped garner support for the disease model; AA has an extensive international membership, which speaks for itself in advocating AA's particular perspective, and there is also some research evidence supporting the benefits of self-help and mutual support in assisting individuals in dealing personally with their alcohol problems.

Separate to AA, the disease model has also dominated formal treatment provision, particularly in the US and more recently in Ireland. Formal treatment adherents of this model support the idea that the healthcare system should accept responsibility for managing these problems and that within this healthcare system the optimum form of alcoholism treatment is within specialist care, although there is little research evidence supporting this particular view. Indeed Sobell has observed that "folk science" more than research evidence has helped the disease model dominate formal treatment (Sobell, 2006). Recent decades have witnessed more investment in alcohol science, contributing to a greater and broader understanding of alcohol treatment. These issues are discussed below in the context of the public health model, which commences with a review of criticisms of the disease model.

PUBLIC HEALTH MODEL – A BROADER BASE FOR TREATING ALCOHOL PROBLEMS

This section deals with the emergence since the early 1970s of an empirically-based perspective on alcohol-related problems which effectively contradicts the main tenets of the disease model. This perspective, referred to as a “new public health approach” disaggregates alcohol problems “into a wide diversity of health, causality, interactional and social problems”, thus presenting these problems as having many degrees and dimensions rather than as an all-or-nothing disease. (Room, 2001, 37). The public health perspective also views societal alcohol consumption rates and patterns as a key variable in determining the prevalence of such problems and it emphasises the effectiveness of therapeutic interventions from a wide variety of health and social service professionals – including generic and primary care personnel – in their resolution (Edwards, 1994; Babor et al., 2003). The public health approach therefore is modelled on an eclectic mix of harm-reduction and health perspectives; it advocates *both* abstinence *and* controlled or reduced drinking as appropriate treatment aims, and it suggests a wider diversity of interventions, including individualistic models for supporting cognitive change and increasing personal motivation to change, as well as brief counselling, social networking, and systemic and family therapies (Miller and Hester, 1989).

The emergent public health perspective was developed initially in the context of various criticisms of the disease model. In particular the disease model’s central concept of loss-of-control of alcohol attracted criticism on conceptual grounds and

through experimental testing. In his philosophical critique (Fingarette, 1988) points out that if loss of control was a distinct physical mechanism then alcoholic persons would not feel compelled to drink when sober and thus abstention would be quite easy; in fact, he argued, many such persons formulate an intention to drink while they are still sober so other explanations are required. Peele (1995) and Peele et al., (1991) are highly critical that the "loss of control" argument unnecessarily reinforces addict-identity models, and undermines individuals' capacities to assert control and to leave behind them their addiction or dependency.

The loss of control concept was also challenged through experimental research findings. Whereas Jellinek attributed loss of control to a distinct physical mechanism, experimental research illustrated the role of cognitive and environmental factors. Heather and Robertson (1997), drawing from various research studies, argued that while excessive drinking could be associated with an impairment of self-control and/or reduced responsiveness to social control, this did not constitute a loss of control. Some drinkers considered to fit a definition of alcoholic disease could be shown to exercise self-control in refraining from drinking and building up a stock of drink for a forthcoming bout of drinking or to protect privileges gained in a treatment setting (Cohen et al., 1971) or to return to controlled forms of drinking following discharge from treatment (Davies, 1962; Orford et al., 1976; Edwards et al., 1976; Armor et al., 1978).

The disease concept's relevance in societies where lack of self-control is not viewed as problematic is also queried (Room, 1985). In his analysis, Levine (1993) supports a social constructivist explanation for loss of control as a disease manifestation,

highlighting that historically the disease model arose out of particular social circumstances that prevailed in Anglo-American society and not necessarily repeated elsewhere.

The characterisation of alcoholism as a progressive medical condition also attracted criticism. A methodological criticism of Jellinek's research is that his initial ideas on this progression rely on data from self-selected members of AA, who by virtue of this membership constituted a limited, clinical sample and had already adopted a disease concept thereby potentially biasing their responses to Jellinek's surveys (Seiden, 1960). Vaillant (1983) argues that the notion of progressive disease arises from focusing only on skewed clinical samples. His research of a non-clinical, population sample reveals that many persons who might be defined alcoholic recover spontaneously and that individual characteristics and social and environmental factors influence the development of drinking patterns and problems, a point that was also highlighted by Cahalan's (1970) sociocultural analysis of alcohol problems. According to Sobell et al., (1996), most persons with alcohol problems either never engage with professional, specialised treatment or overcome their problems without recourse to treatment such as through natural or self-change processes (Klingemann, 2001), or through an ongoing engagement with non-alcohol-specialist social and health services (Weisner and Matzger, 2003).

The characterization of alcoholism as a progressive disease also drew criticism because it disregarded the interaction between individual attributes and social and environmental factors in influencing the development of *drinking careers* (Cahalan, 1970; Edwards, 1980; Edwards, 1984). The career concept draws from ecology

(Bronfenbrenner, 1979), stressing the variable interactions of individuals to their surrounding social, cultural and environmental influences, and the way in which patterns of drinking behaviour are shaped by these interactions, including early social influences, processes of socialisation in adolescence and early adulthood and learning influences, particularly as these effect tolerance and withdrawal.

An overriding criticism of the disease model is its one-dimensionality and its reliance on a single, fixed biologically-based conception. Indeed many critics of the disease concept have been anxious to underline the importance of a biological component but have also stressed the necessity to view this in the context of its interaction with other components (Pattison et al., 1977). A broader, multi-dimensional perspective contributed to the development of the concept of *alcohol dependence syndrome* as arising from an interaction between biological processes and social learning. It is argued that the continued compulsion to take alcohol does not reside solely in biological processes although, in particular instances, these may have been set in motion as reactivity to alcohol; learning processes are also involved, such that an individual's expectation of discomfort arising from the absence of alcohol can in fact stimulate the desire for further alcohol and, over time, compulsive drinking behaviour is reinforced through both social and psychological stimuli (Edwards and Gross, 1976). A *sense of loss of control* can inevitably emerge alongside a clustering of other signs and symptoms that need not all be simultaneously present, nor is the presence of some of these symptoms always evidence of dependence (World Health Organization, 1977). These symptoms are listed in Box 2.2 below:

Box 2. 2: Symptoms of drug dependence syndrome

- 1 Narrowing of the drinking *repertoire* with type of drink and patterns of drinking behaviour becoming different to social norms or individual's previous patterns, and also becoming increasingly fixed;
- 2 *salience* of drink-seeking behaviour with the drinker prioritising the need to maintain alcohol intake despite health problems, work problems, finance problems, isolation from family and friends and legal problems arising from drink-driving, social disorder or other offences;
- 3 increased *tolerance* to alcohol such that the drinker is able to function at blood alcohol levels that would incapacitate others;
- 4 repeated *withdrawal* symptoms that increase in frequency and intensity according as dependency progresses and that vary from mild physical sickness, through affective mental disturbance and serious delirium tremens;
- 5 *relief or avoidance* of withdrawal symptoms by further drinking;
- 6 *subjective awareness* of compulsion to drink or loss of control that is brought about through a combination of alcohol ingestion and other factors that vary according to individual and socio-cultural factors;
- 7 *relapse* or reinstatement of the syndrome following a re-commencement of drinking after a period of abstinence.

Source: (Edwards et al., 2003)

The above symptoms vary in intensity according to psychological, social and cultural influences. It is considered that the syndrome does not exist as a categorical absolute but rather on a continuum with degrees of dependence. Assessing the degree of dependence is considered an important diagnostic competency and as different degrees of dependency are likely to involve different interventions or treatment goals, an assessment obviously requires the ability to comprehend the syndrome's multiple variations (Edwards et al., 2003).

Use of the term "syndrome", as well as the notion of a continuum of alcohol dependencies, casts some doubt on the reliability of this approach as a medical conception, although there have been some criticisms that it is a re-worked version of the disease concept (Shaw, 1979; Shaw, 1985; Heather and Robertson, 1997).

However, it became a very important conception, not least because it facilitates an

understanding of alcohol problems from multiple perspectives, and with explanations for widely varying patterns of individual presentation. This inclusive understanding was also helped through differentiating alcohol dependence syndrome and alcohol-related disabilities (see below) a distinction that highlights the possibility that some persons can have serious alcohol problems without being alcohol dependent and *vice versa*. This concept of alcohol dependence is commonly accepted within medical, practitioner systems. Although the concept of dependence is, in itself, medically defined, an acceptance that the syndrome is linked to the interplay of different social, environmental and personal factors, rather than a reliance on biological factors, provides a strong basis for broader, rather than clinically restrictive, treatments and interventions. In addition to the WHO's work in developing the idea of alcohol dependence syndrome the shift towards a broader approach was also facilitated by evidence in support of early, opportunistic brief interventions suggesting that short assessment and advice could effectively reduce alcohol consumption among heavy drinkers (Babor and Grant, 1994; Bien et al., 1993; Chick et al., 1985; Heather, 1995; Orford et al., 1976).

The work of the WHO based research team opened up discussion on the concept of *alcohol-related disabilities*, including *physical* (liver cirrhosis, cancer, cardiovascular disease and foetal alcohol syndrome), *psychological* (depression and anxiety) and *social* (alcohol-related road injuries, violence, domestic problems, homelessness, workplace problems) (Edwards et al., 1976). The idea of alcohol-related disabilities (more often since referred to as alcohol-related problems) expands further the distinction between those whose alcohol problems include that of dependency and those who have other serious problems but who are not dependent; the conception

suggests that alcohol problems are often best perceived as heterogeneous or as on a continuum from mild to serious with multiple dimensions to these problems at any single level. In its seminal document *Broadening the Base of Treatment for Alcohol Problems* (1990) the Institute of Medicine (US) offers the following arguments in favour of this broader conception:

First: ..treatment for any problem tends to originate as a result of attention being drawn to severe cases. Initially treatment consists of applying to these cases the existing remedies that are available when the problem is first recognised. As time passes however, it becomes increasingly clear that (a) cases other than severe exist and (b) other methods can be used to deal with them. The history of the treatment of most problems follows this progression; diabetes, tuberculosis, and cancers offer illustration. Thus, it is not surprising to find the same progression in the treatment of persons with alcohol problems.

Second: Originally, a restricted number of treatment options were applied to a relatively homogeneous group of persons with similarly severe problems by a small number of therapists who were reimbursed for their efforts in a restricted number of ways. Today, treatment involves a large number of very different people with very different problems who are treated in a variety of ways by a diverse group of therapists who are reimbursed for their efforts through multiple mechanisms.

Third: Until quite recently, the treatment of alcohol problems was viewed as the exclusive province of a specialised treatment sector. Specialised treatment for alcohol problems is a vital and necessary component of the overall therapeutic approach. There has been increasing recognition however, that it cannot constitute the whole of the therapeutic approach to alcohol problems.....It has become apparent that although some people have multiple alcohol problems, most people who have alcohol problems have a small number of such problems....and are likely to seek help for the individual consequences of their problems.....without recognising the critical role that may be played in such problems by excessive alcohol consumption.

The Institute of Medicine's report accepted that persons with mild to moderate problems comprise the majority of those within the broad spectrum with alcohol

problems, and that their aggregate social, economic and health cost is much greater than that of those with serious dependency. Operating from a disease model however, alcohol services have tended to target this latter group with intensive treatments, whereas the potential for averting future problems and related costs through broader provision of less intensive interventions to the former group is considered greater (Babor et al., 2003). Thus the broader approach supports the idea of targeting interventions at larger populations, such as heavy drinkers, primarily, rather than at sub-groups with problems of addiction or dependency only. This approach conceives the alcohol treatment system as operating both a non-specialist service through primary and community care personnel to persons with mild to moderate drinking problems and a screening and referral service to those with serious problems, *and* a specialized service to those with serious alcohol problems and / or co-morbidities, where the need for intensive treatment has been clearly indicated. This broader approach was also developed in relation to drug problems with the use of the terms *problem drug taker* and *problem drug user* (Advisory Council on the Misuse of Drugs, 1982).

The dual approach towards both problems of dependency and other alcohol-related social, psychological and physical problems is consistent with three major, World Health Organization-sponsored alcohol policy research projects over the last 30 years (Bruun et al., 1975; Edwards, 1994; Babor et al., 2003). These projects involved cross-national collaborations of authors / researchers drawn from health, social and behavioural sciences who conducted in-depth literature reviews and statistical reporting of selected themes, drawing from epidemiology, sociology and health economics. The reports assert two complementary prevention frameworks. The first,

single distribution theory, posits that there is a connection between increased alcohol availability and alcohol problems (Bruun et al., 1975; Skog, 1985). Overall alcohol consumption levels in a population are considered to be related to total mortality and to specific causes of mortality and morbidity including liver cirrhosis, traffic accidents and violence; this position contends that societies can reduce their drinking problems through measures that restrict and reduce consumption, arguing the need, for example, to move away from individually-targeted education programmes, which are considered ineffective (Moskowitz, 1989), to a greater emphasis on social, environmental and legislative processes of change (Room, 1992).

This total consumption approach has a strong basis in the alcohol control policies of Nordic and some English speaking countries (Makela et al., 1981) although with the expansion of the European Union a permeation of market liberalisation and consumer choice policies has brought about a reduction in controls, where these existed (Sulkunen, 2000). The approach is contested by writers who liken it to a new form of temperance (Peele, 2001) and also by the drinks industry (Grant and Litvak, 1998) which favours individually-targeted educational programmes for promoting “sensible drinking” and also argues that other preventive measures should be targeted at “actual alcohol abusers” (Amsterdam Group, 1993).

The second, harm reduction and prevention framework supports the idea of targeting but at a much broader group than “actual alcohol abusers” as envisaged by the drinks industry. This framework contends that many alcohol-related problems – including social and health harms (Room et al., 1995), non-fatal injuries (Cherpitel et al., 1995), alcohol dependence (Caetano et al., 1997) and drunk driving (Midanik and Tam,

1996) - can occur even with relatively low levels of consumption and are also widely distributed in the drinking population (Edwards, 1994). This framework shifts the emphasis of social measures of prevention onto problematic drinking patterns (such as binge drinking) and hazardous drinking environments (Rehm and Ashley, 1996; Plant et al., 1997; Stockwell et al., 1996).

A mix of both of the above frameworks sets the main public health policy paradigm for the management of alcohol-related problems (World Health Organization, 2000; World Health Organization [Europe], 2006). At first glance, it might seem difficult to specify a precise role for treatment within the context of these frameworks given their overall priority to reduce the consumption of alcohol in society through supply regulation and control, and the focus on reducing demand through re-configuring social patterns of drinking behaviour. Treatment, on the other hand, is, by definition, centred on individuals, and is often formulated in terms of person-directed residential or day-care therapies and supports, which are designed to modify or change individual alcohol use and related behaviour. The value and efficacy of the public health approach to treatment however, is that it allows for treatment across a range of individual problems, with variable social dimensions. Treatment therefore can be understood as an intervention, or series of interventions, directed towards overcoming an individual's *problems of dependency* and / or other *problem drinking*, to develop their capacities to avoid relapsing to pre-treatment patterns of problematic alcohol use behaviour, and to offset the impact of their problematic drinking on others.

In this model, treatment in the first instance, is provided in the form of early brief interventions, mentioned already above, and motivational interviewing (Stockwell et

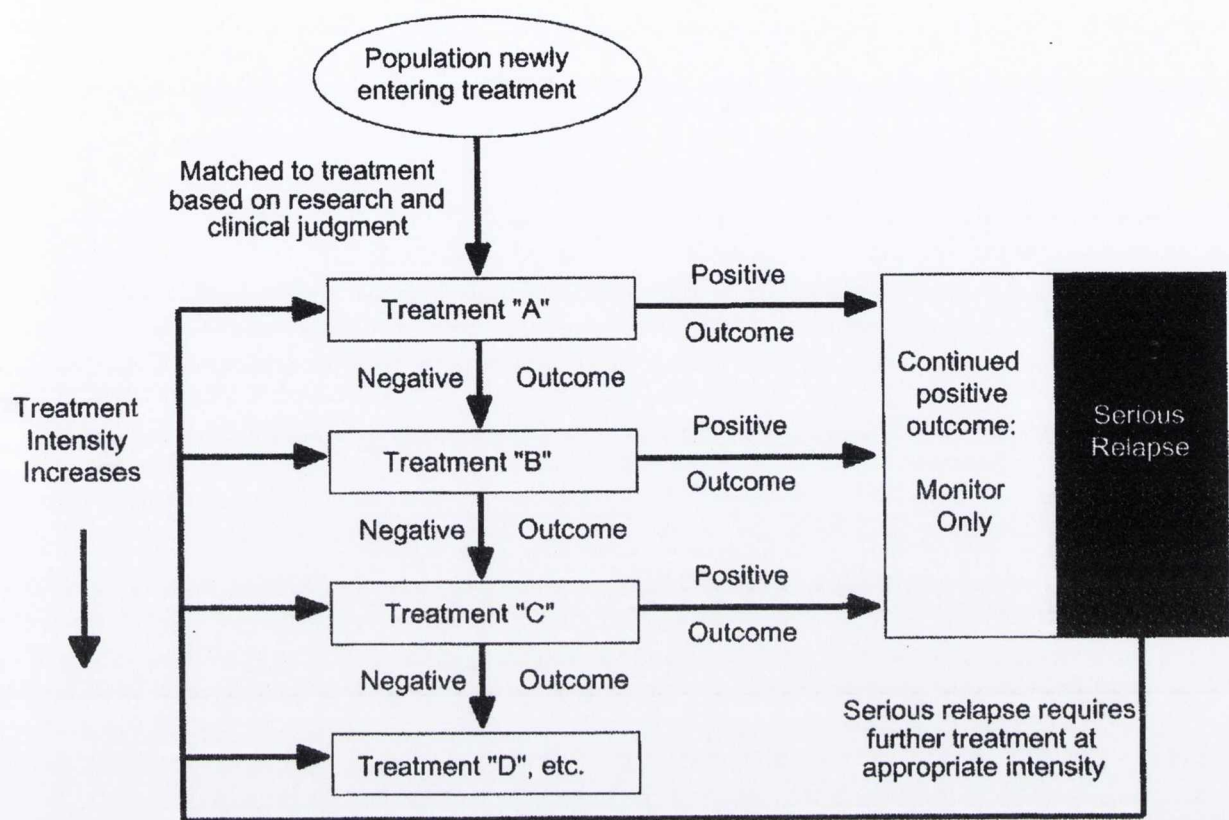
al., 1996). Such interventions are focused on initiating intrinsic motivations to change and in bringing about changes in alcohol behaviour prior to these becoming very serious. Bearing in mind that many persons overcome their alcohol problems without using formal treatments (Sobell et al., 1996) professionals in these less intensive interventions adopt a guiding but non-directive role, differentiated from Minnesota Model programmes; the latter tends to be directive, and sometimes confrontational, with more emphasis on structuring the therapeutic programme around a specific engagement with AA; the former draws from Bandura's (1977) cognitive social learning theory and its emphasis on personal choice in setting treatment goals as an important factor in motivation.

The role of treatment professionals in this alternative approach is to initiate the intervention process, to deal with technical questions and clarifications, and to assist, in a non-directive manner, in the process of self-reflection. Prochaska and Di-Clemente's (1986) conceptual differentiation between deciding (motivation) to change and action to bring about change has importance here, because it helps to explain that people could bring about change with minimal professional help because their desire or motivation to do so was strong. This suggests that the emphasis in formal therapeutic engagement needs to be more in the area of encouraging motivation and choice-making, and less directive, less focused on suggesting a singular approach to treatment.

Alongside, early interventions through primary care, community care and hospital settings, there is also the need to operate a *range of treatment services*, for persons

whose alcohol problems require some specialist assistance, with varying levels of treatment intensity, corresponding to the severity of problems encountered (*Broadening the Base of Treatment for Alcohol Problems*, 1990). This is described as the *stepped-care model* (Sobell and Sobell, 1999), which is illustrated in Figure 2.1 below whereby persons with alcohol or other substance misuse problems enter (or re-enter) treatment at levels that match the seriousness of their problems.

Figure 2.1 Stepped-care model



Source: (Sobell and Sobell, 1993)

In the stepped-care approach, treatment can be understood as an intervention, or series of interventions, directed towards overcoming an individual's *problems of dependency* and / or other *problem drinking*, to help re-focus the individual towards a lifestyle where they are abstinent or no longer reliant on drugs or alcohol and to develop their capacities to avoid relapsing to pre-treatment patterns of problematic alcohol use behaviour. Crucially, for a range of presenting alcohol problems, the focus of intervention is not necessarily to bring about alcohol abstinence but, rather, to bring about a reduction in the harms associated with alcohol use, such as reductions in alcohol-related violence, alcohol-related car accidents, and alcohol-related personal

injuries or health problems (Marlatt and Donovan, 2005). These latter changes may or may not include abstinence.

Unlike the disease model, which provides a single, clinical modality for treatment intervention, the public health approach, as illustrated by the stepped-care diagram above, allows for a plurality of treatment modalities. It also underlines choice-making, both in terms of the range of treatments that a treatment system decides to support, fund and make available, and in terms of making assessments of individual needs, as individuals enter and advance through a treatment system. Furthermore, prospective clients are potentially provided with information to assist in their own decisions about treatment participation. This approach to decision-making is consistent with the idea of evidence-based practice, whereby policy and practice decisions are explicitly informed by research evidence, which is used alongside clinical expertise and informed, client consent, and do not impose a single, preferred intervention, particularly in circumstances where alternatives are also available (Sackett, 2000; Gambrill, 1999).

Since the 1970s formulation of alcohol-related problems, or the public health approach, an abundance of research and meta-reviews has addressed issues of efficacy and efficiency in the treatment of alcohol problems, and suggesting a proliferation of alternatives to a single disease model approach. In reviews of cost-effectiveness (Holder et al., 1991; Finney and Monahan, 1996) the three interventions: social skills training, community reinforcement treatment and behavioural marital therapies; are included in the top five treatments. These treatments rank in the top treatments in

Miller & Wilbourne's (2002) review of effectiveness, which also identifies motivational enhancement therapy and brief counselling – these findings are consistent with an earlier meta review (Miller et al., 1995). McCrady (2000) reviewed thirteen treatments with strong evidence of effectiveness and assessed these according to American Psychological Association (APA) criteria of efficacy. Three treatments: brief counselling, relapse prevention (social skills training) and motivational enhancement therapy met APA criteria of “efficacious” or “probably efficacious”. Taken together these reviews suggest that: low-intensity, brief treatment is better than no treatment; no single treatment stands a cut above all others; and a small number of treatment modalities, with some similar features – specifically their focus on treatment domains other than alcohol *per se* – consistently show positive results (Meyers and Slesnick, 2002). This overall position is supported by Miller, Zweben et al's (2005) review of ten separate reviews of substance misuse interventions – summarised in Table 2.1 below:

Table 2.1: Summary of evidence of effectiveness based on (n = 10) research reviews

<i>Treatment types</i>	S-EBP ++	EBP +	Total No. of +
Cognitive behaviour treatment	3	3	9
Community reinforcement	3	3	9
Motivational interviewing	1	7	9
Relapse prevention	1	7	9
Social skills training	4	1	9
Behavioural / marital	3	1	7
Brief intervention	2	2	6
Behavioral self-management	1	2	4
Community reinforce + vouchers	1	2	4
Behaviour contracting	1	1	3
Biblio- (self-change + manual)	1	1	3
Methadone + psychosocial	1	1	3
12 steps facilitated		3	3
Aversion therapy		2	2
Covert sensitization		2	2
Individualized drug counselling		2	2
Matrix model		2	2
Stress management training		2	2
Supportive-expressive psycho-therapy		2	2
Behaviour therapy adolescents		1	1
Client-centred counselling		1	1
Cue exposure		1	1
Day treatment, abstin + vouchers		1	1
Group therapy		1	1
Intensive case management		1	1
MDFT – adolescents		1	1
Multi-systemic therapy (MST)		1	1
Therapeutic community		1	1
Voucher reinforcement in MMT		1	1

Table drawn from: Miller, W. R., Zweben, T. J., Johnson, W. R., (2005) Evidence-based treatment: Why, what, where, when, and how? *Journal of Substance Abuse Treatment* 29, 267– 276

S-EBP: Review identified the treatment / intervention as being strongly evidence-based ++

EBP: Review identified the treatment / intervention as being evidence-based +

Total: - total no. of + for each specific treatment based on ten reviews

Treatments are arranged in order of evidence of effectiveness

Table 2. 2 – Treatment modalities with evidence of effectiveness

<i>Brief counselling:</i>	consists of a short sequence of scheduled counselling sessions during which the therapist assesses levels and patterns of drinking behaviour and provides advice around potential harms and assists the client to plan reduced or less-harmful drinking.
<i>Community reinforcement therapy:</i>	focuses on assisting clients to achieve abstinence from alcohol through eliminating positive reinforcement for alcohol and improving positive reinforcement for sobriety. This is achieved through building motivation, planning and setting goals for sobriety, rehearsing sobriety, initiating and evaluating tests of sobriety and involving significant others in the reinforcement process.
<i>Motivational enhancement therapy:</i>	focuses on people’s own motivation to change with therapists adopting a facilitative, non-confrontational role. Therapists help clients clarify their own views and attitudes towards drinking and to develop an understanding about their own core values and their drinking behaviour and in developing their own impetus to change, as appropriate.
<i>Social skills training:</i>	this intervention focuses on teaching clients the skills needed to avoid problematic drinking situations; to develop alternative coping mechanisms for dealing with stressful situations that might otherwise lead to drinking, to deal more effectively with relationships and to become more assertive in everyday situations.
<i>Behavioural therapies:</i>	are derived from learning theories and focus on cognitive processes for developing drink-avoidance techniques, thereby encouraging clients to re-shape their thinking in relation to drink, replacing thoughts about drinking with other thoughts, developing stress management and also developing a positive outlook towards non-drinking.
<i>Behavioural family therapies:</i>	are interventions where the family, partners or significant others in a client’s life, are treated alongside and in conjunction with the client, and where the focus is on relationship dynamics and their re-structuring in support of other, drink-related behavioural objectives.

All of these treatments, summarised in Table 2.2 are consistent with public health, community-based models of intervention, and although they can be provided in either outpatient or residential settings, community settings are less costly and also offer the

best prospects of attracting into treatment persons whose problems do not prevent them from full normal functioning, thus it does not become necessary for such persons to cease working or education, or to move away from their families.

These approaches to treating alcohol problems provide encouragement to shifting from intensive treatments – both in-patient alcohol disorder and specialist Minnesota Model treatment - towards a less-intensive, eclectic range of interventions, provided within the context of a stepped-care model of service. Such approach potentially transforms the model of alcohol treatment from that of *treatment services* to *systems of care*, wherein alcohol problems are managed in much the same manner as chronic medical conditions such as diabetes or hypertension, that is through ongoing systems of case management, with fluctuations in intensity of care linked to changes in the presentation and seriousness of problems.

In a reflective paper: *Is "Treatment" the Right Way to Think About It?*, Miller (2002) proposes a re-think in how health care systems conceive and manage alcohol (and other substance misuse) problems; he highlights the critical importance of primary health care, social care and community systems in providing ongoing contact, support and encouragement to persons with substance misuse problems, and argues that in the dominant, specialist literature, these systems are referred to as after-care, and are attributed a high level of importance in maintaining the gains that have been achieved in acute treatment, leading to the following propositions:

Acute Treatment + Aftercare = Improvement

Acute Treatment with no Aftercare = Poorer Outcome

Miller suggests alternative propositions that underline that the essential component to treatment is Aftercare, which he re-names Continuing Care. Thus:

Continuing Care = Improvement

No Continuing care = Poorer Outcome

Miller's propositions significantly reduce the importance of acute specialist treatment, although he suggests that acute specialist treatment might be considered a "forecare" or a "prelude to effectively addressing the problem" (23), in much the same manner as detoxification is so considered. Miller argues that in the same way that an acute episode of inpatient treatment for diabetes, hypertension or heart disease, would not be expected to resolve these problems, so too acute episodes of treatment should not be considered "necessary and sufficient in resolving substance use disorders" (Ibid) – fundamentally, there are no magic bullet solutions to alcohol problems. Miller's main arguments in support of his propositions, drawing from studies cited below, are:

- Despite the evidence of clinical research studies highlighting the benefits of treatment, people overcome their alcohol problems through a variety of different ways (Fletcher, 2001), and population studies show that most of these changes take place outside of formal treatment (Vaillant, 1983).
- The stages of change that people pass through in dealing with their problems of addiction are much the same in *both* formal treatment *and* natural processes of change and recovery (Prochaska et al., 1992).

- The literature on brief interventions highlights that most change in formal treatment takes place during or as a consequence of the first stages of intervention (Miller, 2000).
- Random assignment to inpatient vs outpatient or longer vs shorter treatment shows similar results (*Broadening the Base of Treatment for Alcohol Problems*, 1990; Miller and Hester, 1986a; Project Match Research Group, 1998).
- Radically different treatments can yield very similar positive results (Project Match Research Group, 1998).
- Treatment can work even though the desired effect of specific interventions was not achieved, for example people can do well as a result of social skills training even though the training did not result in them acquiring the intended coping skills to avoid alcohol (Morgenstern and Longabaugh, 2000).
- Therapists have an important role in determining treatment outcome (Miller et al., 1980; Najavits and Weiss, 1994) with differences in empathy having more importance than education or experience (Miller and Baca, 1983; Valle, 1981).
- Pre-treatment client characteristics and the characteristics of their post-treatment environment have more impact on client outcomes than specific treatment factors (Moos et al., 1990).

Taken together these varied factors provide convincing evidence for Miller to look beyond time-limited, in-patient, specialist treatment, which dominated the treatment of addiction problems in the US since the 1940s, toward a more generic, eclectic model of care, based on public health principles. He also argues that an added momentum for change is fuelled by changes in US health economics, whereby health care and management decisions were transferred from service professionals to managerial systems (managed care). While the new system is driven by a managerial, rationalist ethos, and its sweeping cost-cutting measures are open to criticism, Miller

argues that it brings a badly-needed “jolt” to review the way in which substance misuse interventions were being provided and to seek greater comprehensiveness and integration with other health and social services, which after all were encountering persons with alcohol and drug problems through a concern with other personal and social issues, such as general health care, child care and protection, probation and criminal justice (Weisner, 2002).

Of particular importance, Miller argues is the need to understand alcohol and drug problems within the “broader natural context” of these other concerns, “rather than as an isolated and decontextualized problem”(2002, 24); in this sense persons presenting for specialist treatment have a range of other problems or issues that are unlikely to be addressed through exclusively focusing on their alcohol or drugs problems. He further argues that substance misuse interventions that consistently show positive results in meta-reviews, such as those identified above, tend to be focused around wider issues of personal and social functioning rather than substance misuse behaviour *per se*. The logic of these findings, and indeed the general logic of the public health model is that alcohol (and drug) treatment services need to be more comprehensively integrated with mainstream, primary health and community social services.

The main implications in moving forward in developing such comprehensiveness, according to Miller are:

- The introduction of routine screening for substance misuse problems within health and social service systems;
- A co-ordinated, case management system within health and social services for substance misuse problems, drawing from a stepped-care model of care;

- The integration and co-location of substance misuse services with other services in the community;
- The need for in-service training across a wide range of health and social service providers who regularly have contact, for other health care, welfare or psychosocial reasons, with persons with substance misuse problems.

The third WHO report (Babor et al., 2003), referred to above, which provides a comprehensive update of the public health framework, including treatment, for dealing with alcohol problems, is generally supportive of Miller's position. In its review of policy measures, the report, which draws from epidemiological research to report on alcohol's 4% contribution to the global burden of disease (9% in western developed countries), applies an evaluation assessment for rating seven separate broad sets of prevention and intervention strategies according to their evidence of effectiveness, their breadth of research support and their cost to implement and sustain. Measures considered to be achieving highest evaluation standards include taxation and pricing and regulating physical availability. Education, persuasion and regulation of alcohol promotion achieved a relatively low evaluation standard. Treatment and early intervention achieved an average standard. None of the treatment measures considered achieved a high level of effectiveness and only brief interventions - low threshold, opportunistic, non-specialist interventions usually undertaken through primary and community care personnel - achieved a moderate level of effectiveness, with moderate costs. Costs of treatment are assessed as low (for self-help), moderate (for brief interventions) and high (for specialist alcohol treatment interventions).

Babor et al's (2003) cautious evaluation of alcohol treatment and early intervention potentially casts some doubt on the efficacy of treatment, particularly given the seemingly superior value of taxation and other control measures. Despite these limitations, the report is rather optimistic about the value of treatment, arguing that treatment needed to be considered within the context of a holistic model of prevention and whilst treatment responses are designed and directed with individuals in mind they potentially have wider impacts at community and population levels, including:

- raising public awareness about alcohol problems
- helping to set a policy agenda at national and community levels
- involving health professionals in prevention roles
- providing supports to families
- providing secondary benefits to other community members such as employees and car drivers.

From the above review of the public health approach to alcohol it is clear that a wide variety of interventions are proposed for tackling alcohol-related problems, including both broad population measures, as well as more focused and targeted responses to individuals with harmful drinking, as well as dependency problems. It is suggested that the disease model is too narrow a conception of alcohol problems and that by focusing on a small number of persons carrying the disease it can help reduce societal concerns for broader problems. The public health model is derived from a considerable body of empirical and theoretical research and in particular there is a strong evidential basis to supporting a range of treatment interventions that can be provided outside specialised, health care service systems and with the direct engagement and involvement of primary and community care personnel.

IMPLEMENTING THE PUBLIC HEALTH MODEL

It may reasonably be concluded from the previous two sections of this literature review that the evidence base for the public health approach to conceptualizing and managing alcohol problems is quite compelling, while research support for the more traditional disease concept is considerably weaker. Before concluding this chapter, however, it is important to map out what could be the features of a public health model and also to look at the extent to which this research has influenced public policy and service provision in other jurisdictions.

In their important report Babor et al (2003) advocate the need for comprehensive treatment systems, developed within public health, as distinct to specialist models. The report cautions however, that while an extensive, international literature is now available to help guide the development of treatment systems, treatment continues to be determined not by a rational assessment of best evidence, but often by compassion and the desire to help people, to help individuals. They point out that treatment driven by compassion, not by rationality, is not likely to achieve public health potential. The report's authors are clearly aware that while there is strong evidence in support of the broader, public health approach, that this evidence is not new and that despite the existence of this evidence, many treatment systems have developed along alternative lines, guided at times, more by emotion engendered from focusing on the exceptional

circumstances of extreme, and often public cases of severe alcoholism and dramatic recovery, but limited attention to the greater number of ordinary problem drinkers whose aggregate drinking behaviours have much deeper, and often more far reaching effect on, and cost to, society.

Conscious of these difficulties Miller (2002) puts forward a number of proposals on the main steps that need to be taken to develop integrated care systems, in this case for both alcohol and drug problems – referred to together as substance misuse problems. His proposals are made in the context of a critical review of specialist treatment systems. Blumenthal *et al* (1993) put forward a similar framework for developing a comprehensive, integrated treatment system for drug and alcohol problems. The work of both writers is underlined by the need for levels of intervention that straddle screening, assessment and case management issues and the need for variable community and specialist services; the issue of vision, direction and structures for service development is also referenced.

First, it is argued that a comprehensive, integrated system requires a clear sense of vision and direction and that there are in place executive and management structures capable of planning and delivering programmes that are consistent with this vision and of ensuring accountability and compliance with monitoring and evaluation.

Second, it is argued that persons who use the main health and social service systems need to be regularly and routinely screened for drug and alcohol problems. The overall prevalence rates of these problems are sufficiently high to warrant widespread

screening and given that these rates are likely to be even higher amongst persons who regularly attend health and social service systems, there is a compelling argument for introducing screening within these systems.

Third, a range of treatment services, with varying levels of intensity, corresponding to the severity of problems encountered needs to be available. This may be described as the stepped-care model as outlined by Sobell & Sobell (1993). Prospective clients need to be able to access those services that are most appropriate to their needs and to have a continuum of care according as their situation progresses or remits. In this sense treatment needs to be perceived not as a set of different treatment programmes but as a system with different treatment components, that could be provided by different agencies (voluntary and statutory) but have an overall coherence, a shared vision and direction and a common system for planning and development.

Fourth, the treatment system as a whole – as distinct to its different programmes – needs a coordinated mechanism for undertaking assessments and case management of clients. Prospective clients need access to the forms of treatment that are most appropriate to their needs in a manner that is consistent across the whole system. This suggests the need for a standardised assessment procedure and / or the creation of a single mechanism for case managing clients when they come into the system.

Fifth, specialist drug and alcohol services need to have both practical and visible linkages with primary and community care service providers in health centres, social service agencies and in community settings. There needs to be ongoing opportunities

for drug and alcohol personnel to work alongside community and primary care personnel, particularly in relation to providing brief interventions, organising home detoxification programmes, providing medication programmes and organising short-term counselling and psycho-social interventions.

Sixth, it is argued that expanded education and training for health and social service professionals be provided on an ongoing basis. Perhaps most importantly this involves training personnel in screening and brief interventions, as it is clear that the earlier the intervention the more likelihood it is that these problems can be overcome.

Having provided some mapping as to how a comprehensive treatment system might shape up it is important to reflect on the extent to which the strong and growing body of evidence in support of the public health model has succeeded in transforming the way in which, at policy level, alcohol problems are conceptualized and, at service delivery level, human services have responded to these problems? Have other countries moved substantially to a position where alcohol problems are conventionally viewed in terms of a spectrum of such problems - varying in type and intensity - and routinely managed by primary care or generic professionals, and not mainly by specialists in alcoholism or addiction treatment? The answer to this question is largely in the negative, as will be illustrated here by reference to some attempts to implement this new approach.

In the United Kingdom the publication of *Responding to Drinking Problems* (Shaw et al., 1978), still a highly regarded text, was seen as providing a rationale and impetus

for greater involvement of primary care professionals in the management of alcohol problems (Anderson, 2006). This was a report which did not see alcoholism as a unitary disease, and which offered practical suggestions - through its development of the concepts of *role legitimacy*, *role adequacy* and *role support* - as to how a range of generic workers could develop greater therapeutic commitment to working directly with drinking problems, as opposed to referring them on to specialist addiction services. This work, which had its origins in the Maudsley Alcohol Pilot Project, was a major influence on service developments in the United Kingdom during the 1980s, particularly through the establishment of Community Alcohol Teams - which were intended to transform the way in which generic workers approached these problems. As predicted by some (e.g. Baldwin, 1987), the Community Alcohol Teams did not succeed in this ambition, and the development in more recent times of the 'tiered' approach to alcohol treatment service provision (Raistrick et al., 2006) reflects yet another attempt to overcome the reluctance of non-specialists to work directly with drinking problems.

Similarly, in the United States, despite the clarity and logic of the Institute of Medicine's *Broadening the Base of Treatment for Alcohol Problems* (1990) no radical change has taken place in a society where disease concepts remain hugely popular and where residential rehabilitation systems still have considerable cachet (Peele, 1995; Miller and Weisner, 2002).

At the level of international collaboration, by far the most significant and telling results were those originating within the WHO's *Collaborative Project on Detection*

and Management of Alcohol-related Problems in Primary Health Care, which ran from 1982 until 2007 with the involvement of research centres in Australia and in 11 European countries. While this project showed that, under experimental or research conditions, family doctors could be helped to work effectively at early identification and brief interventions (EIBI) with problem drinkers, it ultimately produced “equally firm evidence of a failure to implement EIBI in practice” (Heather, 2007, 679). In other words, this WHO project never succeeded in institutionalizing therapeutic commitment to problem drinkers as an ongoing feature of primary care medicine.

In short, the international experience generally suggest that research evidence which supports the introduction of a public health approach to the management of drinking problems has not succeeded to any great extent in changing service provision in this regard. In all of the instances discussed here a combination of popular support for disease concepts and professional resistance to change has meant that, at best, limited gains have been made in changing the style of health service response to drinking problems. In light of this international experience, the action research reported in this thesis started with a clear acknowledgement that the health board being studied should anticipate difficulties in its ambitious attempt to develop an evidence-based response to alcohol issues within its functional area. Whether management commitment at regional level could hope to combat resistance to change remained to be seen.

CONCLUSION

By way of analysing the main literature in alcohol treatment this chapter has reviewed two overarching models: the disease model of alcoholism and the public health model of alcohol-related problems. There are clear differences between these. The former claims alcoholism as a unitary disorder, causing some, but not all persons to develop an addiction, a loss of control, or inability to stop, that can only be effectively dealt with through developing a lifetime abstinence from alcohol. Informally, this process of recovery can be facilitated through self-help and mutual support, particularly through the involvement of bodies such as the AA fellowship. Formal treatments based on the disease model, often referred to as Minnesota Model programmes however have become an established, specialised component of alcohol treatment in health care, in both psychiatric and non-psychiatric, residential systems.

The public health model is more eclectic and tends to see alcohol problems from varied perspectives and dimensions; addiction is acknowledged as a particular, but not the only problem, and a wide variety of broadly-based interventions are advocated; the model also upholds the role of the non-specialist health and social care professional. Although, there is strong research evidence in support of the public health approach, the disease model is quite embedded in society, so that the transformation of alcohol intervention systems to reflect this research evidence poses significant public policy challenges, and indeed there is some evidence that the transformation has quite simply not occurred. Developments in alcohol policy in

Ireland, particularly over the last 20 years or so, have reflected these challenges, which are explored later in this study. However, before proceeding to a more contextualized, case-study discussion of these issues, the general framework for conducting the study is outlined in the following chapter 3 on methodology.

Chapter 3: Methodological framework and methods of data collection and analysis

INTRODUCTION

The methodological framework for undertaking this study draws influence from realist research as outlined by Anastas (1999), Kazi (2003) and Robson (2002). Methodologically the study is concerned with evaluating policy on the treatment and management of substance misuse problems within a single Regional Health Board: more specifically it is concerned with how an alcohol treatment system favoured a disease model in service development, despite a lack of evidential support for this model and where there was substantial evidence and policy agreement in support of an alternative approach, alongside considerable effort by both management and practitioners to introduce this alternative. The study uses a mixed methods approach. It uses qualitative data, drawn from focus groups and key informant interviews with addiction and other professionals, in order to explore the background to service provision and the many factors contributing to or impinging on policy change and development. There is an action research dimension to the collection and analysis of this qualitative data. The study also draws from a secondary analysis of national and regional quantitative data on alcohol psychiatric hospital admissions, specifically in order to identify and elaborate on trends in the implementation or not of a policy decision to reduce such admissions.

This chapter outlines the methodological framework, or paradigm that provides guidance to the study, together with summarizing the specific methods used in the collection and analysis of study data; methods of data collection are not paradigmatic but basically constitute a set of procedures – such as observations, interviews, questionnaires – for collecting and analysing data; the choice of method follows from the specific research paradigm in which the study is set. Issues of method are returned to later in this discussion, which for now focuses on paradigmatic differences and their general impact on evaluation design.

PARADIGMATIC DIFFERENCE – POSITIVISM AND INTERPRETIVISM

By way of commencing this discussion on methodology, it is useful to locate the study's data collection model within a general classification of evaluation approaches and methods. It is important to note that there is no single definition of evaluation research for any specific practitioner field within the general area of human, social and community services and programmes. Attention is drawn therefore to the idea of different models, and while acknowledging that this diversity contributes to a rich discourse about evaluation practice, it also contributes to the often contentious debate on the different ways in which social research knowledge is constructed (epistemology) and contrasting beliefs about the nature of social reality (ontology). The debate underlines a traditional divide between those – including many adherents of evidence-based practice - who support the role of experimentation in generating facts about social programmes and their outcomes (Campbell, 1969) and others who

emphasise the interpretation of stakeholder meanings and values (Lincoln and Guba, 1985). An engagement with these philosophical differences has also brought focus to the idea of multiple ways of knowing and to the use of mixed methods in order to develop new insights into the operation of social programmes and policy implementation (Greene, 1997)

Differences in how evaluations are conducted reflect variable starting assumptions and contrasting beliefs about the value of different methods. Paradigms help to define these issues by guiding how a social enquiry is framed, what questions get asked and “where to look for the answers?” (Rubin and Babbie, 2005, 38). Essentially, a paradigm

..frames and guides a particular orientation to social enquiry, including what questions to ask, what methods to use, what knowledge claims to strive for, and what defines high quality work (Greene, 1997, 6).

Various paradigms are postulated within philosophical research debates (Hughes and Sharrock, 1997; Williams et al., 1996), but three – positivism, interpretivism (or constructivism) and realism - tend to dominate contemporary evaluation research discourse (Stern, 2005).

Positivism accepts the ontological position of being (Chia, 2002), that is the position of social reality existing outside of the individual and as having some stable, identifiable features: “an existence that is independent or separate from actors” (Bryman, 2004, 16). Valid knowledge of this reality is derived from observation and measurement and unambiguously represented through language, ideas and symbols

(Bentz and Shapiro, 1998, Appendix, 177-85). The essential epistemological principle in this approach to research is that objective enquiry is possible; the standard for research validity, for drawing a distinction between scientific and normative conclusions, is the rigorous application of quantitative, mathematical, and therefore, it is implied, value-free techniques (Bryman, 2004).

In positivist evaluation, researchers are concerned with the relationship between the programme, intervention or policy being evaluated (independent variable) and others, such as the characteristics of programme designers, providers or participants, (dependent variables), who could be individuals, groups or organisations; typically, purposeful alterations of the independent variable are used to assess their impact on the dependent variable. In social programmes the focus of researchers is on whether alterations in policies or interventions have differential impact on their targets, with whether they cause “change to occur in the outcomes” they were “designed to influence, and whether any such change has occurred in the right direction” (Government Social Research Unit [UK], 2007, 7:3). For example does a multi-component, system-level programme for reducing alcohol consumption and improving alcohol regulation and monitoring lead to a fall in the number of alcohol-related deaths, illnesses and social and psychological problems? (Holder, 1998).

Interpretivism is derived from a separate ontology to that of objective *being*; that is an ontology of *becoming* (Chia, 2002); this ontology assumes a state of social chaos, ambiguity or fragmentation whose meaning cannot be objectively represented or ordered in the same manner as the natural world, as it lacks structure or stability, has been constructed subjectively, and sometimes unconsciously, and can only be

understood through interpretivist or constructivist epistemology and with an appropriate appreciation of the role of research and of the interactions between researchers and subjects, in constructing meaning (Berger and Luckmann, 1967; Guba, 1990). Interpretivists do not view knowledge as value-free, but as variable and subjective, and contextually-bound.

Interpretivists argue that research needs to provide a way of understanding how meanings that lie behind reality are constructed and mediated. Social meanings therefore, need to be understood from the subject's perspective, that is by trying to enter the world of a subject or set of subjects – such as those who are perceived as having alcohol problems and as needing an intervention and those who are deciding alcohol policy and providing such interventions - usually through the use of qualitative as distinct to quantitative approaches to research enquiry, such as ethnography, heuristic enquiry and discourse analysis. In a study of Alcoholics Anonymous (AA) for example, Rudy (1986) spent 16 months of participant observation attending AA meetings and visiting AA members in their homes and also attending various care facilities that incorporated AA philosophy and ideas. On the basis of this research, Rudy suggested an alternative conception of alcoholism as “a characterization attached to drinkers by others when those others question the drinker's behavior and when the drinkers lack the power or desire to negotiate another explanation” (99). In this characterization, Rudy departs from a typical positivist taxonomy of alcoholism and provides an important illustration of the constructivist contention.

Constructivists suggest there is no objective, fixed state of social problem, such as addiction leading to precise definitions for positivist research. Indeed variable patterns of beliefs towards alcohol behaviour add to the constructivist position that these problems are pluralist. In any single study therefore many interpretations can be made and addiction exists in so far as an individual experiences it or ascribes meaning to it, but there is no objective measure of addiction. Thus the medical definition of alcohol problems that is so central to the viability of experimental research does not stand up within an interpretivist critique wherein it is contested and therefore difficult to apply within broadly defined, treatment systems (Gusfield, 1996; Reinarman, 1988; Room et al., 1984).

Positivism and interpretivism provide divergent frameworks for initiating and undertaking research for policy development and evaluation, each providing justification through posing separate philosophical questions: one concerned with the relationship between objectified, observable, measurable variables; the other more pre-occupied with subjective meanings and intentions. Contrasting intervention insights are provided through their separate application. A pragmatic perspective suggests the utility of multiple methodologies and increasingly both approaches are used in evaluation design albeit often in separate studies (Parry-Langdon et al., 2003; Greene, 1997; DePoy and Gitlin, 1998). The *United Kingdom Alcohol Treatment Trial*, for example, included a separate qualitative research design (Orford et al., 2006). A review of best practice in adolescent substance misuse treatment services in the US also included a qualitative research component (Currie et al., 2003). A closer integration of both positivist and interpretivist research is advocated in the realist, pluralist model of research (Robson, 2002) and is legitimated in realist research for

both pragmatic reasons and also through realism proclaiming a separate methodological philosophy (Anastas, 1999).

REALIST EVALUATION

Because it provides a structure for the use of both positivist and interpretivist methods, *realism* can be represented as a compromise between these two traditions, although it does claim its own philosophical position in relation to ontology and epistemology. The *ontological position* is that an objective reality is presumed in our actions, it is *intransitive* and exists independently of individual cognition or perception (Sayer, 2000). In contrast, the *epistemological position* is that the concepts that people use to refer to the social world are *transitive*, and are “formed through historical and culturally determined understanding that changes over time” (Scocozza, 2005, 241). Thus, while accepting the existence of a social reality, realism questions whether this reality can be objectively known, thereby suggesting that research knowledge is always tentative, subject to contextual variation – across both time and space - and therefore not easily transferred (Pawson and Tilley, 1997) or capable of determining practice choices in given situations (Frost, 2002).

Like positivism, realism accepts there is an objective reality but disputes that knowledge of this reality can be provided only through the collection and analysis of quantitative data. Social reality it is argued can be explained by variable theories or discourses, although this does not mean that social reality itself is variant. The fact

that social researchers change their minds about social phenomena that they study does not mean that the phenomena change. Using an analogy, the fact that society historically moved from a flat earth theory of the physical world to a round earth theory does not mean that the shape of the world changed; what has changed, and continues to change, is how science references the world (Sayer, 2000).

In accepting that the world *is*, and not dependent on current actors' subjective acceptance or understanding, realism is juxtaposed with forms of social constructivism, such as post-modern relativism, that hold that a subjective construction of the social world cannot be transcended, or objectively represented. Realists argue that individuals are confronted by objective social conditions that they did not create, but which they can transform through intentional actions, thereby setting the future social conditions for others. In this sense, realists, while disputing the claims of relativists, take serious the notion of agency, that individuals are social actors and that, for example, observed changes within social programmes are not simply the consequence of given programme components but of the varied actions of individuals – programme participants and providers - operating at different levels.

Realists also argue that the mechanisms that generate change, for example in social programmes, are not always easily observed. The existence of things is not dependent on them being observed, so rather than rely on observations in order to make claims about reality, the realist argues that it is possible to make claims about unobserved entities – about what is real - by reference to observations about effects, which are explained as the products of these entities. Scientific method therefore can transcend everyday transitive knowledge and thereby reveal particular characteristics of an

intransitive world, such as organizational power, that are not, otherwise, observed (Sayer, 2000). In this regard one can identify and discuss unobserved organizational issues through observing their consequences in certain circumstances; probing deeply into and making sense of these issues even though they cannot be observed, and even though the acquired knowledge is often tentative, imperfect and fallible. Such probing cannot be undertaken through reliance on the methods of positivist science, thus realists support the application of interpretivist methods of enquiry, alongside positivist methods, in certain circumstances.

References to “black, “grey” and “white” box evaluations terminology are used as a way of understanding the difference between realist and other research (Katz and Pinkerton, 2003; Scriven, 1994). Experimental research focuses on intervention effects and outcomes in order to generalize and to make claims about causal laws, but with little consideration of programme components or processes, which are referred to as the “Black Box”. Grey box evaluations examine the programme or service components through in-depth interpretivist research, but without providing a structured analysis of underlying, common effects or outcomes. In realist research, white box evaluations are concerned with both effects and components and with making connections between these: with opening up the “Black Box” not for the purpose of generating causal laws but in order to seek internal explanation for causes of change even though these causes cannot be observed. Such causes could, for example, include potential for change, thus leading to the generation of theory about how change can occur – *given the right conditions*. The realist evaluation agenda therefore is framed not simply by the single question of ‘what works’, but is rather more pluralist: concerned with what works in what contexts and through what

mechanisms; in the context of this study this approach can be re-framed in the context of asking: *What contextual factors have contributed to or inhibited policy and organizational change in the treatment of alcohol problems?*

FOUR MODELS OF EVALUATION

The thrust of this chapter so far has been to broadly outline paradigmatic differences in the conduct of programme evaluations, including the evaluation of alcohol treatment interventions and policies. Drawing from the above outline, this chapter now proceeds to presenting a framework, or models of evaluation. Stern (2005) identifies four general approaches to evaluation, which together embrace many forms of evaluations across a variety of settings. The clustering does not provide a definitive classification, but it does help in providing a structured approach to describing the main approaches to evaluation and it is also consistent with a similar framework for health-based evaluations, as outlined by (Ovretveit, 1998). The four models are summarized in Figure 3.1 below and are also briefly described.

Causal / experimental

Experimental studies such as Randomised Controlled Trials (RCTs), and other modified or quasi-experimental studies, draw from the positivist tradition and focus on assessing quantified outcomes across various programmes in order to ascertain relative efficacy. In this approach to evaluation, programme components are reduced

to variables that lend to observation, quantification and measurement; standardised instruments are used at separate points before, during and after the programme's study period. In order to minimise the influence of external, non-programme variables, research subjects – which may be individuals, groups, organisations or communities – are randomly assigned to either the programme or an alternative or no programme; in non-randomised, quasi-experimental studies matching comparison groups are used instead. Measurement results are statistically tested and analysed. Through this high level of control and pre-design, researchers use their findings to hypothesise about what causes change in a programme. Data is cumulated across many similar studies and results are also generalised to wider populations. While this experimental approach suggests a rather mechanistic view of the social world it nonetheless retains a dominant position within evaluation research (Davies et al., 2000; Stern, 2005; Gomm and Davies, 2000). Indeed, the expanding academic discourse about evidence-based public policy, which is fundamentally a discourse about 'what works?' is hugely guided by the 'systematic review', a synthesis of individual studies of this type (Oakley et al., 2003).

Allocative / economic

The approach here, which builds on the experimental model and uses the same basic techniques, is to assess the relative costs of alternative programmes, thus assessing cost effectiveness and efficiency in addition to outcome efficacy. This involves quantifying the resources that would be required for a particular programme, relevant to other or no programmes and then putting an economic value on the consequences,

in terms of resources saved as well as those that are used. Costs and consequences are assessed relative to other programmes or to no programmes.

Management / performance

In management performance studies the main focus is accountability and assessing whether a programme operates according to agreed standards, procedures and targets. Various methods are used for collecting data including modified, non-experimental assessments addressing inputs, outputs and outcomes; these would usually take the form of cross-sectional surveys of providers and programme participants. Additional data might be collected through semi-structured interview or through focus groups or through site visits. This is a very common approach to evaluation research and, compared to experimental research, it represents a less costly and quicker way for policymakers to get information back about their programmes in order to justify their next decisions within a policy cycle.

Developmental

Developmental evaluations draw mainly from interpretivist research and focus on assisting programme providers to assess what is going on within programmes, to improve the programmes and to make them more relevant to their immediate target groups. The main method of enquiry is qualitative; at its most systematic this could involve a detailed ethnography or action-research study whereby the researcher becomes immersed into the everyday operation of the programme or aspects of the programme or a particular policy. Semi-structured interviews, focus groups, other

groups, document analysis can also be used. Various studies use small scale surveys and these can help to provide a quantitative dimension to the programme, such as numbers of participants, activities, outcomes and so forth. A participatory action research model could also be used by way of engaging targeted individuals, groups and communities in conducting their own evaluative research, thereby giving voice to the participant within programmes that value this dimension. One of the main limitations of developmental studies is that they do not lend to generalization, that the results of evaluation within one particular context do not apply to another context.

Figure 3.1. Models of Evaluation

	FOUR BROADLY DEFINED MODELS OF EVALUATION				
	1. Causal / experimental	2. Allocative / economic	3. Management / performance	4A Formative	4B. Participatory
<i>Positivist</i>	Experimental with a focus on effects and outcomes	Experimental with a focus on input and output costs	Cross-sectional surveys with a focus on inputs and outputs	Cross-sectional surveys with a focus on provider / participant self-reporting	
<i>Interpretivist</i>	Preliminary process studies to help identify issues and definitions for larger, experimental study		Process studies assessing inputs, outputs (qualitative interview and focus groups, site visits, document analysis)	Process studies, with a focus on progress and outcomes (ethnographic, qualitative interview, focus groups, document analysis)	Process – participant voices
<i>Realist</i>	Realist experiment – using mixed methods to explore context and mechanisms for generating change				
			Small – scale evaluations – using mixed methods, including action-research, to generate knowledge about change: THIS THESIS		

As outlined in the introduction the overriding purpose of this study is to evaluate policy implementation at programme management and practice levels. The study is framed within a realist paradigm; one that accepts objectifying alcohol and addiction problems, although drawing attention to their variable historical and cultural contexts, and bringing focus to mechanisms for bringing about policy change. Within this realist model contrasting approaches to undertaking the study could be suggested. For example, one particular approach is a realist experiment whereby a specific alcohol policy change within a particular context is intensively tracked over a period through collecting both quantitative and qualitative data. Such a study might be described as a combined quasi-experiment and process evaluation. To initiate such study however, would first require an alcohol policy decision and second a decision to undertake a prospective evaluation of this policy decision from its commencement. At the outset of this particular study neither of these prospects were evident in relation to alcohol treatment policy; indeed the author was drawn into the study by way of retrospectively finding some explanation as to why policy developments had not brought desired changes. As outlined in the review of literature in the introduction to this thesis however, it was evident that a number of relevant policy decisions had previously been taken although there was no evaluation research dealing explicitly with these developments.

A retrospective case study – located as a form of developmental-formative evaluation in Figure 3.1 above - emerged as an appropriate way to proceed, and this particular approach underlined the author's initial engagement with this study. However, in tandem with this early engagement a specific request emerged from within a relevant organizational system – in this case a Regional Health Board – for the author to assist

the organization in dealing with internal difficulties arising from the implementation of policy. In this regard the Regional Health Board's concerns related to a broadly-defined addiction policy; however it was clear that the overriding concern within this policy, as defined regionally, was alcohol. The author agreed to provide the Regional Health Board with the required assistance and also negotiated with the health board that he could use data collected in the course of providing this assistance as material for his study. The study therefore took some influence from action research and reflected the realist approach of intentionally intervening in a given system.

Action research is underlined by a realist, pragmatist philosophy (Levin and Greenwood, 2001; Shani et al., 2004), but also draws from constructivist epistemologies (Kemmis, 2001; Lincoln, 2001) and critical theory (Hall, 2001; McNiff and Whitehead, 2002). It is referenced in realist research and Robson (2002, 41) argues that realist research "provides a third way between positivism and relativism". Greenwood and Levin (2007) draw from both systems theory and pragmatist (realist) thought in their introductory text to action research in organizational learning. Coghlan and Brannick (2005) state that critical realism as outlined by Johnson and Duberley (2000) aligns with their approach to doing insider action research, and similarly Winter & Munn-Giddings (2001) present a critical-realist theoretical model for a collection of health and social care action research case studies.

There are two broad categories of action research: participatory action research, involving members of a social group or community using a self analysis of their own data to change or transform power relations (Boog et al., 2003; Fals-Borda and

Rahman, 1991; Freire, 2000; Stringer, 2007; Whyte, 1990); and a second category that involves the application of research to organizational settings in order to evaluate or change organizational mission, focus, structure and communication patterns, or external relations (Coghlan and Brannick, 2005; Preskill and Torres, 1999). Both categories are separately concerned with the utility of research in solving problems that actors (or subjects), as distinct to researchers, have helped to define. The former category – located as *Developmental – Participatory* in Figure 1 above - is concerned with issues of exclusion and power, with moving “beyond dominant constructions of history” to link people’s lived experiences “to political contexts through critical reflection and action” leading to “sustained efforts for social change” (Finn, 1994, 27). The latter – located as *Developmental - Formative* is linked to what Susman and Evered (1978, 582) describe as a “crisis in organizational science” whereby improved quantitative research techniques are perceived as having limited use “for solving the practical problems that members of organizations face” and where there is a need therefore, for methodologies that assist researchers to work with organizations on issues that are of “genuine concern to them and in which there is an intent by the organization members to take action based on the intervention” (Eden and Huxham, 2002, 253). This study is focused on evaluating policy within an organizational and practitioner system that is providing treatment for alcohol-related problems and it is therefore, located within the second of the above action-research categories.

As already discussed the study was conducted within the context of a statutory, sub-national, Regional Health Board in Ireland. The study commenced in October 2003; the main fieldwork was completed during 2005 and the thesis was finalised during 2008. At the study’s outset key organisation stakeholders were Regional Health Board

management and practitioner personnel who had alcohol and drugs responsibilities; additional management personnel with limited responsibilities for alcohol and drugs were also involved. An organizational map for this study is provided in Appendix 1.

The author drew from a classic, seven-phase consulting model, as outlined by Wacławski and Church (2002), in devising an overall structure for this project, although in practice, the data collection and analysis adhered to an iterative, action-research cycle, as described in later section below. These seven phases are summarized as:

- 1 *Entry:* during this phase the author met with RHB representatives to discuss, in broad terms, an outline for his consulting and research roles.
- 2 *Contracting:* the author discussed and agreed with RHB the general structure of the action research, the type of activities involved (regional forums, focus groups, interviews, etc), arrangements for organizing meetings and feedback, the compilation of reports and the production of a more detailed study.
3. *Data collection:* the author engaged with Regional Health Board personnel at various levels, including regional meeting, sub-regional focus groups and individual interviews.
- 4 *Data analysis:* the author analysed and summarised data and prepared a preliminary report for discussion with Liaison Group, to discuss the next stage.
- 5 *Feedback:* author also undertook to feedback preliminary conclusions at sub-regional meetings of Regional Health Board personnel. Following this feedback the author finalised report, had further meetings with Regional Health Board at which it was agreed to convene a regional forum to outline the report's findings, conclusions and recommendations.
- 6 *Intervention:* various mechanisms were put into place to implement the report's recommendations
- 7 *Evaluation:* the success or failure of the exercise gets determined.

The researcher played an important role in moving the action research project through its various stages (see discussion of stages of data collection and analysis below); the process also involved ongoing discussion with Regional Health Board management and practitioner personnel: A Liaison Group was convened by the RHB to link with the researcher and met four times over the course of the research. While this Liaison

Group oversaw the action research it did not have a management function in relation to this process. The research was conducted independently and although the researcher had a consulting role with the health board, this role did not require the researcher to report to health board management, although clearly the researcher maintained ongoing liaison with management personnel.

It is important to note at this stage that a mechanism for supporting the implementation of recommendations arising from this process (phase 6 in the seven-phase consulting model outlined above) was not sustained. It had been envisaged that this study's author continue in a consultative role in this process and clearly this would have provided further opportunity for evaluating policy developments (phase 7). As will be explained in Chapter 7, various inter-sectoral difficulties within the Regional Health Board inhibited the full implementation of the action-research dimension to this study³.

Various internal Regional Health Board documents summarising policy discussions and internal administrative data on alcohol and drug treatment helped provide an initial shape to the study. Also, annual national mental health services' reports, based on National Psychiatric In-Patient Reporting System (NPIRS), which was established in 1971, provided regional and sub-regional figures on alcohol admissions to in-patient psychiatric services. The Health Research Board manages this database. A

³ A formal contractual arrangement for this phase might have helped ensure its continuance. However, the above outline was never formalized in a document. The main reason for this is that the arrangement, which involved the researcher in a dual role as consultant and researcher, did not fit standard health board contractual agreements, which would have required the researcher to provide an account or report on progress on a regular basis. While the researcher was happy to liaise with management in an ongoing manner, he was also concerned that the study's independence be maintained. He believed that a consulting contract would jeopardize the study's overall integrity. For its part health board management, given the overall importance it attributed to this work, was happy to proceed in the absence of a written contract.

preliminary analysis of recent reports helped to establish a context for conducting the study. The need for a more comprehensive analysis of this published data was identified in the course of the action research and is provided below in Chapter 4. The data used in these reports is based on returns submitted to NPIRS by psychiatric hospitals and units for each admission episode during any single year (any single patient could have a number of admissions, each of which is separately recorded, and submitted). The form used is standard across all locations, although clearly some variations are likely to occur depending on hospital decisions about assigning responsibility for form-filling, deciding when the forms are filled and also the procedures for deciding diagnoses that have multiple components. Despite these potential limitations the system has been in place for nearly forty years, it is regularly monitored through the efforts of the Health Research Board and the fact that reports are published each year provides some momentum for ongoing improvement of reporting standards. It can be deduced that the annual reports provide a reasonably accurate picture of long-term trends in psychiatric hospital admission, in this case admission levels for alcohol problems, over the period covered.

The principal methods employed in gathering new data for this study were direct consultations with organizational members through which the researcher and management and practitioner personnel exchanged ideas and claims about practice knowledge, theory and policy. These consultations took place formally in both group and individual discussion, drawing from two separate research techniques: focus groups and semi-structured interviews. These methods of data collection, which are now separately outlined, function as mechanisms for engaging with practitioner and management personnel in order to practically change the situation in which the

research is based and specifically, in this case, to bring about an improvement in the management and treatment of alcohol problems, while at the same time providing a framework to stand back and assess organisational change.

FOCUS GROUPS

Morgan (1997, 6) defines focus groups as:

a research technique that collects data through group interaction on a topic determined by the researcher.

A focus group is essentially a group interview technique that draws attention to a specific theme, which is explored in depth, and during which the interviewer, who brings focus to the group, is concerned with how individuals address this theme as group members and with how perspectives on this theme emerge or are constructed from within the context of group dynamics and interactions (Bryman, 2008). This is a key distinguishing characteristic of focus groups; by bringing together persons with a pre-existing perspective on interview themes, and by focusing their attention on common experiences, the researcher can get insight into complex issues that otherwise would not be available through individual interviews or other forms of data collection (Morgan, 1997). In this current study, management and practitioner personnel in the field of drugs and alcohol in separate county areas, or clusters, within a regional Regional Health Board structure, were twice brought together for focused discussions; broad themes relating to alcohol (and drug) problems were addressed during the first series of focus groups, while the second series constituted feedback to

more specific issues and recommendations relating to the development of community addiction services. This second round of focus groups also functioned as a mechanism for assessing the credibility of the researcher's analysis and feedback. The themes of both these groups arose within the context of the action-research cycle (discussed below) and its ongoing analysis of other specific discussions with key management and practitioner personnel.

Focus groups are to be distinguished from group interviews, usually a gathering of individuals for simultaneous interviewing in order to save time and resources and are also distinguished from nominal groups and Delphi groups (Stewart et al., 2007), which do not involve interaction between group members and are used as consensus-reaching mechanisms in prioritizing member issues and in forecasting.

Morgan outlines three uses for focus groups:

- As a self-contained method where focus groups are the primary source of data and as they form the basis of the study they need to be carefully planned, structured and designed so that they provide the data necessary to meet the study's aims.
- As a supplementary method where focus groups are used as a secondary source of data, either as a preliminary source of data used in the design or planning of further study using an alternative primary method, or as a follow-up source of data to clarify or expand on primary method findings.
- As a method of collecting data in a multi-method, qualitative study where no specific form of data collection dominates, and where use of a range of types – focus groups, individual interviews, participant observation – depends on the specific needs of the study, which can potentially change as the study progresses.

This current research tends towards the third of these uses where focus groups, individual interviews and other discussions formed critical elements in the action-research cycle. The study however, did not involve participant observation of the type that would have the researcher engaging with study participants to observe open-ended interactions in a variety of settings. Rather, observations in this study are more limited, and basically these were confined to verbal interactions during both group discussions that were set up and moderated by the researcher and Liaison Group meetings that were scheduled to facilitate and develop the research project and also provided a basis for commenting on preliminary findings. Clearly, such interactions are but a constituent of the overall interactions engaged in by participants in planning, developing and operating their work, many of which could never be re-created in the context of an artificially created and moderated discussion group (Morgan, 1997). Nonetheless, the focus groups used in this study did have a task that fitted participants' naturalistic processes for developing their work.

The following "rules of thumb" for focus group planning and design are suggested (Ibid, 34):

- (a) use homogeneous strangers as participants,
- (b) rely on a relatively structured interview with high moderator involvement
- (c) have 6-10 participants per group, and
- (d) have a total of 3-5 groups per project.

These "rules of thumb" are put forward not as an essential standard but as a descriptive summary". Each rule of thumb requires the application of a set of questions before proceeding, and these depend greatly on the type of study and the extent to which its conclusions are to be generalized. In broad terms this study was

undertaken according to three of these rules of thumb. Seven focus groups were conducted; eight were planned but one was discontinued without any data collection. Due to the level of interest in the topics being discussed one focus group had 16 members; the remainder had 5-7 members in attendance (see Appendix 2 for a breakdown of attendance at focus groups and at other research-related events)⁴.

The focus groups were moderated, according to a pre-determined structure and the researcher was highly involved in steering and facilitating discussion. Morgan discusses the trade-offs between highly-structured and less structured focus groups. In either case the moderator is highly involved in managing group processes: keeping a focus on a pre-determined agenda with highly-structured groups; and encouraging a more free and open discussion in less structured groups. Morgan (39) suggests that a high level of structure suits focus groups where there is a “pre-existing agenda for the research”, such as when the research questions are clear and there is a need to keep a focus on these questions. Less structured groups suit exploratory research where there is a need to get new information, new ideas and where there is an emphasis on hearing participant voices.

A number of factors influenced the decision about focus group structure in this study. The overall study was seeking new information and to this extent there was a need to maintain a relatively flexible structure. However, at an early stage it was indicated that too-flexible a focus group structure might not attract sufficient prospective

⁴ Separate to the fieldwork for this study, the author also, during 2006, conducted a series of four area-based focus groups specifically exploring the development of an adolescent treatment framework within the region. These latter focus groups involved both RHB and non-RHB personnel and constituted a separate exercise to this study, and although they were well attended and provided interesting insights into the development of local alcohol and drug services, data from these focus groups is not used in this thesis.

participants and there was a need therefore to provide a practical basis for bringing people together. This practical basis arose from a regional forum (see Chapter 7 below), which provided impetus for relevant, area-based personnel to come together on specific themes in the development of policy and services. The first round of focus groups therefore tended to have a moderate degree of structure consistent with the exploration of these pre-selected themes. The second round of groups had more structure mainly because these were focused on emerging themes and study recommendations. More open, flexible discussions took place during individual interviews. Separate interview schedule for both sets of focus groups are provided in Appendix 3.

It was not possible within this study to adhere to the use of homogeneous strangers as focus group participants. Participants were homogeneous, across certain criteria, but they were not, strictly-speaking, strangers. An important argument in favour of bringing strangers together is that interactions between acquaintances are often facilitated through tacit, taken-for-granted theories and assumptions that are themselves often the focus of study. In a focus group of acquaintances these assumptions may remain under-the-surface and the moderator/researcher is unable to pick up on them or explore them further. In a group of strangers, participants may need to make clear their tacit theories in order to ensure persons with whom they are not acquainted understand these, thus allowing for the researcher to explore the basis of these theories and assumptions further.

In the current study, participants were relatively acquainted: they worked within the same organizational structure and in the same geographical areas, although in

practical terms participants had different roles and functions and in two groups it was clear participants had little previous opportunities to meet and discuss issues of mutual concern. However, the “stranger” factor was not taken into account, or adhered to, in planning these groups as participant recruitment was based on the idea of bringing together inter-disciplinary professionals working on drug and alcohol issues irrespective of their shared knowledge of each other and of each other’s work or discipline. Their homogeneity related to their professional focus on drug and alcohol problems and the exercise of their functions within shared geographical areas, or clusters . All of the participants concerned were employed by the Regional Health Board and involved in the management or provision of services in the field of drug and alcohol problems, or related problems. It was taken-for-granted that each invited participant would have something to say in relation to the development of services and the implementation of policy. Lists of prospective focus group participants were drawn up by researcher in consultation with Substance Misuse Team (SMT) Coordinators and based on attendance of relevant personnel at Regional Forum; all area-based attendees at this latter forum were invited to participate in Focus Groups⁵.

⁵ The overall attendance at the Regional Forum was in excess of 50 persons; however, not all of these had direct responsibilities in the addiction area. Some had overall executive management functions and others were in an administrative support role. A few attendees represented the Department of Health and Children. In all 38 persons were identified as direct or indirect regional functions in relation to addiction and addiction-related issues. Thirty-five of these were subsequently invited to participate in focus group and other data collection events; three other relevant personnel who could not attend this Regional Forum were subsequently identified and invited to focus groups. The remaining three from Regional Forum were deemed to have central, executive functions and were not therefore invited to area-based events; however they were involved in other data collection events.

INDIVIDUAL INTERVIEWS

As in most social research the focused individual interview is a key method in action research. Although the interview is a complex, multi-varied research technique, because of its multiple applications, there is always the risk of it becoming a “taken for granted method of data collection” (Anastas, 1999). Its core purpose is to create a conversation between researcher and interviewee that generates data of use to the research. The interview can be broad or narrow in scope; it can provide in-depth accounts of a specific topic or theme, or it can deal with these in a relatively simple or superficial way; and, it can be concerned with reflecting views on preexisting hypotheses, or with generating new ideas or theories in relation to specific phenomena. The techniques required in interviewing differ according to whether the research is fixed or flexible, although both share common principles and procedures relating to getting respondent cooperation and increasing their motivation to provide the desired research information. Frankfort-Nachmias & Nachmias (1996, 239) outline three factors that can assist respondent cooperation and motivation in interviews:

1. *The respondents must feel that their interaction with the interviewer will be pleasant and satisfying.* It is up to interviewers to make respondents feel that they will be understanding and easy to talk to.
2. *The respondents need to see the study as being worthwhile.* The respondents should feel not only that the study may benefit them personally but also that it deals with a significant issue and that their cooperation is important. Interviewers should interest the respondents in the study by pointing out its significance and the contribution that the respondents can make by cooperating.

3. *Barriers to the interview in the respondents' minds* need to be overcome. Interviewers must correct misconceptions. Some respondents may be suspicious of the interviewers, seeing them as salespeople or as representatives of the government .

Robson (2002, 270) differentiates three interview types: structured, unstructured, or somewhere in between (semi-structured); structured interviews proceed according to fixed, pre-determined questions that are asked in a set-order and such interviews differ to questionnaire-based surveys only in so far as they provide for open responses to specific questions; semi-structured and unstructured interviews are commonly used in flexible (qualitative) study designs such as action research, and particularly where the interviewer is exploring respondent perceptions or historical accounts of changes and developments relating to particular phenomena, or the meaning of such phenomena as they relate to respondents.

According to Frankfort-Nachmias & Nachmias (1996, 234) the focused interview (semi-structured or unstructured) has four key characteristics:

1. It takes place with respondents known to have been involved in a particular experience,
2. It refers to situations that have been analysed prior to the interview,
3. It proceeds on the basis of an interview guide specifying topics related to the research hypotheses,
4. It is focused on the subjects' experiences regarding the situation under study

In semi-structured interviews the researcher has decided a broad set of questions in advance of the interview, but is prepared, as the interview progresses, to refine,

modify or abandon some or all of these questions, depending on their judgment of question-relevance or appropriateness (Robson), and also to explore variations and contradictions in question responses (Frankfort-Nachmias & Nachmias). This approach also allows interviewees to explore their own definitions of research concepts and situations as these are presented. During unstructured interviews, the interviewer is non-directive, allowing the interviewee to move the research discussion along, according to broad, general themes, but with no pre-determined questions (Robson).

A total of 44 RHB personnel attended either the regional forum or the first round of area-based focus groups, or both. Of these, 42 were followed-up for interview; the two remaining were senior executive managers who were not separately interviewed but who did participate at Liaison Group meetings, and aired relevant views at these events. Of the 42 who were followed up for interview, 27 (64%) (M=15; F=12) participated in direct interview, although in the case of six persons it was requested, and agreed, that these interviews, take place in 3 x pairs. Six prospective interviewees were uncontactable for follow-up interviews; three of these were locums and two were Mental Health Managers. Because of locum status and because the latter two persons worked in areas where other Mental Health Managers were interviewed, these particular interviews were not pursued further. The remaining uncontactable prospective interviewee was a consultant psychiatrist and it later emerged that this person was on sick leave, at the time. Three other consultant psychiatrists were unavailable for interview, and indeed no interviews with consultant psychiatrists took place at this stage. Two CAS Counselors, a Child Care Manager, a Child Psychiatrist and a SMT education coordinator were also unavailable for interview.

The individual interviews focused on exploring more deeply issues that had already arisen, in broader terms, in the course of focus group and other discussions. There was a relatively-fixed agenda of items that needed further discussion, so interviews were organised within a semi-structured model, whereby key issues requiring exploration were identified, questions relating to these issues were formulated and sequenced and various probes for eliciting further information were prepared. The schedule for individual interviews is outlined in Appendix 4.

INSIDER / OUTSIDER PERSPECTIVES

Alongside the various, standard preparations made for both focus groups and semi-structured interviews in this study, consideration was also given to the influence of insider / outsider perspectives on interview structure and techniques. Agar (1986) distinguishes insider meanings, which follow an internal cultural patterning, from outsider ideas, which are constructed through an external analysis of available knowledge. In positivist research, the distinction can be quite clear, as researchers tend to be quite detached from the systems of change. In action research, as with other forms of research that draw influence from interpretivist design, neither researchers nor researched necessarily represent respective positions in a pure sense. Rather insider / outsider perspectives are interchanged and both researchers and researched move along a changing continuum of insider and outsider perspectives, reflecting compatible or different cultures, backgrounds, training and values (Coghlan and Brannick, 2005; Reason, 1988; Shani et al., 2004).

The insider / outsider distinction can help make explicit the possible bias researchers bring to their framework of theory and analysis, thus providing a stronger basis whereby readers can assess the value and use of knowledge. It can also influence the way in which researchers structure their engagement with research subjects, how they structure research questions and how they subsequently check out their understanding of the answers given. In addition researchers can potentially bring their own insider organizational perspective, for example through the researcher's previous practitioner or management experience in similar roles; it is important that such perspectives do not impose on the study, but certainly it is important to make clear to research participants – through occasional and appropriate reference - that there is this background and context (Sands and McClelland, 1994).

The insider / outsider distinction can, and should, influence the way in which researchers develop and refine their research and pursue specific research questions. The researcher in this study had a previous background in practice, management and research roles dealing with addiction-related issues. This background therefore was referenced at the outset of open meetings, focus groups, and indeed, as appropriate, during individual structured interviews. Various issues also arose in taking account of insider / outsider perspectives in the preparation and framing of these focus group and interview discussions. The researcher fully explained each research engagement at its outset, and gave over time for questions and clarifications, making clear a preparedness not to proceed with the engagement if respondents were unwilling to. In fact arising from such concerns one focus group did not continue.

In preparing an engagement with Regional Health Board addiction personnel, the researcher was concerned not to pre-suppose or impose a generalized model of practitioner, management and administrative actions. It was important to recognise that research participants functioned as individuals in their organizations, each bringing unique perspectives and understanding of their roles and duties. Interviews were structured such that participants could represent and explore these perspectives in a systematic way; thus while the interviews reflected a pre-defined structure, they also varied as they progressed through separate individuals. For example, not every overriding question – as outlined in Appendix 4 - was pursued in any, individual interview. The researcher used the first overriding question as setting a context for the interview, and depending on the direction of answers arising from this question, interviews varied in how other overriding questions were broached and explored.

In addition to recognising individual, organizational roles, it was also important to acknowledge insider views on the policy process and to avoid assuming that participants' work, or that their understanding of this work, could fit one of any number of pre-defined policy positions. Rather, it was important that organizational members be able to tell their "stories" about their work, using a fluid, open-ended framework, and to build knowledge about policy through analysis of these varied stories. At the opening of each interview therefore, the researcher invited the interviewee to tell their own story of their involvement with addiction issues, both generally but more specifically in relation to the health board. This approach varied according to the level of direct interviewee involvement with addiction issues, for example, for an addiction counsellor (either CAS or SMT) the researcher posed this questions and subsequent probing questions - as follows:

Hi (name), you've worked as an addiction counsellor with the (Regional Health Board) now for how many years? (answer). I am interested in your background in this position?

Prompts

- What attracted you to it?
- What were you doing before coming into this position?
- What was the job like at the point at which you started?
- What were your expectations?

An alternative approach however was used with interviewees who did not have such direct engagement with addiction issues, but who were involved in an overall management position, in which the issue of addiction also featured. So, for example, in interviewing Community Care Managers, the background questioning proceeded as follows:

Hi (name) you've worked in Community Care now for how many years? (answer)
I'm interested in hearing how, in your role as health board manager, you first became aware of addiction problems?

Prompts

- When was the first time that these problems were represented to you as an issue you should be concerned with, and how was this representation made?
- What was your initial thoughts on realizing this was an issue you were going to have to deal with?

STUDY LIMITATIONS

As already mentioned an action research study is context-bound, and tends to focus on dealing with issues and problems in particular situations, such as a geographic location or a practice agency or setting. This focus is important in terms of engaging with research participants, representing their perspectives and generating new knowledge that would not be available through other forms of research. It is contended that these insights could potentially, transform such contextualized situations (Reason and Rowan, 1981; Whyte, 1990), thereby providing considerable justification for their limited, approach. The focus on situational context however, inherently limits the research's broader application or external validity. Such research findings cannot be generalized and the researcher's ability to comment on external developments outside of the study area are limited.

The contextualized approach however, can be used to make sense of, other situations. Eden and Huxham (2002, 257) stress the importance of this dimension, underlining that the "ability of the researcher to characterize or conceptualize the particular experience in ways that make the research *meaningful to others* is crucial" (*original italics*). As a result, other practitioners or stakeholders are able to use the research to inform practice in alternative situations and similarly other researchers can use it to generate new knowledge or theory development. From the outset of this study, and particularly in the context of data collection, it was continually emphasized there were two dimensions to data collections exercises: one concerned with the utility of research and reporting to assist the Regional Health Board move forward in implementing its agreed policies, while the second takes a broader view of connecting

the study to a theoretical framework, and although this process does not provide an adequate, generalised test of theory, it does nonetheless provide a basis for assessing the consistency of findings with those from other studies.

Potentially, the researcher's dual approach could have caused some role confusion at a number of levels within the study. At the level of the relationship between RHB management and the researcher, there was always the potential that the researcher would be perceived as an organizational consultant with a formal consulting contract with the RHB. This matter was discussed at an early stage and as already mentioned it was agreed there would be no contractual arrangement between both parties that would suggest such a formal role. Although the RHB nominally covered some research expenses, the researcher was not obliged in return to submit reports to RHB management; a draft internal report on the process, when it became available, was circulated widely among RHB personnel for discussion and comment before being finalized.

At the level between researcher and other stakeholders, the researcher always made clear, at each research event, his dual role. He clarified that in a regional report on the process he would not be making direct reference to focus group or interview data: it was always intended that such a report would summarise data in a general sense. He also clarified that although such data would be referenced in the wider, thesis study, this data would be treated in confidence and not used in such manner that could identify individual respondents. These clarifications helped secure stakeholder engagement with the study.

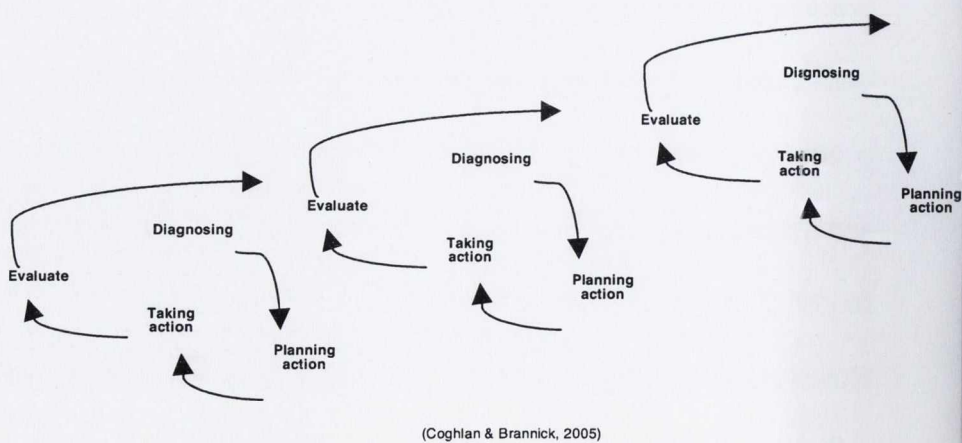
There were other, internal limitations to the study. There was, in particular, a lack of involvement by consultant psychiatrists in interviews. None agreed to be interviewed during the interview stage although some attended focus groups. Conscious of the absence of data from psychiatrists, the author made a later attempt to seek their views and perceptions during 2007. Three agreed to speak to the author, at this stage, one by telephone. Although these discussions helped clarify some issues and detail that had arisen in the course of study, they lacked the same action-research context within which other data was gathered and analysed and therefore had overall, limited value. It is important to note also that the overall contribution from one of the sub-regional county areas was limited, due mainly to the non-continuance of the first focus group and the unwillingness of some individual personnel to be interviewed.

Although the study was focused on addiction services, the issues it raised had potential relevance for a wider range of RHB personnel, particularly social workers and GPs. The prospective involvement of GPs was discussed at Liaison Group meetings where it was highlighted that previous attempts to involve this professional group in other issues had failed, despite putting a lot of energies into trying to get this involvement. There was a lack of enthusiasm for trying to get GPs involved with the process, although one GP did attend regional fora. The prospective involvement of other Community Care personnel such as social workers was perceived more positively. A Child Care Manager and Child Psychiatrist participated in regional fora and a focus group; some senior social work personnel, a community psychologist and funded youth work personnel also participated in a round of late discussions. However, the participation of non-addiction Community Care personnel was limited, reflecting a reluctance by professionals to become involved with addiction issues.

STAGES OF DATA COLLECTION AND ANALYSIS

In fixed design research, data collection and analysis tend to occur at different points; issues and themes tend to be pre-agreed and the selecting out of trends and patterns happens usually when all the data has been collected and collated. The process of analyzing qualitative data in this action research however was more process-oriented and linked to an ongoing dialogue between the researcher and stakeholders. This process, referred to as the action-research-cycle is perhaps the most distinguishing characteristic of action research, whereby the researcher is involved in different stages of planning an engagement with a system, intervening with the system and observing it, followed by further reflection and evaluation and in repeating the cycle until such time that it is considered that sufficient cycles have taken place (Coghlan & Brannick, 2005; McNiff & Whitehead, 2002; Stringer, 1999). The iterative action research cycle may be represented by Figure 3.2, which is based on Coghlan and Brannick (2005).

Figure 3.2: Action Research Cycle



Coghlan and Brannick argue the need to be flexible in approaching any action research project, on the basis that the full range of stages and number of cycles required will only really become apparent as the study progresses. An important feature of the action research cycle is the inclusion of a participation feedback loop, whereby the assessment of data alongside the exploration of theory is undertaken through regular discussion (feedback meetings) with research participants (stakeholders). In this sense data collection and data analysis are linked such that a structure for data analysis begins to take shape, even as the study is being developed and data is being gathered. Although themes are not pre-decided, as in fixed research designs, they can and do emerge in the early stages of a research process. So clearly, the outcomes of early data analysis have influence on further data collection, in a circular relationship.

In this study, for example, it is asserted that an analysis of data highlights the importance of an emergent Theme A. However, it may have been decided, at an earlier point of the research process, to pose specific questions about Theme A, especially if this theme had not been identified as a matter of overriding concern prior to commencing the study. The ascribed importance of Theme A therefore in later data analysis, may have emerged quite simply as a result of posing Theme A questions. So, in explaining the process of data analysis, it is important to reference why Theme A questions were posed in data collection, in the first instance. Such explanations contribute to the study's internal validity, which for qualitative research is often referred to as research credibility (Lincoln & Guba, 1985; Robson, 2002).

It is also important to reference the mechanisms used in deciding to pose these questions. Researchers, for example, may not always share with research participants the same contextual framework for assessing information that arises in the course of research interactions and it becomes necessary to construct, through the course of dialogue with research participants, an agreed representation of this interaction; in effect this is based on the quality of the collaboration between the researcher and the stakeholders, and this collaboration constitutes the main mechanism for establishing research credibility (Greenwood & Levin, 2000). In this regard, the researcher plays a role in bringing together the diverse perspectives of different stakeholders and also brings into the frame external knowledge. The various mechanisms for sharing knowledge, provides a basis for making more decisions, sometimes of an action nature, than in turn can lead to further knowledge generation. This iterative process or action-research cycle in this study is summarised in five stages, as outlined below:

Stage 1

Oct-Nov, 2003

In consultation with addiction personnel, management personnel in the Regional Health Board devised a new area-based, community policy on the management of alcohol and drug problems, and wished to proceed with its implementation. However, management became aware of considerable opposition to the policy. It planned to bring all relevant personnel together at a Regional Forum to explain the policy further and to try and get support for its implementation. The researcher was approached to assist in this and related tasks and a Liaison Group was convened to meet the researcher. The Liaison Group consisted of the leading executive from each of the health board's two programmes, Mental Health and Community Care, a representative of Mental Health area management and an SMT coordinator, who was also a regional coordinator for substance misuse problems.

In discussions with the researcher, it was decided to structure the forum so that the policy differences between the proposed new approach and previous approaches would be outlined and explained. This decision provides a justification for the dichotomy that is underlined as a constant in this study: the previous, traditional approach is described in the literature review as the disease model, while the proposed new approach is represented as an evidence-based, public health model.

The Liaison Group also decided that at the Regional Forum the implications of the new policy would be discussed at sub-regional level, through area-based breakout groups. This particular decision eventually served to underline much of the contention that was evident throughout the study. On the one hand there was a tendency for management to suggest that addiction personnel in both Community Care and Mental Health programmes needed to more effectively integrate their separate interventions in this field, while in practice, on the other hand, personnel from these separate programmes had limited experience of meeting and working together on issues; indeed many area-based personnel were not as familiar with each other as one would expect and regular area-based meetings involving all addiction personnel had not been taking place.

Stage 2

Jan- May 2004

In reviewing the regional forum at a Liaison Group meeting, the researcher – drawing from an analysis of his notes and observations - suggested that the implications of policy change were not understood at an area level and there was a need to explore these implications more deeply at this level. Researcher proposed using focus groups at each of these levels as a way of generating further information on the prospective impact of the proposed policy and on the underlying difficulties that contributed to area-based concerns. The researcher convened, structured and moderated three area-based focus groups. The groups were structured to consider whether or not there was an agreed RHB vision for addiction services development, and whether personnel believed they could subscribe, in a practical sense, to developing and implementing this vision.

It emerged through these focus groups that the broader context and demand for change was not previously, fully explored with personnel. Two specific issues of concern emerged from a preliminary analysis of focus group data, and these helped shape the study's overall structure:

First, there was a view that, in the wake of *Planning for the Future*, Community Alcohol Services were established and were more or less left isolated in trying to develop a response to addiction issues and that current policy proposals were not taking sufficient account of this experience or the perspective of those who worked within these services. There was a perception that management, having ignored CASs for years, was dissatisfied that CAS practices no longer matched current requirements and wished to have these practices changed. This perception inhibited CAS personnel capacities to move with change. In reviewing these perceptions, it became clear that the study would need to provide a detailed background covering *Planning for the Future* and its implementation. These issues are covered in detail in Chapters 4 and 5 in the study.

Second, there was also a view that current demands for changing service configurations was being imposed from above and was driven by policy changes in the field of illicit drug use, more so than alcohol, which was the dominant addiction problem within the region. The emergence of this issue suggested there was a need to provide a detailed background of the influence of developing drug policies on concurrent demands for and processes of change. These matters are addressed below in Chapter 6.

Stage 3

June – Sept 2004

In discussions with Liaison Group, the researcher suggested there was a need to get further information on individual personnel experiences of policy development and dealing with policy change, going back to *Planning for the Future* and current policy changes under the *National Drug Strategy*. The researcher proposed undertaking focused individual interviews, which were subsequently undertaken with 27 separate practitioner and management personnel. During these interviews there was an in-depth exploration of current

practice issues in context of their understanding of both old and new policies. For example, this allowed for an exploration, with individual interviewees, about the relevance of the following, within the context of both previous and contemporary policies:

- Appropriateness of intervention aims
- Appropriateness of training of addiction personnel
- Appropriateness of personnel supervision and management systems
- Availability of back-up, specialist advice
- Appropriateness of being physically located within Mental Health or Community Care facilities
- Linking-in with hospital admissions or admission to other residential facilities
- Linking in with wider, community prevention activities

The themes that began to emerge from a preliminary analysis of data from these interviews were: (1) personnel had a strong sense of overall failure by the health care system in dealing with the issue of alcohol since *Planning for the Future*, and although some remained positive about their individual contribution to service development, there was an underlying belief that these service developments did not live up to expectations; (2) there was a strong fear that individual personnel risked being blamed for these failures, which it was argued were more systemically based; (3) new attempts to bring about change would also fail unless there was a genuine attempt to learn from past mistakes; (4) new proposals for service development needed to include measures that gave due recognition to the active role Mental Health services played in this field over the previous decades; (5) there needed to be a deeper recognition that Community Care personnel lacked interest and engagement with addiction issues, and (6) shortcomings in the broader policy context with respect to alcohol needed to be acknowledged as a barrier to further, practical service development. These various issues are drawn together in Chapter 7.

Stage 4

Oct-Dec, 2004

The researcher proposed re-convening area-based focus groups, in order to present a preliminary analysis of data findings and to stimulate practitioner discussions on further policy development, within the context of responding to

a preliminary outline of proposed service developments, to be outlined by the researcher. These focus groups were convened. The researcher presented a summary of preliminary data findings and also outlined a draft model for service development. In general, personnel agreed with these findings and were more willing than previously, as a result, to comment on the feedback and to contribute further to the discussion about future service developments. Three specific issues emerged from a preliminary analysis of these focus groups:

First, there was a strong sense that the discussion of failure with respect to *Planning for the Future* needed to have a more substantial data background through analyzing alcohol admission figures over the long-term. Some personnel expressed a lack of confidence in the qualitative research process and believed the overall analysis needed to be complemented by a more systematic analysis of admission data (see Chapter 4). To an extent, the analysis of admission data, contribute by way of triangulation to the study's general credibility, as it confirms some of the findings that emerged from qualitative data.

Second, there was a need to specify some Mental Health clinical leadership in the development of a new, community model, especially as there was such reluctance at Community Care level for a substantial involvement with addiction issues. This matter is addressed in the recommendations arising from the study.

There was a residual sense of hurt among CAS personnel of being blamed for past failures and a sense that this might not be sufficiently overcome to allow them to fully embrace the proposed new changes. This issue is addressed in Chapter 7

Stage 5

April 2005

The RHB decided there was a need to move ahead with its strategic direction for alcohol and policy, given that many practitioner personnel who previously were not fully behind this strategy, now had a better understanding and were willing to engage further in the policy development. In consultation with

researcher it was suggested that a report be prepared that would draw from consultations to date in making recommendations to assist the RHB in moving forward. This report was drafted and it was circulated to RHB personnel a week prior to a re-convened regional forum, held in April 2005, almost 18 months after first forum. RHB set up an implementation group to assist in moving forward on the report's recommendations. It was envisaged that the researcher have a consultative role on the implementation group; however, this does not happen. The group met twice and its work subsequently lapsed. It was explained that its deliberations were superceded by wider, national policy developments.

The credibility of this iterative process is linked to the researcher's efforts to involve the stakeholders in confirming the accuracy of the findings and is reflected in the willingness of the stakeholders to move forward on the basis of the emerging findings within the action research process (Rubin & Babbie, 2005). Clearly, a willingness to implement recommendations at the end of a research project can reflect confidence in the process, but expressions of confidence can also happen at earlier stages too and the accumulation of such expressions contributes to overall confidence. Credibility is also linked to the efforts made to bring forward ideas that do not correspond to the researcher's interpretation of findings. However, in action research it is important to avoid an over-reliance on stakeholder agreement; the fact that stakeholders support a study's conclusions is not in itself sufficient justification for claiming internal validity, although there is a view that locates credibility within the concept of stakeholder ownership of research findings (Fetterman, 2005). The issue of research credibility is contested within qualitative research, on paradigmatic grounds (Morse, 1999). However, this particular thesis accepts the importance of research credibility, which, from a realist perspective, has pragmatic considerations: the study's credibility is linked to the willingness of stakeholders to continue participating in the process,

according as ideas emerged and were processed. Although not everybody that was requested participated in the process, the overall level of engagement by relevant addiction and management personnel was good. Based on this participation, the emergence of issues, themes and recommendations through data analysis was processed and analysed through a series of consultations and structured feedback, and linked back to further data collection, focus groups and interviews, and repeated. In summary, credibility is linked to the completion of this, iterative, action research process.

SUMMARY

This chapter outlined the study's methodological framework, located within a broader structure describing evaluation models. The chapter also summarized the specific methods and techniques used in collecting and analyzing data for the study. The discussion commenced with reference to paradigmatic differences in evaluation research; three separate paradigms – positivism, interpretivism and realism – were identified. Each of these was discussed separately in order to provide an overview of philosophical and methodological differences underpinning their variable approaches to evaluation.

The importance attributed to positivist, experimental methodology in assessing evidence of what works in social programmes is underlined. Experimental research, and other forms of positivist research are highly regarded in public policy, particularly

in health care, for providing insight into what works and for making assessments about the relative value of alternative interventions. Although there is considerable scepticism on the utility of experimental research within social interventions, it is a well-tried and tested approach in the management and treatment of alcohol problems, and its outcomes are considered as providing relatively conclusive evidence about the type of social interventions that do work. In the field of alcohol in particular there is a robust body of knowledge on treatment that has been generated through experimental research.

Positivist research however, is less informative with respect to *how* interventions work and *what* makes them work, or indeed *why* such interventions, despite evidence of their efficacy, lack implementation in particular circumstances? Potentially, research from an interpretive paradigm can help provide answers to these questions, except that such research can often raise substantial, philosophical difficulties in establishing common definitions of alcohol problems and in establishing a common basis for posing evaluative questions, thus limiting the applicability of its answers.

Realism is advocated as providing a bridge between positivism and interpretivism and as an alternative paradigm for approaching questions about the evaluation of social interventions. Reference is made to the prospects of realism providing a basis for understanding social actions within particular social, cultural and historical contexts and in this regard it provides guidance to this study's task of conducting a case study on the implementation of alcohol treatment policy within a regional health care system.

Based on a general discussion about research paradigms, alongside a consideration of issues of purpose in evaluation design, a framework of four different approaches to evaluation is outlined. This particular case study is located within this framework; more specifically it is identified as *Developmental - Formative* evaluation with a focus on assessing progress in policy implementation alongside engaging with a service system in order to help it change. The twin concerns of knowledge *and* practice development characterize the study as a form of organizational action research, utilizing focus groups and semi-structured interviews. The discussion above describes the main features of the action research model as used in this study, outlines the main methods used in data collection and analysis, and identifies the study's main limitations. It also identifies key issues that arise in action research studies such as this, particularly in relation to dealing with insider / outsider perspectives, with maintaining credibility and also maintaining a focus on the need to generate knowledge and insights that have wider meaning and relevance than simply that of the study area.

Chapter 4 - The Treatment and Management of Alcohol Problems Through Psychiatric Hospital In-Patient Admissions

INTRODUCTION

This chapter is focused on the development of Irish policy with respect to the treatment of alcohol problems and drawing from a new, secondary analysis of psychiatric in-patient reports, 1965-2006, it assesses progress in restructuring the use of hospital admissions for treating alcohol problems. The study overall is focused on the treatment of alcohol problems with particular attention to treatment services within a single health authority, referred to below as the Regional Health Board. The literature review for this study (Chapter 2) juxtaposes the disease and public health approaches to the management and treatment of alcohol problems. The former, disease approach is represented as a long-established model and proposes alcoholism as a single unitary disorder that causes those persons who are affected to develop a loss of control and inability to stop drinking that can only be dealt with effectively through abstaining from alcohol. Treatment therefore is focused on achieving and maintaining lifetime abstinence: formally this is provided by specialist health and social care professionals, often in psychiatric hospitals but also through Minnesota Model residential programmes; informally the self-help international fellowship AA has helped sustain widespread personal commitments to total abstinence as a form of disease recovery.

The public health perspective is more eclectic, and more an approach than a model. It disaggregates alcohol problems into various psychological, social and economic components, in which alcohol dependence is acknowledged as one of a number of problems that need to be tackled through various broadly-based interventions that involve non-specialist, as well as more specialist health and social care professionals. This study's literature review concluded that the latter, public health approach was more supported, in the academic literature on evidence-based interventions, but that the disease model continued to dominate field practice: the study therefore sought to evaluate the diffusion of an evidence-based policy into practice settings, within a particular Ireland-based regional context.

In the decades prior to 1985 Irish policy relied on the use of inpatient admissions to psychiatric hospitals as a mechanism for formal treatment. Since the mid-1980s the policy has shifted to a public health focus, one that required both the establishment of new community-based services and the discontinuation of inpatient treatment, save in exceptional circumstances. Future chapters (5-7) appraise progress in developing community-based services. This chapter 4 using a secondary analysis of published data on psychiatric inpatient admissions, assesses progress in achieving the proposed reductions.

THE DISEASE MODEL AND INPATIENT PSYCHIATRIC ADMISSIONS

As outlined in Chapter 2 the modern conception of alcoholism as disease, following its initial development in the US, gathered wider international momentum during the 1940s-1960s through the efforts of WHO, psychiatry professionals, AA and other leading advocates. There was a strong social movement in support of this conception and medical and health insurance systems found new opportunities to enter the field of alcohol treatment, which expanded greatly at the time in Ireland, as elsewhere. The *Mental Treatment Act* (Ireland, 1945) provided *inter alia* for both voluntary and compulsory psychiatric admission of “addicts”, defined as “persons who by reason of their addiction to drink, to drugs or intoxicants were suffering from mental illness or were in danger of so becoming or were incapable of ordinary proper conduct”. This Act is regarded as the first Irish policy initiative in support of the disease concept and although previously, psychiatry was involved in treating alcohol disorders, the official stance was harsher, reflecting a general unsympathetic attitude to persons who had drinking problems (Butler, 1998).

No immediate increase in psychiatric treatment of alcohol disorders followed the Act’s passing, although there was a gradual diffusion of the disease model into treatment services, in part influenced by the development of the self-help fellowship AA, which commenced its first European meetings in Ireland in 1946. This group’s convenor previously tried, and failed, to establish AA meetings with the help of media publicity and using priests as referral agents but, significantly, it was the medical director of a psychiatric hospital that provided the group with both a meeting room

and prospective members (Butler and Jordan, 2007), and in due course other AA meetings were established in other psychiatric hospitals (Walsh, 1987a). Insofar as alcohol treatment was being provided at the time it seems clear that formally, psychiatric hospitals provided the settings for such interventions. A pattern of increasing in-patient alcohol admissions into psychiatric hospitals became apparent during the late 1950s and Butler (2002) attributes this increase *inter alia* to the 1957 establishment of private health insurance. By the 1960s a rapid expansion in such admissions was evident; whereas in 1958 there were 644 admissions to Irish psychiatric hospitals with alcohol disorder as primary diagnosis, representing 5% of total admissions, by 1965, this had risen to 1,638 and 11% of all admissions. This increase continued into the 1970s and alcohol admissions peaked in 1981 at 7,345, or 26% of all admissions (Table 1 and Charts 4.1- 4.2 below). There has since, been a reduction in alcohol admissions - in 2006 the level of admission fell to 2,767 – and this aspect will be discussed later below.

Through this period of expanding alcohol admissions, Irish psychiatry played a leading role in supporting both the disease model and the utility of specialised treatment as a response to alcohol problems. The *Report of the Commission of Inquiry on Mental Illness* (1967, 77) accepted that “alcoholism is a disease” and based this claim on the World Health Organization’s (WHO) then stated position. The Commission’s report advocated the development of specialist inpatient alcohol treatment and it also spoke positively of the work of AA and the Irish National Council on Alcoholism (INCA) – an organization set up to promote alcoholism as a disease. According to Butler (2002) the Commission implicitly suggested that critics of the disease concept “were unenlightened or moralistic” (138).

The formation and development of INCA was supported by a group of psychiatrists who had both practice and research interests in addiction issues. INCA's primary if not exclusive aim was to "educate the public about alcoholism as a disease and the needs of alcoholics". A 1973 report by INCA, that was requested by the Minister for Health, lauded the role of private psychiatric hospitals in their response to alcohol problems and strongly recommended specialized alcohol units within public psychiatric hospitals as a way of expanding treatment provision, a position that may easily have contributed to the rapid increase in in-patient treatment that followed the establishment in 1972 of regional health boards, who took overall responsibility for the management of public psychiatric hospitals. The INCA report stated:

The private psychiatric hospitals provide an effective form of treatment. They have demonstrated the fact that regardless of any prejudice which may exist, alcoholics will report to a psychiatric hospital which provides the treatment facilities and specialisation which are necessary. An increase in the personnel establishment of public psychiatric hospitals which would provide for a consultant or staff member specializing in the treatment of alcoholism, supported by a team comprising a Social Worker and nursing staff, would be a practical first step in motivating alcoholics to treatment in these hospitals. The alcoholic unit so formed should have a number of beds in segregated accommodation, an out-patient clinic, and be the centre for community care in the area concerned (Irish National Council on Alcoholism, 1973, 47).

The report's reference to Community Care in the above quote provides some indication that INCA acknowledged the importance of outreach and out-patient services and may also reflect ambivalence among some members of INCA about the utility of in-patient, disease models. Butler (2002) discussed the existence of two

views on this matter within INCA at the time. The main view in support of the disease approach is outlined in the report and includes the above recommendation for expanding the role of psychiatry. Alcoholics are described as:

...excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily or mental health, their inter-personal relationships, and their smooth social and economic functioning...(and) therefore require treatment (Irish National Council on Alcoholism, 1973, 10).

The report accepts the idea of alcoholism as a widespread “definable and treatable condition”; it refers to the WHO’s (and the medical profession’s) acceptance of alcoholism as “progressive disease” (Ibid.), although during the early 1970s at the time that this report was being written the WHO was in the process of re-assessing its approach to alcohol problems, through supporting research, subsequently published by Bruun et al (1975), which, as outlined in Chapter 2 above, eventually led to the idea of alcohol-related problems.

Perhaps because they may have been aware of developments taking place at the WHO and elsewhere, or indeed they may have been conscious of the variable alcohol-related problems presenting in clinical practice, an alternative, but much less-explicit view of alcohol is also apparent in the INCA report. Reference is made to the “difficult to define” problem of “excessive social drinking”. The excessive social drinker, according to the report, is:

....an individual who gives an extraordinary priority to the expenditure of time and money on the consumption of alcohol. In some people, excessive social drinking may be a prelude to alcoholism, particularly where there is an increase in the frequency and intensity of their drinking, leading to a dependency.....On the other hand some excessive social drinkers may be able to maintain the same level of consumption over many years without becoming addicted to or dependent on alcohol. In the latter case, the results of excessive social drinking may not be readily apparent in the bodily or mental health of the individual concerned. They may, however, constitute social and economic problems for the individual and his family where the amounts spent on alcohol is large in relation to his family commitments and the size of his income (Irish National Council on Alcoholism, 1973, 10).

The report includes no recommendations on secondary treatment interventions for excessive social drinkers; its recommendations on treatment are focused almost exclusively on the need for in-patient hospitalization of alcoholics, that is, for that sub-group of excessive social drinkers who were dependent.

In an Appendix and footnotes that were added to the report, following its submission to the Minister for Health, there are further indications of both caution in relation to the in-patient hospitalization model and support for a public health view. The Appendix suggests the need for a philosophical review of alcohol in society and the adoption of a public health approach to the management of alcohol problems, including controls on alcohol advertising, setting good examples through the use of soft drinks at official functions, school and industry education programmes and more stringent measures for tackling drink-driving. Added footnotes suggest that the report's main text makes insufficient reference to the success of existing out-patient programmes and that a lot more could be achieved through their expansion.

This second view in the report is indicative of a fledgling awareness among at least some of the report's stakeholders that there was an alternative to the alcoholism-as-disease model. However, it is clear from the sustained growth in admission figures that followed the establishment of health boards in 1972 that the disease model – as supported by the main body of the INCA report - continued to predominate, reflecting both professional beliefs and a broader public expectation, that alcohol problems could be overcome through medical treatment. This point was well made by INCA in its 1973 report in which it stated:

Their (private psychiatric hospitals) acceptance (by persons with alcohol problems) as a place of treatment is primarily due to the fact that they have met the public demand by providing a specialised service for the treatment of alcoholism with the facilities and staff which this entails (Irish National Council on Alcoholism, 1973, 34).

Arising from the expansion of hospital admissions in general and admissions for alcohol treatment in particular that continued throughout the 1970s – and possibly even alarmed by it – the *Report of the Inspector of Mental Hospitals for the years 1977-9* (Medico-Social Research Board, 1980, 22) commented:

The Board considers that the continuing increase in our admission rates, already very high by international standards, must raise questions about our hospitalization practices and use of alternatives to hospitalization. The Board's report highlights the fact that alcoholism still remains the commonest cause of admission to psychiatric hospitals, accounting for 26% of all admissions. For first admissions alcoholism is also the leader at 29%. Alcoholism and alcoholic

psychosis have shown higher increases than any of the other diagnostic categories.

This sense of alarm was echoed in chapter 13 of the report, *The Psychiatric Services Planning for the Future* (1984) – referred to below as *Planning for the Future* - , which proposed a radical overhaul of the alcohol treatment system. The proposals for alcohol treatment were consistent with this report's general intention to re-shape the provision of Irish mental health services. At the time the report was published residential levels in Irish psychiatric hospitals were among the highest in Europe (Walsh, 1987b). Reflecting an international shift in mental health service policy away from institutional provision in favour of community care (Goodwin, 1997), the report was concerned that existing services were over-reliant on the psychiatric hospital as the focal point of service delivery, with the result that community services were severely under-developed and many persons with a mental illness were treated in isolation from their families and their communities. The report underlined that modern mental illness treatment did not support this institutional role and it proposed that the psychiatric hospital be gradually replaced by an alternative, community-oriented service with multi-disciplinary sectoral teams catering for catchment populations of 25,000-30,000, with in-patient treatment services ideally provided in acute psychiatric units in general hospitals and through the establishment of non-hospital facilities for new long-stay patients.

Planning for the Future's community philosophy is evident in its chapter on alcohol, which also reflects the emerging public health model as discussed above – and also in Chapter 2 - and which was advocated in the above-cited appendix to the INCA report.

Paragraph 13.2 of *Planning for the Future* discusses the nature of alcohol problems as follows:

Until recently, the generic term 'alcoholism' has been used to refer to a variety of problems resulting from alcohol abuse. However, because the word is difficult to define satisfactorily and because it suggests a particular type of alcohol problem to the exclusion of others, it is limited in what it covers. The term 'alcohol-related problems', although more cumbersome, is more accurate. This term acknowledges that alcohol can cause, or at least contribute to, an assortment of social and physical problems, which include public drunkenness, family violence, absenteeism, road traffic accidents, liver and heart disease, and disorders of the central nervous system (*The Psychiatric Services - Planning for the Future*, 1984, 104).

This conception of alcohol-related problems reverses the relative priority of the two concepts of *alcoholism* and *excessive social drinking* in the 1973 INCA report and thereby departs from the well-established disease concept. The report challenged the wisdom of trying to treat and manage alcohol problems through costly in-patient care, arguing that there was no evidence of it being any more effective than community based care and also arguing that the intensive, specialist approach draws the problem away from the community, thereby excluding primary care and community medical and social services from having a role and input. The report recommended that as far as possible these problems needed to be dealt with "at a community level by the primary health care and social services" where the response can be earlier, where it can "take into account all aspects of the drinker's immediate environment, including [the] family" and where the response can "be comprehensive in its scope" (109).

The report also recommended the need for a specialist, local alcoholism service, to be provided through psychiatry. It was proposed that each psychiatric sectoral team develop this new service with a major emphasis on out-patient treatment, with access to a small number (2-3) of beds in circumstances where out-patient treatment is not possible because of distance or social reasons. It was suggested that a consultant in each hospital catchment area take special responsibility to organise and develop these services and that the services would become a resource for alcohol problems to primary care personnel, other community personnel and voluntary and self-help agencies. The report noted the emergence of voluntary agencies providing treatment for alcohol problems. This can be taken as a reference to the establishment of various Minnesota Model programmes, based on the disease model. The report suggested these be closely monitored and evaluated to assess cost-effectiveness, amongst other aspects. It could be inferred from this reference that while the report supported the involvement of voluntary agencies in providing treatment, this did not go so far as supporting the provision of Minnesota Model programmes.

Planning for the Future, in terms of its analysis and proposals for service development, was clearly abreast of international developments in the public health approach at the time, Successive official Irish reports provide further arguments in support of the public health model for managing alcohol problems. The *National Alcohol Policy* (National Alcohol Policy [Ireland], 1996) advocated early pre-dependency interventions in non-residential settings and suggested an avoidance of in-patient hospital admissions treatment. An increased role for GPs was advocated and reference is also made to an Irish College of General Practitioners' submission to the Advisory Council on Health Promotion in which it is recommended that GPs be

“pro-active in the education, identification, diagnosis and treatment of patients with alcohol-related problems” (Ibid). The policy suggests that GPs have access to specialist services in the form of local, intensive therapy available on an outpatient basis. The policy also refers to the role of voluntary agencies, suggesting they continue to be encouraged to provide services of various types but that bearing in mind that “the thrust of policy” is “towards a community-based and out-patient service, Health Boards should be satisfied that the publicly funded services of non-statutory agencies correspond with that policy” (Ibid, 38).

The *Strategic Task Force on Alcohol* (2004) in its section on treatment emphasized the importance of early interventions and the development of effective screening tools. While it referenced alcohol dependency as a “chronic disorder characterized by a cluster of recognizable symptoms” it did not refer to alcoholism as disease. Although the report does not deal with the issue of treatment in detail – focusing instead on issues of broader alcohol consumption, availability and accessibility – it recommends that a range of treatment services needed to be available in each health board region and that “explicit pathways of care for those seeking treatment” needed to be developed.

The *Report of the Expert Group on Mental Health Policy* (2006) – often referred to by its shorter title - *A Vision for Change* – recommended shifting responsibility for addiction problems away from psychiatry altogether. This report concluded that “the major responsibility for care of people with addiction lies outside the mental health system” in primary and community care, whereas the responsibility of mental health services “is to respond to the needs of people with both problems of addiction and

serious mental health disorders” (146). This new position, while clearly continuing to advocate the public health approach, constitutes a significant departure from that outlined in *Planning for the Future*, which envisaged a key role for psychiatry in leading and giving direction to community alcohol services. The *Vision for Change* proposal generated some controversy and the Irish College of Psychiatrists’ Faculty of Addictions has made clear that it does not agree with the position as outlined in *Vision for Change* (Flannery, 2007, 11). Unlike *Planning for the Future*, which set out a philosophical rationale – and a whole chapter - for its proposals on alcohol, *A Vision for Change*, provides little if any discussion of its position on addiction other than to state that in recent years non-psychiatric community services have played an increasing role in alcohol and drug service provision; the section’s main discussion is focused on the issue of co-morbidities and of the role of mental health services in dealing with these. The report’s authors may have had a rationale for excluding psychiatry from having a leading role in alcohol and drugs treatment, and decided not to state this in the report, although it was signalled in advance. For example, the *Annual Report, 2003, of the Mental Health Commission* commented:

There has been an appropriate movement of services for alcohol-related problems away from the mental health services to less formal community-based services based on addiction counsellors....

Such community-based services are more easily accessed, have closer links with primary care and community support systems and take on wider roles in education and preventive activity. They are ideally placed to link in with local employers, schools, youth organizations, concerned relatives, community groups and self-help groups (Mental Health Commission, 2004, 31-2).

The *Mental Health Commission* also comments on its vision of the likely future role of mental health services with respect to alcohol and drugs:

People who abuse alcohol or drugs have a greatly increased risk of developing mental health problems, requiring significant liaison inputs from community mental health teams. Models which allow direct and regular contact between community addiction services and community mental health teams can facilitate this necessary liaison (Ibid., 32).

This particular thesis study commenced in 2003, three years prior to the publication of *A Vision for Change*. Potentially, the study can provide insight into the extent of readiness of services – both those based in Mental Health and those based in Community Care – to take up the challenge presented by *A Vision for Change*. Important yardsticks for assessing this state of readiness is to evaluate progress in achieving the anticipated reductions in alcohol in-patient admissions that were advocated in *Planning for the Future* and also to evaluate progress in developing alternative, community-based services. As already mentioned, these latter aspects are explored further in Chapters 5 – 7; this Chapter here continues with an assessment of advances made in reducing alcohol admissions; the assessment below considers national, inter-regional and RHB data.

NATIONAL DATA ON ALCOHOL ADMISSIONS

Data on psychiatric in-patient admissions is collected by the Health Research Board (previously Medico-Social Research Board), through a *National Psychiatric In-Patient Reporting System*, which produces an annual report *Activities of Irish Psychiatric Hospitals and Units*. A single report for the years 1965-69 was published

in 1971 and thereafter an annual report was published (Medico-Social Research Board and Health Research Board, 1965-2005). These annual reports include data on in-patient admissions for categories of diagnoses, including alcohol (alcohol disorder and alcohol psychosis) as a single category. Data on first admissions is also provided. Table 4.1 below presents data on alcohol admissions, between 1965-2006; information on numbers of *all* and *first* alcohol admissions, alongside epidemiological data on the prevalence of alcohol admissions within the population (per 100,000 16 yrs +)⁶ and percentage level of alcohol admissions against overall psychiatric admissions, is presented. This data is also presented in Charts 4.1 – 4.3 (below).

⁶ Figures on rate per 100,000 (16 yrs+), 1965-1997 are calculated as published figures are based on a rate per 100,000 (all age groups).

Table 4.1: Psychiatric Admissions (All and First) with Alcohol Diagnosis, Ireland, 1965-2006, annual number, rate per 100,000 population (16yrs+) and % of total admissions⁷

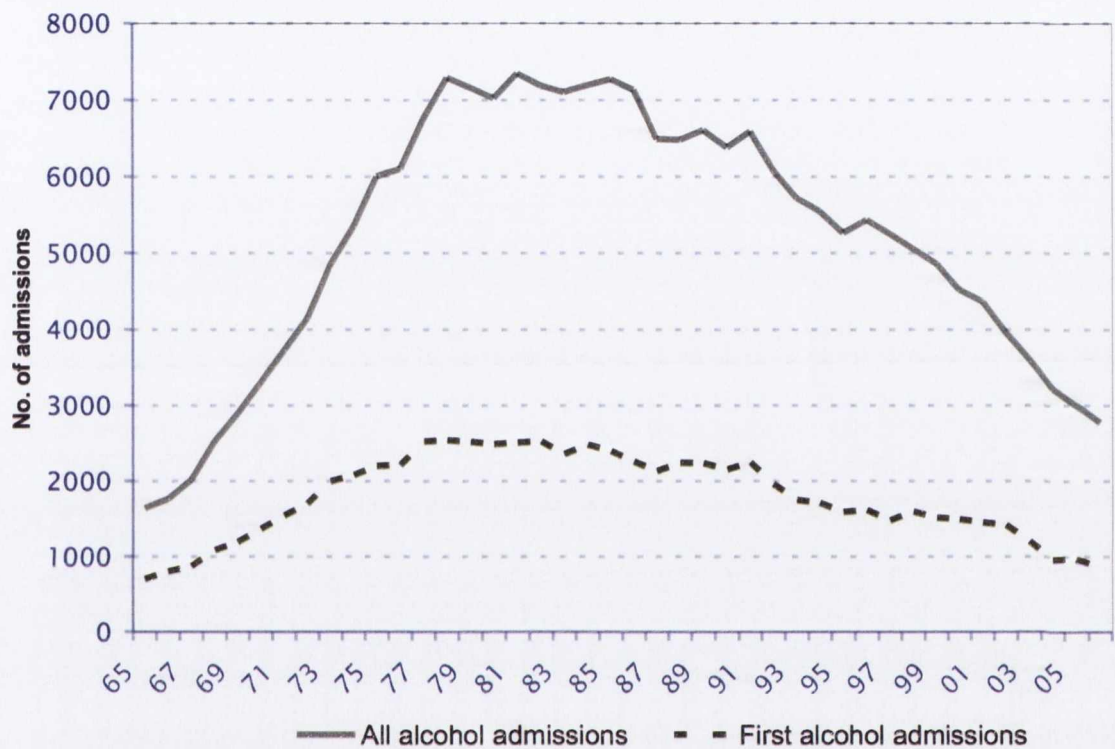
<i>National</i>						
<i>All Alcohol admissions</i>				<i>First Alcohol admissions</i>		
<i>Year</i>	<i>Num</i>	<i>per 100,000</i>	<i>% of total admissions</i>	<i>Num</i>	<i>per 100,000</i>	<i>% of total admissions</i>
1965	1638	67.3	10.6%	699	28.7	11.3%
1966	1757	66.6	10.6%	800	32.9	12.0%
1967	2013	82.7	11.4%	864	35.5	12.5%
1968	2526	103.7	13.3%	1081	44.4	14.8%
1969	2886	118.5	14.7%	1186	48.7	15.5%
1970	3303	135.7	16.2%	1362	55.9	15.4%
1971	3720	187.1	17.4%	1538	77.6	19.1%
1972	4143	208.2	18.0%	1697	85.6	19.7%
1973	4846	244.3	20.2%	1996	100.9	22.1%
1974	5355	261.3	21.5%	2071	101.2	23.2%
1975	6003	293.7	23.2%	2198	107.7	24.8%
1976	6,101	298.0	23.1%	2206	107.8	24.7%
1977	6,765	331.1	25.6%	2518	123.3	28.7%
1978	7,293	356.3	26.4%	2538	124.0	29.2%
1979	7,158	306.0	26.2%	2514	107.6	29.1%
1980	7,021	300.3	25.9%	2480	106.3	29.3%
1981	7,345	313.9	25.6%	2501	107.0	29.5%
1982	7,189	307.9	25.0%	2518	107.9	28.9%
1983	7,100	296.6	25.0%	2349	98.2	27.9%
1984	7,193	299.5	24.9%	2477	103.3	28.3%
1985	7,272	303.1	25.0%	2392	99.8	28.3%
1986	7,132	297.0	24.3%	2252	93.9	27.3%
1987	6,492	270.6	23.3%	2128	88.8	26.8%
1988	6,478	270.2	22.8%	2239	93.5	27.7%
1989	6,608	262.6	24.2%	2234	88.8	29.7%
1990	6,377	253.7	23.0%	2146	85.4	28.3%
1991	6,592	261.9	23.6%	2241	89.0	28.2%
1992	6,081	241.8	22.4%	1958	77.9	26.3%
1993	5,718	227.1	21.2%	1742	69.2	23.8%
1994	5,551	220.6	20.8%	1707	67.8	23.9%
1995	5,262	203.4	19.9%	1585	61.3	21.9%
1996	5,435	209.9	20.4%	1611	62.2	22.6%
1997	5,250	194.8	20.3%	1470	54.5	21.2%
1998	5,055	187.6	20.1%	1589	59.0	22.5%
1999	4,859	180.3	19.4%	1512	56.1	21.3%
2000	4,517	167.6	18.6%	1486	55.1	20.4%
2001	4,366	162.0	17.9%	1447	53.7	19.8%
2002	3,956	130.6	16.7%	1416	45.7	20.1%
2003	3,603	119.0	15.6%	1196	39.5	18.0%
2004	3,217	106.2	14.4%	952	31.4	15.5%
2005	2,995	98.9	14.1%	962	31.8	16.3%
2006	2,767	65.3	13.6%	851	20.1	15.2%

As already referenced in earlier discussion, alcohol in-patient admissions to psychiatric hospitals and units peaked at 7,345 in 1981 and remained above 5,000 per annum for almost 20 years; in 2004, at 3,217, it was exactly twice the 1965 level, and in 2005 it eventually fell to just below 3,000 for the first time since 1969, a reduction

⁷ Source: Medico-Social Research Board and Health Research Board (1965-2005) Activities of Irish psychiatric hospitals and units, Medico-Social Research Board / Health Research Board, Dublin.

of 59% on the 1981 peak figure; the 2006 figure is 2,767. First admission figures peaked in 1982 at 2,518 and have since dropped to 851 in 2006, a reduction of 62% on the peak 1982 figure.

Chart 4.1: National psychiatric in-patient admissions with alcohol diagnosis (all and first admissions), 1965-2006

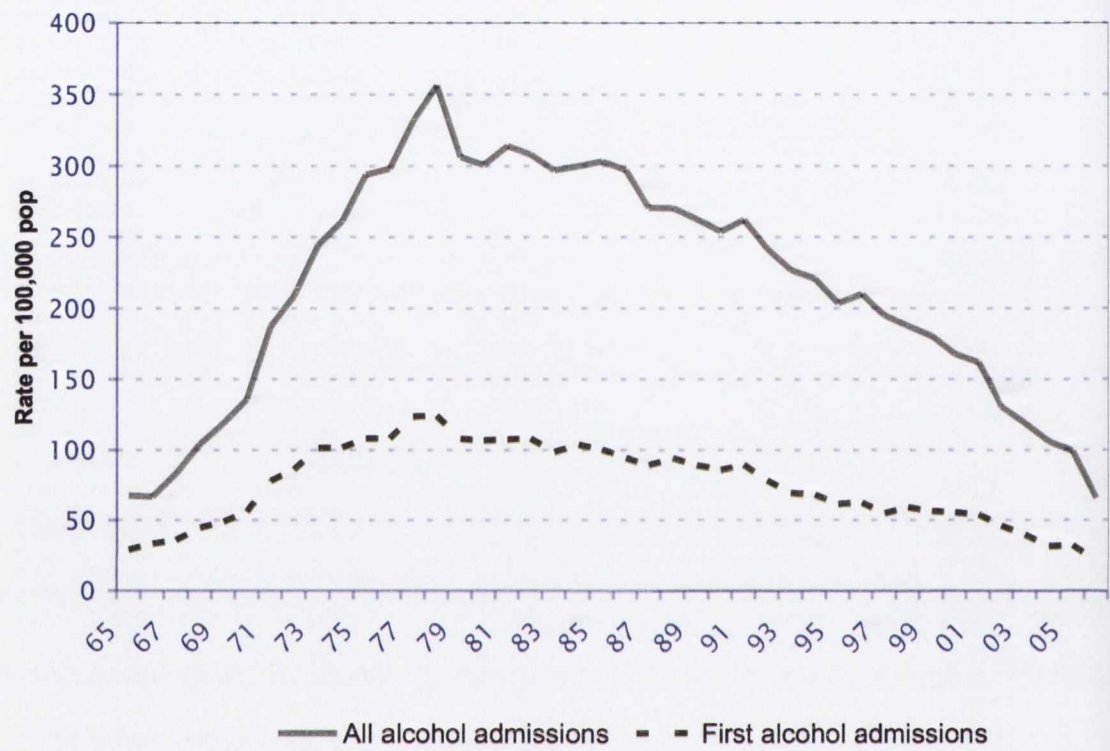


While overall these figures are indicative of achieving alcohol in-patient reductions, it is evident that progress has been slow and given that *Planning for the Future*, recommended no more than a few in-patient bed places for each Psychiatric Hospital Sector, these figures must be viewed as considerably short of that envisaged by this report. Indeed, 2006 alcohol admissions remain 1.7 times greater than the 1965 figure of 1,638; 2006 first admissions are 1.2 times that of 1965.

Chart 4.2 outlines that annual alcohol admissions per 100,000 population (16 years +) rose sharply from 67.3 (28.7 for first admissions) in 1965 to a peak of 356.3 (124.0)

within 13 years, in 1978. At 65.3 (20.1) in 2006 it remains slightly above the 1965 level – having taken 26 years to drop below 100; in all the level of alcohol admissions was above 100 per 100,000 for 36 years.

Chart 4.2: National psychiatric in-patient admissions with alcohol diagnosis (all and first admissions) per 100,000 population 16 years +, 1965-2006



It is also evident from Chart 4.3 below that alcohol admissions as a percentage of overall psychiatric admissions has remained consistently high for most of the period since *Planning for the Future*, remaining above 20% up until 1999, except for 1995 when the figure dropped to 19.9% and rose again; a 6% drop in this proportion of overall admission for alcohol was achieved in the seven year period 2000-2006, while a corresponding drop of 4% was achieved for the fourteen year period commencing 1986 – the first full year following the publication of *Planning for the Future* - and 1999. First admissions for alcohol were 28% of overall admissions in 1985, rising to

30% in 1989 and not falling below 20% until 2001, and resting at 15% in 2006, exactly half the percentage it was at, when at its highest, seventeen years earlier.

Chart 4.3: Alcohol diagnosis as percentage of All and First national psychiatric admissions, 1965-2006



At a relatively early stage of the process of reforming in-patient admissions, the Inspector of Mental Hospitals expressed frustration with a resistance to change within the medical profession, claiming they “relied heavily on their mental hospitals” (Walsh, 1987, 114). The *Report of the Inspector of Mental Hospitals for the Year 1992*, commented as follows:

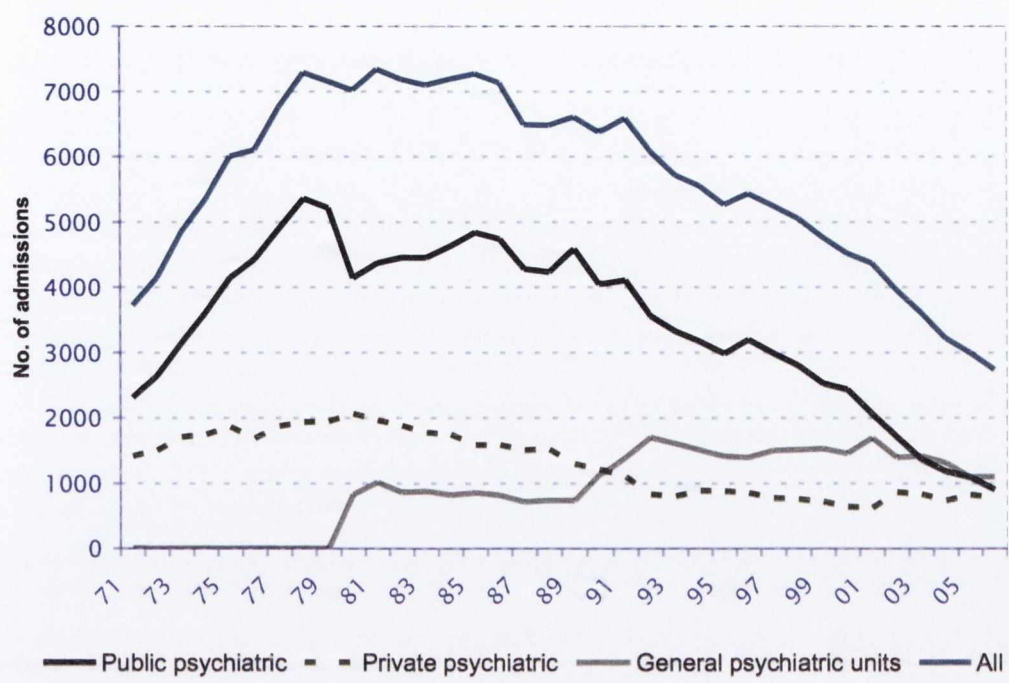
Admissions for alcohol related disorders remained disturbingly high despite the Inspectorate’s recommendations in recent years about the importance of providing alternative, non-residential, services for this category of patient (3).

Some years later this criticism is echoed in the 2001 report:

The Inspectorate is disappointed that alcohol-related problems still constitute almost one-third of psychiatric admissions despite the extensive provision of community-based alcohol treatment services. We reiterate our view that 'detoxification' from alcohol toxicity is inappropriate and, in severe toxicity, an unsafe procedure, in a psychiatric setting. Where toxicity is severe, with the likelihood of severe withdrawal symptoms and possible neurological complications, the safest place for such persons is on general medical wards, not in an isolated psychiatric setting. If, on the other hand, toxicity is of minor degree, the Inspectorate's view is that detoxification should be a primary care function. The Inspectorate has been struck by the number of people with 'alcohol problems' who remain needlessly in acute psychiatric beds, contributing in some cases to perceived acute bed shortages. (Report of the Inspector of Mental Hospitals for 2001)

It is clear from the above Table and Charts that while progress in reducing alcohol admissions has been slow, it was slower in the decade after the publication of *Planning for the Future*, than the following decade; by 1996 the 1986 level of 7,132 alcohol admissions reduced by 24% to 5,432, whereas by 2006 the 1996 level was reduced by 50% to 2,767. In this regard it is important to note that most (60%) of this latter reduction was achieved in the period 2001-2006. The corresponding reductions for first admissions for alcohol are: 28% between 1986 and 1996, 47% between 1996 and 2006; 78% of this latter reduction was achieved in the period 2001-2006. Fluctuations in in-patient admissions for alcohol could potentially be linked to changes in population levels of consumption. During 1965-1996 Ireland experienced a slow but gradual increase in alcohol consumption, which lacks correspondence with the quite, dramatic increase in alcohol in-patient admissions; since 1996 however, Ireland has experienced a more dramatic increase in alcohol consumption, which is

Chart 4.4: National in-patient admissions with alcohol diagnosis by hospital type (public, private and general hospital units) and All hospitals, 1971-2006



quite interesting given the gradual reduction in in-patient admissions for alcohol in latter years (Strategic Task Force on Alcohol, 2004). Potentially, the slow rate of decrease in alcohol admission might, in part, be explained by consumption rates, although this would not explain variable regional patterns of alcohol admission. However, more detailed examination of both data sets, particularly within regional contexts could provide more insight into this possible relationship.

One factor that can potentially help account for slow progress in bringing about a reduction in alcohol admissions is the lack of headway in replacing public psychiatric hospitals with psychiatric units in general hospitals as the main location for acute psychiatric admissions, as recommended in *Planning for the Future*. As is evident from Chart 4.4 above, reductions in alcohol admissions coincide with the expansion of psychiatric units in general hospitals, suggesting therefore that admission policies

in general hospitals tend to be more strict in relation to alcohol admissions than psychiatric hospitals.

Overall, these national figures highlight that progress in reducing alcohol admissions has been slow and that the period between 2001-2006 has been the most active in this regard. This level of reduction may be attributed to pending policy changes as discussed earlier in relation to the report, *A Vision for Change*, which recommended that Mental Health be involved in treating addiction problems only where these are co-related to psychiatric disorders.

REGIONAL DATA ON ALCOHOL ADMISSIONS

Another feature of alcohol admissions to psychiatric hospitals and units is their regional variation; this variation has continued in latter years and is somewhat masked by national figures. The collection and publication of regional data on psychiatric admissions commenced following the setting up of eight regional health boards in 1972 and this data continued to be published until 2004; regional health boards have since been abolished and health service administration has been re-organised under a single national authority, with four administrative areas. Regional data therefore is no longer published, but is available for the four new administrative areas, as well as for individual hospitals and their catchment areas, usually sub-regional counties.

Table 4.2: Psychiatric Admissions with Alcohol Diagnosis, Ireland, 1972-2004, rate per 100,000 population (16yrs+), national, regional, and highest and lowest regional

	<i>National</i>	<i>MHB</i>	<i>MWHB</i>	<i>NEHB</i>	<i>NWHB</i>	<i>SEHB</i>	<i>SHB</i>	<i>WHB</i>	<i>EHB</i>	<i>highest</i>	<i>lowest</i>
1972	208.2	161.4	180.5	244.7	160.9	186.3	159.6	134.7	276.3	276.3	134.7
1973	244.3	153.0	267.5	231.5	208.4	240.3	191.3	169.0	296.1	296.1	153.0
1974	261.3	167.3	308.2	263.5	246.1	271.3	208.2	212.3	297.9	308.2	167.3
1975	293.7	189.5	346.3	286.7	272.6	331.3	244.8	223.7	327.0	346.3	189.5
1976	298.0	216.3	359.6	289.9	341.3	336.5	237.3	223.5	325.3	359.6	216.3
1977	331.1	288.9	408.8	357.8	398.7	347.5	244.1	258.6	350.3	408.8	244.1
1978	356.3	298.1	450.1	372.8	439.0	390.9	256.2	280.0	376.9	450.1	256.2
1979	306.0	308.1	402.8	306.7	516.9	380.1	203.4	272.3	271.4	516.9	203.4
1980	300.3	286.6	422.7	274.4	511.1	397.8	220.4	258.0	251.0	511.1	220.4
1981	313.9	333.2	446.9	269.0	484.8	392.6	260.5	332.5	246.1	484.8	246.1
1982	307.9	324.5	451.1	268.5	413.1	379.2	263.5	330.0	244.7	451.1	244.7
1983	296.6	343.4	392.8	261.1	398.7	355.0	255.7	343.5	240.4	398.7	240.4
1984	299.5	326.8	379.1	257.7	428.3	346.4	240.3	363.8	252.9	428.3	240.3
1985	303.1	381.7	409.9	256.2	379.5	374.4	250.7	379.5	236.3	409.9	236.3
1986	297.0	324.6	394.9	240.3	376.1	393.5	246.1	367.5	236.8	394.9	236.8
1987	270.6	323.2	351.2	177.4	359.0	337.0	195.3	383.7	225.8	383.7	177.4
1988	270.2	354.9	346.1	194.6	340.4	305.7	171.8	361.7	244.6	361.7	171.8
1989	262.6	373.7	314.0	192.0	350.6	322.7	177.8	334.7	227.6	373.7	177.8
1990	253.7	286.5	305.6	201.4	338.1	303.4	174.6	338.2	222.4	338.2	174.6
1991	261.9	307.5	278.6	196.7	400.7	321.9	188.4	351.6	227.4	400.7	188.4
1992	241.8	310.3	212.0	189.1	394.1	263.8	169.2	373.7	209.7	394.1	169.2
1993	227.1	275.7	202.1	112.0	522.5	233.1	160.1	345.1	187.1	522.5	112.0
1994	220.6	249.5	212.7	167.6	551.1	220.7	149.3	294.0	181.7	551.1	149.3
1995	203.4	253.9	188.2	132.9	488.0	208.9	166.3	255.8	166.7	488.0	132.9
1996	209.9	260.0	185.1	127.2	499.1	237.9	154.0	300.3	169.4	499.1	127.2
1997	194.8	284.3	175.5	107.7	411.3	153.9	220.6	302.5	148.3	411.3	107.7
1998	187.6	285.0	163.1	119.9	247.1	243.2	160.3	254.6	159.1	285.0	119.9
1999	180.3	279.7	176.4	101.9	238.7	247.7	136.5	271.1	146.1	279.7	101.9
2000	167.6	306.5	170.8	88.8	221.8	223.1	133.8	258.4	125.4	306.5	88.8
2001	162.0	314.5	177.2	69.4	271.0	213.0	113.5	253.5	116.9	314.5	69.4
2002	130.6	227.0	123.2	67.8	164.3	180.0	98.5	212.7	101.9	227.0	67.8
2003	119.0	236.4	105.2	45.8	141.1	167.6	92.3	173.9	98.6	236.4	45.8
2004	106.2	162.7	111.3	63.1	130.4	147.5	77.4	125.6	95.7	162.7	63.1

Comparative data across eight regions between 1972 and 2004 is outlined in Tables 4.2 – 4.3. Table 4.2 outlines alcohol admissions per 100,000 population (16+), while Table 4.3 outlines alcohol admissions as a percentage of overall psychiatric admissions. Both tables highlight each annual highest and lowest level figure, as well as providing the comparative national figure.

Table 4.3: Psychiatric Admissions with Alcohol Diagnosis as a Percentage of Overall Admissions, Ireland, 1972-2004.

	<i>National</i>	<i>MHB</i>	<i>MWHB</i>	<i>NEHB</i>	<i>NWHB</i>	<i>SEHB</i>	<i>SHB</i>	<i>WHB</i>	<i>EHB</i>	<i>highest</i>
1972	18.0%	15.4%	14.7%	24.5%	14.8%	13.9%	14.8%	13.4%	22.6%	24.5%
1973	20.2%	15.8%	20.8%	22.5%	19.1%	17.7%	17.6%	14.9%	23.2%	23.2%
1974	21.5%	17.6%	21.9%	23.7%	20.8%	19.6%	18.5%	18.0%	24.0%	24.0%
1975	23.2%	19.2%	22.9%	25.6%	21.0%	22.2%	21.4%	19.5%	25.5%	25.6%
1976	23.1%	18.8%	23.7%	25.5%	24.9%	22.3%	19.2%	18.9%	25.8%	25.8%
1977	25.6%	25.4%	26.1%	29.4%	28.3%	22.9%	20.7%	24.6%	27.4%	29.4%
1978	26.4%	24.8%	28.5%	28.7%	29.7%	25.1%	20.4%	25.7%	27.7%	29.7%
1979	26.2%	28.0%	29.1%	26.7%	34.5%	26.2%	22.4%	23.2%	24.7%	34.5%
1980	25.9%	25.9%	28.9%	24.8%	33.6%	27.3%	21.9%	22.2%	25.1%	33.6%
1981	25.6%	28.2%	27.3%	25.8%	31.3%	27.1%	23.0%	25.5%	23.2%	31.3%
1982	25.0%	25.7%	26.8%	26.3%	30.0%	25.5%	22.9%	25.0%	23.2%	30.0%
1983	25.0%	28.0%	24.5%	27.0%	30.5%	24.9%	22.5%	26.4%	23.4%	30.5%
1984	24.9%	28.6%	24.4%	24.5%	32.1%	24.5%	21.6%	28.0%	23.5%	32.1%
1985	25.0%	32.0%	25.3%	26.6%	30.5%	25.4%	22.0%	29.6%	21.7%	32.0%
1986	24.3%	29.1%	27.1%	23.2%	30.7%	26.0%	21.7%	28.2%	20.5%	30.7%
1987	23.3%	30.4%	24.3%	19.3%	30.2%	24.3%	20.0%	31.4%	19.7%	30.4%
1988	22.8%	30.9%	24.0%	19.7%	29.8%	22.7%	17.9%	29.3%	20.2%	30.9%
1989	24.2%	31.5%	25.6%	21.7%	32.8%	25.4%	19.8%	29.1%	21.2%	32.8%
1990	23.0%	27.7%	25.5%	21.4%	29.5%	23.3%	18.8%	29.5%	20.1%	29.5%
1991	23.6%	30.8%	25.7%	21.4%	34.3%	24.9%	18.7%	29.3%	20.5%	34.3%
1992	22.4%	32.4%	20.5%	22.9%	34.9%	22.0%	17.1%	30.5%	18.9%	34.9%
1993	21.2%	29.3%	19.7%	15.5%	40.8%	20.4%	16.1%	27.9%	17.0%	40.8%
1994	20.8%	28.4%	20.7%	21.7%	42.1%	20.0%	15.6%	25.9%	16.1%	42.1%
1995	19.9%	26.0%	19.0%	18.5%	40.2%	19.3%	17.6%	23.4%	15.7%	40.2%
1996	20.4%	26.5%	19.2%	17.7%	39.5%	21.9%	16.8%	25.8%	15.8%	39.5%
1997	20.3%	28.5%	19.7%	16.6%	35.3%	21.3%	17.5%	28.2%	15.2%	35.3%
1998	20.1%	27.6%	18.5%	19.0%	23.4%	24.3%	18.8%	25.3%	16.5%	27.6%
1999	19.4%	25.9%	20.7%	17.0%	23.1%	23.2%	17.3%	25.9%	15.2%	25.9%
2000	18.6%	27.4%	19.6%	15.7%	22.6%	20.7%	15.0%	25.7%	14.7%	27.4%
2001	17.9%	26.5%	20.6%	13.0%	24.2%	20.2%	13.2%	23.7%	13.8%	26.5%
2002	16.7%	23.5%	17.0%	14.5%	19.2%	18.8%	12.9%	23.6%	13.7%	23.6%
2003	15.6%	26.0%	15.8%	9.6%	18.4%	17.9%	12.5%	22.3%	12.8%	26.0%
2004	14.4%	18.0%	17.1%	13.0%	18.0%	16.7%	11.3%	16.8%	12.6%	18.0%

The above tables, and Charts 4.5 – 4.6 below, illustrate tremendous variation across regions with respect to both per 100,000 levels of alcohol admissions and alcohol admissions as percentage of overall psychiatric admissions. Extreme examples of this variation include a 551.1 per 100,000 population level of alcohol admission in 1994 (ten years after *Planning for the Future*) in the North Western Health Board (NWHB) region as compared to 149.3 in the Southern Health Board (SHB) region in the same year; the respective figures for alcohol diagnosis as a percentage of all psychiatric admissions are 42.1% for the NWHB and 15.6% for the SHB.

Variations have persisted into latter years when national rates showed a marked decrease; the Midland Health Board (MHB) per 100,000 figures for 2001 is 314.5 as compared to 67.3 for the adjacent North Eastern Health Board (NEHB); the respective figures for alcohol diagnosis as a percentage of all psychiatric admissions are 26.5% and 13.0%. Overall, three health board regions, NWHB, MHB and WHB dominate annual highest figures for alcohol admissions per 100,000 population and annual alcohol admissions as a percentage of all admissions. Clearly, the above tables and charts highlight sharp variations between different regions in their progress in achieving a reduction in alcohol admissions. Even during the period 2001-5, when considerable progress was being achieved nationally, it seems clear that rapid progress in some regions is offset in the figures by much slower progress in others.

Chart 4.5: In-patient psychiatric admissions with alcohol diagnosis, per 100,000 population (16 years +), national, highest and lowest regional annual rates, 1972-2004

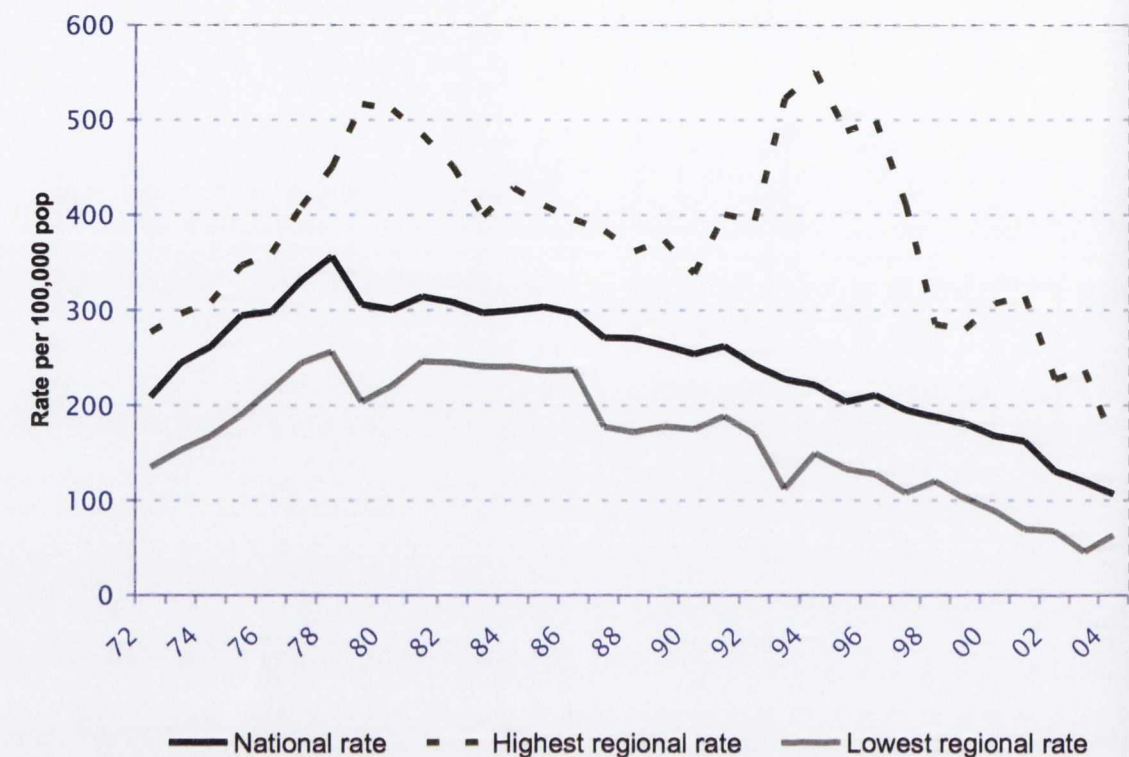
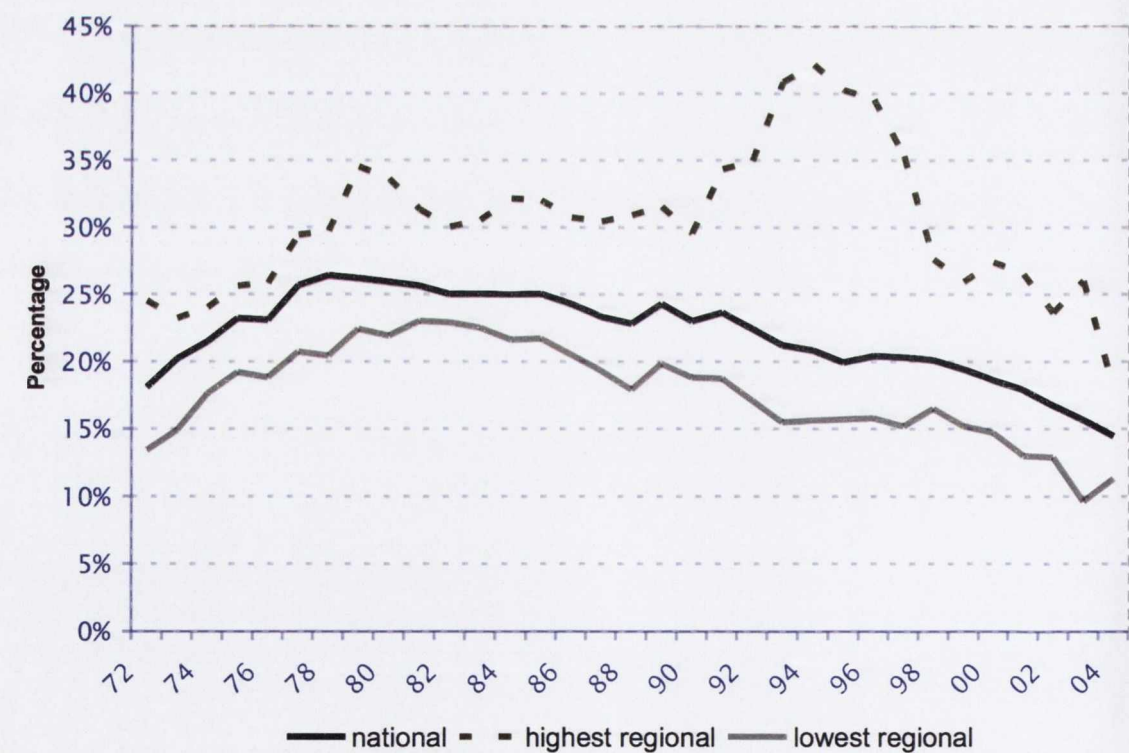


Chart 4.6: In-patient psychiatric admissions with alcohol diagnosis as a percentage of all admissions, national, highest and lowest regional annual rates, 1972-2004



Overall the regional figures highlight that whatever impact broader national developments might have had on the decline in alcohol admissions the reductions are

not uniform across regions, thus underlining that factors other than national policy have effect.

This study does not explore regional variation in alcohol admissions in detail. Since 2005 regional health organizations have been abolished and replaced by a single centralized agency, the Health Services Executive (HSE), which has four administrative areas. The RHB – the region that is the focus of this study - is now located in one of these new administrative areas and in order to provide further insight into regional variability, alcohol admission figures for the RHB are compared to a second regional health authority – referred to here as the Adjacent Health Board (AHB) – which now belongs to the same HSE administrative area as RHB.

Chart 4.7: In-patient admissions with alcohol diagnosis per 100,000 population (16 years +), national, Regional Health Board (RHB) and Adjacent Health Board (AHB), 1972-2004

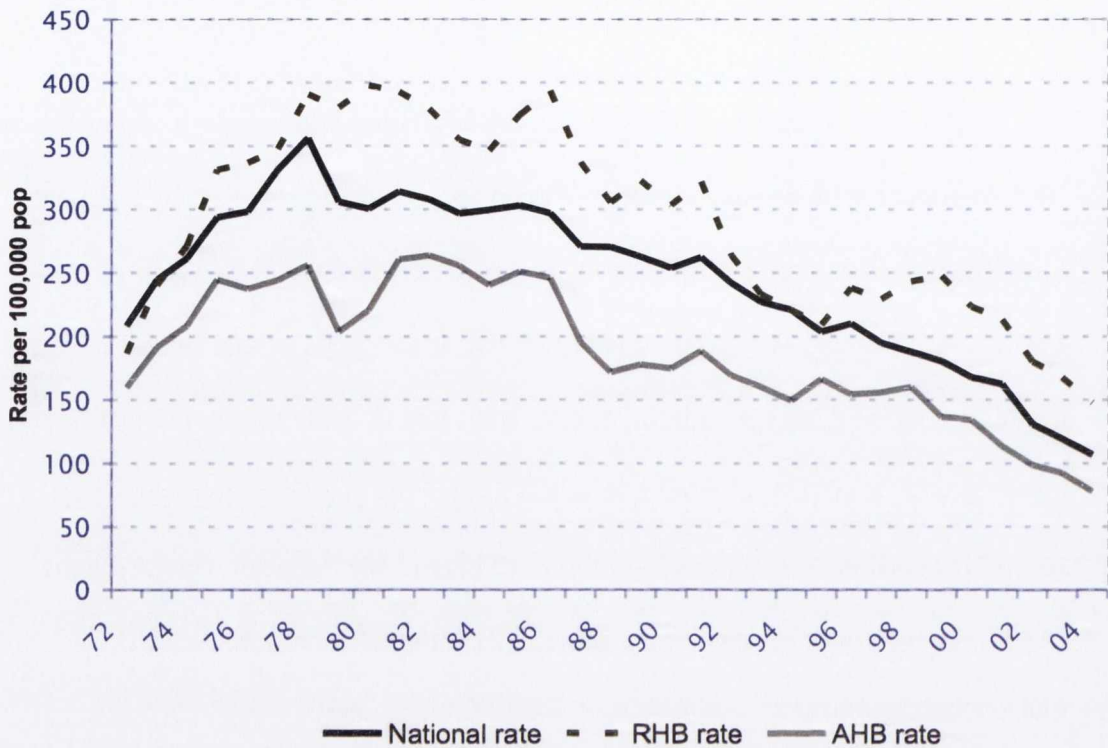
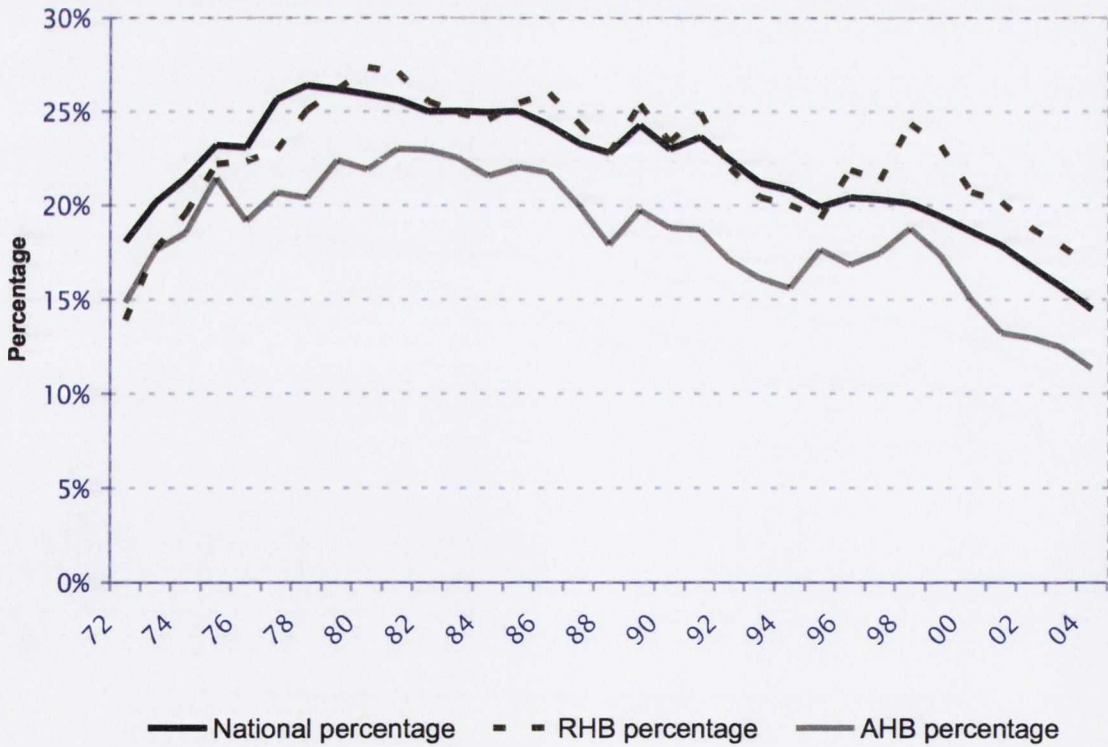


Chart 4.8: Alcohol diagnosis as percentage of all psychiatric inpatient admissions, national, Regional Health Board (RHB), Adjacent Health Board (AHB), 1972-2004



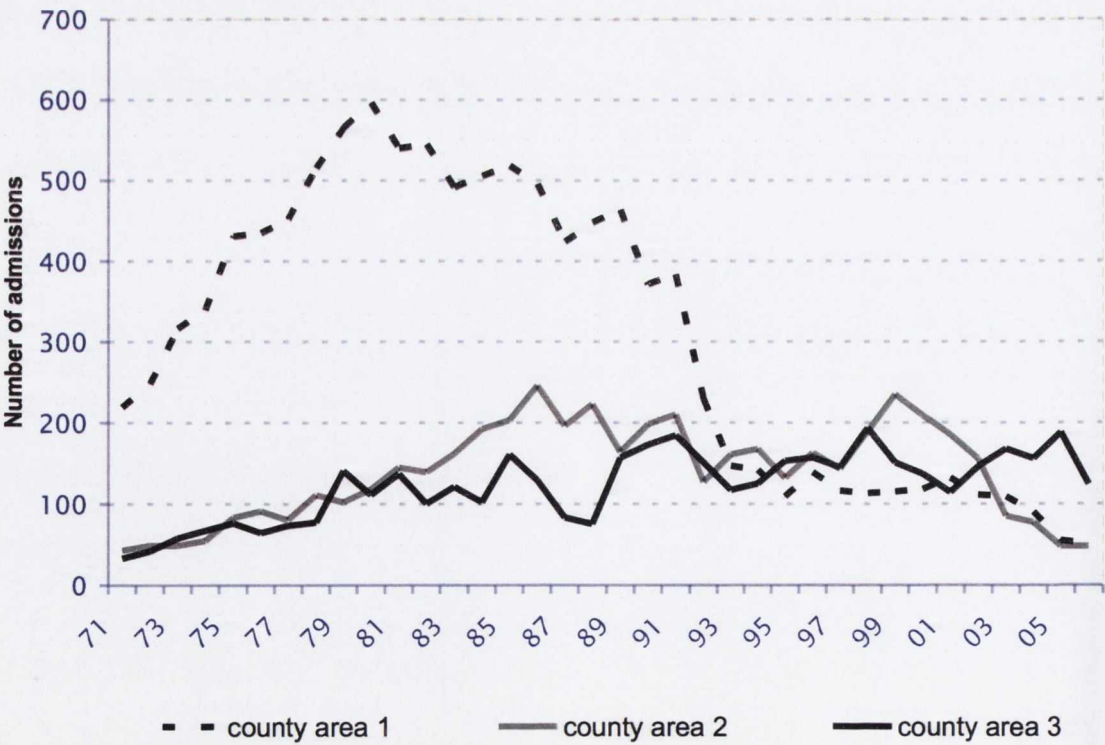
Charts 4.7 – 4.8 respectively outline alcohol admission population rates and percentage levels of overall psychiatric admissions for both RHB and AHB, alongside respective national data. Chart 4.7 illustrates that for over thirty years RHB admission rates have consistently been greater than national rates, while AHB have been lower. At their outset in 1972 both RHB and AHB had slight differences in the per 100,000 population level of admission; this small difference increased quite rapidly although in recent years it shows some convergence. Similarly, Chart 4.8. illustrates that alcohol admissions as a percentage of overall admissions in AHB remain lower than both national and RHB levels between 1976-2004.

The above Charts 4.7 – 4.8 illustrate that RHB alcohol admissions are both above national levels and also higher than the levels of an adjacent region that is now also part of the same sub-national administrative area within the new national Health Services Executive. It should be clear that whatever concerns there may exist at national level resulting from the continued high rates of psychiatric in-patient admissions for alcohol problems, there is justification for further concern at regional level, including at RHB level.

RHB DATA ON ALCOHOL ADMISSIONS

Chart 4.9 illustrates the pattern of alcohol admissions for three RHB county areas between 1971 and 2006. It is clear from this chart that in 1971 two of these areas (2 and 3) had similar admissions and apart from a four-year period during the late 1990s this similarity continued until 2000-2006 when county area 2 had a dramatic reduction in admission, which is not matched by county area 3. This reduction in area 2 coincides with the closure of acute beds in a psychiatric hospital and the opening of an acute psychiatric admission ward in a general hospital. There is no provision for acute admissions in the general hospital in county area 3 where the level of admission in 2006 is at the same as 1984, when *Planning For The Future* was published.

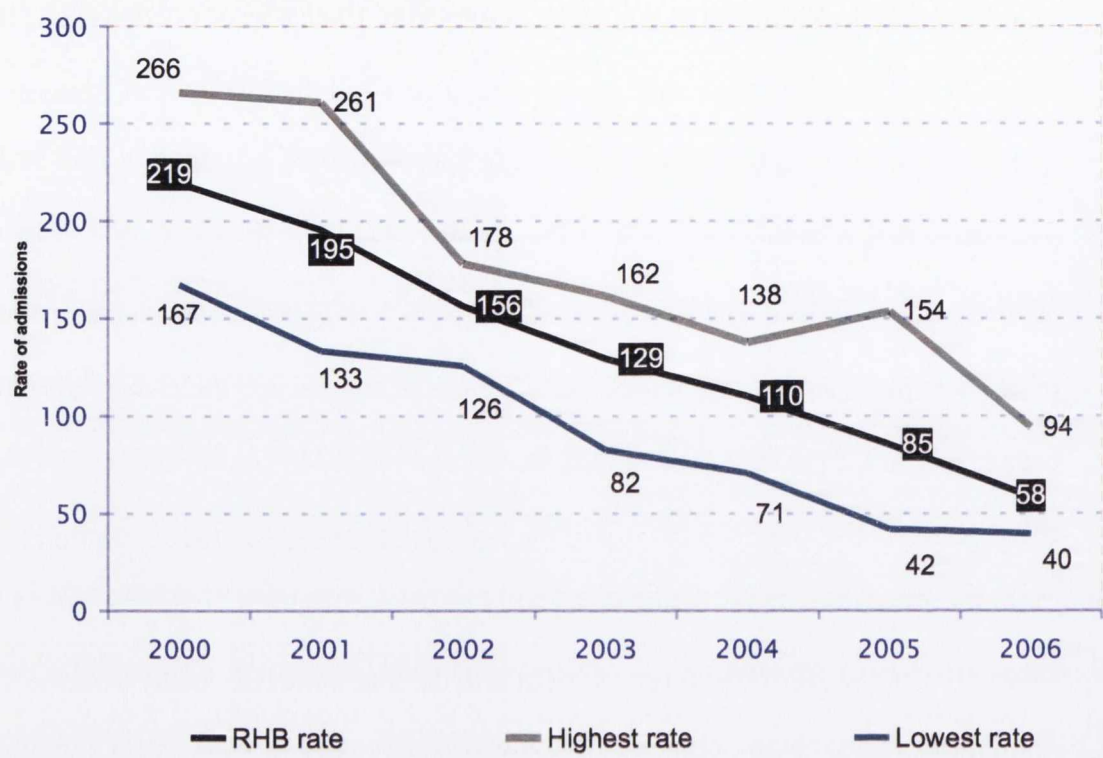
Chart 4.9: Alcohol diagnosis in-patient admissions in three county areas in the Regional Health Board (RHB), 1971-2006



The above Chart also shows that in 1971, county area 1 had a level of admissions in excess of four times that of either county areas 2 or 3 and that the level of admission in this area is now at a similar level as county area 2. In 1971 there were two psychiatric hospitals in county area 1. Two phases of reductions in inpatient admissions are evident. The first commenced in 1980 and coincides with the opening of an acute psychiatric ward in the county's general hospital and the closure of acute beds in one of the psychiatric hospitals; the second reduction commenced in 1990 and coincided with the complete closure of the county's second psychiatric hospital.

Chart 4.10, below, provides further insight into the internal RHB county position by outlining the rates of admission for the whole region alongside the highest and lowest county areas for the years 2000-2006. It is clear from this Chart that the period, 2000-2006 that experienced important reductions in admissions, both nationally and regionally, significant sub-regional differences persist. In 2005, for example, the highest county rate of admission is 3.5 times that of the lowest, in 2006 the highest it is 2.5 times that of the lowest.

Chart 4.10: Alcohol diagnosis in-patient admissions in RHB, and highest and lowest county areas, for each year, 2000-2006

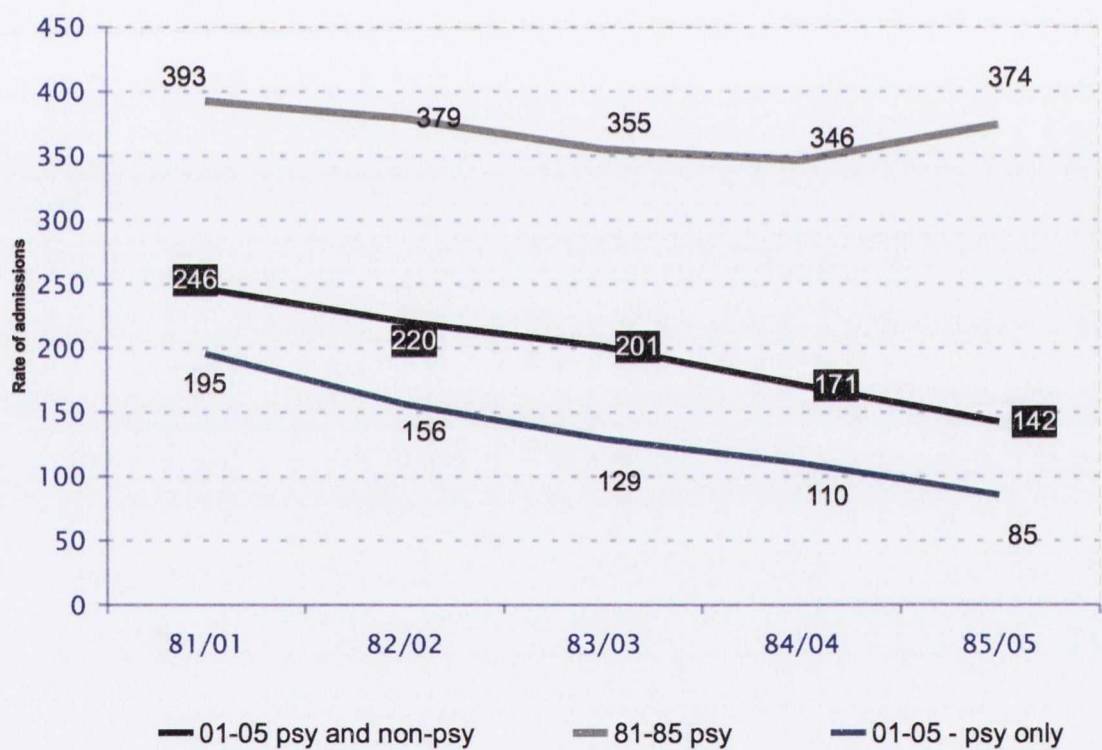


Finally, the above general discussion of alcohol admissions has not taken direct account of admissions to non-psychiatric residential facilities. As discussed in Chapter 2 in the literature reviews, non-psychiatric residential facilities are based on the Minnesota Model of alcohol and drug addiction – a disease model - and were first set up during the 1970s and have expanded in the decades since. The relevant Minnesota Model facilities within the RHB region provide annual data on admissions for alcohol and drugs of persons who are resident in the region; in addition, for this study, relevant data was also collected from a facility that is based outside the RHB region and which draws residents on a national geographic basis⁸. This information, based on returns for the period 2001-5, has been analysed alongside relevant psychiatric admissions data for *both* alcohol and drugs for the same period. The

⁸ Personal communication to the author

relevant data is outlined on Chart 4.11 below providing a comparison with alcohol and drugs admissions for the period 1981-05. It is clear from this Chart that while an overall reduction has been achieved in recent years as compared to the early 1980s that on average 25% of reductions are counter-balanced by an increase in non-psychiatric residential admissions, suggesting therefore that the level of reductions recently achieved is not so dramatic when account is taken of admissions to Minnesota Model programmes.

Chart 4.11: Regional Health Board alcohol and drugs admissions to both psychiatric and non-psychiatric residential facilities, for periods 1981-85 and 2001-05



SUMMARY

The above outline of policy developments and analysis of data on psychiatric admissions for alcohol problems, 1965-2006, provide an important starting point for presenting findings in this study. For the first two decades of this period Irish policy on alcohol treatment was shaped by a disease model with in-patient admission to psychiatric hospital as the main, if not only, instrument of this policy. These admissions increased dramatically over this period reaching a peak in 1981. For the later two decades of the 1965-2006 period, policy – as represented through successive government policy documents - has been shaped by a public health model, one in which alcohol in-patient admission is considered to have but a minor role, as against the much more important role of outpatient, community-based services. A basic tenet of the new policy is that use of in-patient admissions for treating alcohol problems should be radically reduced. From the data findings that have been outlined above it is clear that while a reduction in inpatient admissions over the latter two decades has been achieved, progress has been slow and uneven and indeed it is clear that the rate of progress over the last five years outweighed that of any of the previous five year periods.

On a national level, progress in reducing alcohol admissions may be linked to the expanding role of psychiatric units in general hospitals and the closure of public psychiatric hospitals; put simply the non-availability of beds in the older public psychiatric hospitals potentially creates more pressure on mental health services to make use of alternatives to in-patient admission to acute units in general hospitals, in their response to alcohol problems.

There are clear regional disparities in both the level and extent of alcohol admissions and progress in bringing about their reduction; at one point the highest rate of alcohol admission in one region was almost four times the lowest regional rate for the same year. Recent years show some convergence in these figures although clear disparities remain. The regional disparities are also evident when RHB rates are compared to the rates of an adjacent health board. Although both these regions are now part of a single administrative area within the new national health authority, the Health Services Executive, it is clear they carry a legacy of separate psychiatric admissions policies with respect to alcohol.

Sub-regional disparities are evident within the RHB region. It is clear for example that in two county areas the closure of psychiatric hospitals has coincided with decreased alcohol admissions, whereas the continued operation of a public psychiatric hospital in a third county area, in the absence of a psychiatric unit within a general hospital, coincides with increasing alcohol admissions. While the region converges towards a national pattern of reduced alcohol admissions, some sub-regional disparities persist.

Finally, when account is taken of admissions for both alcohol and drugs to non-psychiatric residential treatment centres, the comparative differences in admissions between previous and current periods are not as great as is implied by an analysis of psychiatric admissions alone, suggesting therefore that a reduction in psychiatric admissions has been accompanied by an increase in non-psychiatric residential admissions.

In summary, prior to the mid 1980s, the treatment of alcohol problems was dominated by a disease model and this is manifested in the level of alcohol in-patient admissions to psychiatric hospitals. A major departure from this approach was adopted through policy changes that should have seen a radical reduction in such admissions. Over twenty years later it is clear that the reduction has not been radical; it has been slow and uneven, although in recent years there has been more speedy progress. As already referenced this overall lack of progress provides an important context to this study. Alongside a reduction in alcohol in-patient psychiatric admissions, the public health policy changes of the mid 1980s also recommended the need to develop outpatient and community-based services. Over the next three chapters, progress in developing these alternatives is assessed.

Chapter 5 – Community Alcohol Services

INTRODUCTION

Drawing from data collected from focus groups and interviews, this chapter assesses progress in developing Community Alcohol Services, as recommended by *Planning for the Future*. As discussed in the literature review in Chapter 2, the public health perspective sees alcohol as contributing to a spectrum of health and social problems, many of which may be effectively managed by generic, community-based services rather than - as was suggested by the disease concept of alcoholism - necessitating specialist in-patient treatment. The data presented in Chapter 4 have revealed that policy recommendations to reduce the number of alcohol-related admissions to the mental health system were implemented slowly and inconsistently in the wake of *The Psychiatric Services: Planning for the Future (1984)*. The alcohol policy recommendations contained in this latter report were unequivocally of the public health variety, both in relation to prevention and treatment; while they accepted that the mental health service continued to have a role in the treatment of drinking problems, they argued that such problems should not routinely be admitted into in-patient care but instead should be managed within community-based mental health services. While arguing for a greater role for primary care professionals and voluntary bodies in this sphere, *Planning for the Future* specifically recommended that new Community Alcohol Services (CASs) should be based within the sectorised mental health services. This latter recommendation was clearly intended to provide an alternative therapeutic option to what was seen as the unhelpful and unnecessary

practice of admitting problem drinkers into mental health in-patient facilities.

Successful implementation of this proposed CAS system would, of course, depend on many factors, including: effective health management, the cooperation of a range of specialist and non-specialist healthcare professionals and popular cultural acceptance of community rather than hospital services.

The aim of this chapter is to present data on the development of CASs within the RHB being studied here. The discussion is based on interviews and focus groups discussions, which have been outlined in earlier discussions in the introduction and in Chapter 3 on methodology. Clearly this data is based on retrospective accounts. The chapter commences with an overview of in-patient alcohol treatment prior to *Planning for the Future*. The chapter then discusses the early stages of developing Community Alcohol Services and issues such as staff and training, team organisation, supervision, resource back-up, impact of services

BEFORE PLANNING FOR THE FUTURE

The widespread escalation in alcohol admissions to Irish psychiatric hospitals during the 1970s and into the 1980s is documented, and assessed in chapter 4 above; unfortunately little is known of the hospital practices and therapies that accompanied this escalation, although, as already mentioned, the report *Planning for the Future* was clearly alarmed by the increase. However, many alcohol and drug personnel

currently working in either RHB practitioner or management roles have previous experience of working within psychiatric services prior to the changes that resulted from *Planning for the Future*. In the main they recall that the primary focus of in-patient treatment was detoxification and medical stabilization through the use of prescribed medication, and sometimes also using multivitamins and in various instances using disulfiram – a drug that produces an unpleasant reactivity to alcohol intake. Psychiatrists and psychiatric nurses provided in-patient care, but there was little additional psychotherapy. There was a view that hospitals did not have the personnel trained in psychotherapeutic interventions for alcohol problems. There is also a view that the then absence of psychotherapies was reflected across a spectrum of psychiatric disorders treated within the hospitals.

According to RHB personnel, social support to in-patients admitted for alcohol disorders was also virtually non-existent during this period and only in a small number of instances did hospital-based social workers have a role. Where social support did exist it consisted mainly of encouraging persons to attend AA; although some hospitals did not support this practice others provided hospital rooms for AA groups to meet on a regular basis:

We were sort of referring them to AA people, we were referring them here and there we were looking for voluntary places. We hosted the meetings up here, we facilitated as much as we could but we hadn't got the personnel who were trained in the area (Drew - mental health manager)

There was little, if any, post-discharge follow-up into the community, apart perhaps

from a discharge letter, which was sent to the client's GP; there was little or no contact with social services. Post-discharge the hospital had no patient contact unless and until the patient was re-admitted. There is a view that at the time hospital-based personnel were quite unfamiliar with developments taking place outside of the hospital and unaware of the activities of an expanding number of voluntary organizations, operating in the field of mental health. According to one SMT coordinator, Lesley: "psychiatry talked to itself" when it wanted to find out what was going on outside hospitals; a comment that perhaps reflects just how radical were the general proposals contained in *Planning for the Future*.

Alcohol treatment prior to *Planning for the Future* is currently described as a "revolving door system"⁹ – it was demand-led with little, if any, pre-admission or post-admission engagement. In-patient treatment was, according to Elisha, a consultant psychiatrist interviewed at a later stage during this study, "our first port of call". While the period witnessed the emergence of voluntary services providing alternative residential, psychosocial treatment - based on a Minnesota Model – there was, in effect, prior to *Planning for the Future* no formal, community-based treatment system, so that in effect in-patient treatment was not only the dominant treatment, it was the only formal treatment.

⁹ This particular phrase was used quite a lot in focus groups and individual interviews

DEVELOPING COMMUNITY ALCOHOL SERVICES

Following *Planning for the Future*, Community Alcohol Services (CASs) were set-up in the late 1980s / early 1990s in various health board areas and in the RHB county areas in this study. Potentially, the decision by the RHB to set up CASs provided the basis for what was perceived as a “new approach”, a “new model of care” in line with chapter 13 of *Planning for the Future*, and as an alternative to the “revolving door” of in-patient treatment. As discussed previously in Chapter 4, the decision to set up these services coincided with the start of a more wide-ranging process of de-institutionalizing psychiatric care, with providing alternative, community-based supportive accommodation for long-stay patients, together with providing outpatient and day-care facilities for new and less-serious referrals. Given the envisaged radical changes in facilities, clinical practice, working arrangements, overriding structures, as well as patient expectations, this deinstitutionalization process was always likely to be slow, particularly for patients who as a result of long periods of hospitalization had become institutionalized. Unlike other categories of in-patient care however, alcohol admissions were usually short term with the result that mental health services were not burdened with the need to develop alternative long-stay residential facilities. An expectation that the envisaged changes in this area of care would take place quite speedily was well founded.

There are varied views among RHB personnel about progress in developing CASs. At their early stage of development these services – staffed by addiction counsellors - are

commonly described as imbued with great energy, enthusiasm and some idealism, and with exploring different methods of work, including groupwork, in the context of developing community programmes; in one county area, for example, a CAS linked up with a GP practice to develop interventions for persons who experienced work-related alcohol problems. The services were also involved in preventive work through an engagement with GPs, other professionals and with schools and community / voluntary bodies:

The [services] were so proactive, they had to be...the only thing they had was their enthusiasm. There was no structure to it. It was sort of like a green field site ...They referenced other places, looked at other places ...so they saw bits that were good, bits that were bad and created new bits for themselves (Lee - CAS addiction counsellor)

The fact that these services were now operating within the context of a community model was perceived, by their staff, as affording greater flexibility as compared to a very structured ward environment. This was seen to be both personally and professionally beneficial, potentially, providing a more meaningful engagement with a more broadly-defined client group and not only persons who entered treatment as a result of severe dependence, as evident by the following comments from CAS counsellor participants in a focus group.

I think it is extremely valuable in the mental health service to see people early on. I don't think we should only see very severely dependent people. I think it is most important to get to the people who are developing a problem and haven't fully realized the implications of their behaviour and they might manage with a brief intervention. But they might need a very thorough assessment and very

thorough help at that stage. So you can't really say only severe, very dependent people need apply, because those who are just at early stages are equally important and may need enormous input (FG: Merle – CAS addiction counsellor].

When I started at this job my personal view was that the access to alcohol services or whatever had to be very open, a bit like if I am walking down the street and I feel [that] I want to go to an AA meeting that I can basically walk in off the street and go into the meeting. Now I would feel and I still feel to this day that access to addiction services has to be like that, so if somebody presents we don't know what the story is until we actually sit down and assess them. It may be an alcohol awareness programme that they need to do. It may be that they have some kind of concerns about their drinking. It may be that they have concerns about their partners' drinking. We don't know, but I think the important thing is that the individual can engage with a professional with the minimum of red tape and fuss and then we can take it from there. If somebody presents to a general hospital with their leg hanging, it is obviously broken, so it is easy to see what has to be done. But when somebody presents to addiction services we don't know until we sit down and assess it and after that and it might be obvious very quickly, but it might take a couple of sessions (FG: Lee – CAS addiction counsellor].

A perceived limitation in the development of these services, albeit one that is not entirely shared by either managers or practitioners, is that they continued to be managed from within structured hospital settings that were pre-occupied with more pressing mental health issues and problems; it is this particular arrangement that inevitably created difficulties, for while CASs had opportunities for some exposure to alternative public health realities and ideas, their main sphere of professional influence was the psychiatric hospital, which as already outlined continued to operate within a predominantly disease-oriented model. There are a number of elements to the perceived limitations, and indeed, there are contrasting views; some personnel view mental health service management as restrictive and not progressive while others

continue to view it as the best available arrangement for developing these type of services.

In one county area, for example, the early setting-up of the CAS coincided with the decision to transfer responsibility of acute admissions for mental health to a psychiatric unit in a county general hospital. In this instance, there is a view that the transition has led to a more community-based service; because in-patient admissions for alcohol disorders are *via* the psychiatric unit in the general hospital, admission is not so easily achieved with the result there has been an emphasis on developing outreach services; it is claimed that the use of this outreach approach can depend “on the consultant psychiatrist who is holding the post” (Sidney - SMT – coordinator). These developments have helped to regulate and reduce the level of in-patient admissions, and where acute psychiatric units were set up in general hospitals alcohol admissions have decreased more significantly than elsewhere. Consultant psychiatrist, Gale, commented as follows in relation to this:

There was a pattern of admitting directly into long-stay wards of people known to the system with alcohol problems. A lot of these admissions were out-of-hours, by junior doctors. Now however, all admissions are discussed. Priorities of general hospital take over (Gale – Consultant psychiatrist).

As already outlined in Chapter 4 above, progress in reducing in-patient admissions is not consistent across the whole region. The discussion below focuses on some common dimensions to CASs and explores these different elements by way of providing a basis for assessing the progress of service development.

STAFF AND TRAINING

From their outset the structural arrangements for developing CASs meant that initially, staff were recruited from an existing pool of psychiatric nurses and who, as a result, remained under the administrative management of hospital-based directors of nursing (or assistant directors) and under the clinical direction of consultant psychiatrists. The decision to recruit staff in this manner arose from pragmatic considerations in the midst of other decisions about resource rationalization. The planned shift in care provision, that followed *Planning for the Future*, created a surplus of hospital trained psychiatric nurses, and personnel for various new non-hospital positions were recruited from among these nursing ranks. For example, many community psychiatric nurses who took on the role of supporting patients living in sheltered accommodation were recruited from the ranks of ward nurses. In some respects these nursing positions required the same or similar professional skills as ward nursing, albeit in different settings. Potentially, staff for the new CASs however, would require a different range of competencies and skills to those that were based in ward nursing. *Planning for the Future* (110) suggested that CAS staff

...should get involved in educational and preventive work, for example, educating people to see the contribution of alcohol to work difficulties, teaching personnel managers how to deal with employees who have alcoholic problems, lecturing local groups about the nature of alcoholism....[and] use their expertise to

support others who may in the course of their work come in contact with persons with alcohol problems.

As is evident from the discussion earlier, there was relatively little experience or expertise within psychiatric hospitals for dealing with alcohol problems in outpatient settings, let alone undertake these new outreach roles, as outlined in the above paragraph. *Planning for the Future*, referred to the prospective use of the “alcoholic counsellor” to staff CASs and to undertake the roles as described above. However the report did not make clear the specific training or qualification that such counsellors should hold. It could have been suggested for example that consideration be given to non-typical mental health occupations in deciding the staffing of CASs. For example social workers, at the time, had been active in providing various community-based social services and were also having an increased role in dealing with the social dimension of mental health services; in some instances hospital-based psychiatric social workers retained membership of local Community Care social work teams. Generic type training such as in social work might have been considered more relevant to that of nursing. Indeed in the UK at the time, Shaw et al (1978) advocated the involvement of social workers and probation officers in local alcohol services, but it appears that this prospect was not considered in the development of these services in Ireland: given the general economic situation at the time, if it was even considered, there was little prospect of being able to recruit new disciplines into a service while there was an over-supply of other, similarly qualified disciplines.

Planning for the Future referred to the need “to provide for programmes to retrain psychiatric nurses for their new role” including that of ‘providing a community

service”. Although it is not stated, it could be inferred from this that it was intended that nurses fill the positions in CASs. Whatever the report intended there is little evidence the issue was given much consideration at the time CASs were being set up. While the issue of new training did arise, the decision to confine recruitment to psychiatric nurses was not, it appears, questioned. The rationality of the decision to recruit from within the ranks of existing psychiatric nurses is underlined by the following comment from an SMT coordinator:

Basically what happened for a lot of the addiction counsellors that are now in place was that there was a load of posts in services that were done away with on farms and all sorts of things and like everything we were doing at the time, you just rejig or realign your services and say well: ‘if we are getting rid of them three over there, then we’ll put these [other] three over here’. It was a realignment of budgets in a lot of cases (Lesley - SMT coordinator).

In effect, this approach to service rationalization meant that the CASs were hugely reliant on persons whose main training and previous practitioner experience was in institutional settings; settings that in the 20 years prior to *Planning for the Future*, had dramatically increased their in-patient intake for alcohol problems within a disease model of treatment, and with little evidence, if any, of psycho-therapeutic or social provision.

A dearth of relevant therapeutic skills among psychiatric nursing personnel was evident at the outset of the CASs, and as a way of dealing with this deficit, arrangements were made for newly recruited staff to undertake specialist training. Invariably these arrangements involved forms of “addiction counselling” training

although neither at the time nor since has there been a statutorily-recognised and / or accredited system for such training. In due course, staff in CASs were referred to as “alcohol counsellors” or “addiction counsellors”. At the time non-accredited alcohol counselling courses were available through Irish National Council of Alcoholism, which as already discussed in Chapter 4, had an active role in promoting the disease model. The fact that 75% of the participants on these courses were nurses (O'Hagan and McGovern, 1987) may have contributed to a focusing on this profession for the new staff positions in CASs. INCA, which as already mentioned, functioned primarily to promote the disease model, was subsequently involved in setting up the Irish Association of Alcohol and Addiction Counsellors (IAAAC), which acts as an accrediting body for addiction counsellors, although it has no official status in this regard (Anderson, 1992). Thereafter, various psychiatric nurses who were assigned to RHB community alcohol services, were self-styled as either alcohol or addiction counsellors, and a separate, distinct discipline began to emerge.

The rather uneven approach to developing skills generated this comment from Lesley, a SMT coordinator:

There was no consistency in the approach to training. No consensus. They were all trained in different places. So, you then had five different services, with each hospital operating as an independent republic (Lesley – SMT coordinator).

Some counsellors undertook placements at centres providing either residential or day-attendance treatment within the Minnesota Model; as a result of this and other influences the Minnesota Model had considerable impact on these fledgling services, which is ironic given the lack of reference to this disease-oriented programme in

Planning for the Future and also given this document's focus on a public health approach. Other counselling personnel undertook the Diploma in Addiction Studies course at Trinity College Dublin. This course contrasted with Minnesota Model training; using a public health model, the course, in addition to addressing wider policy issues in relation to both alcohol and drugs, also emphasized an eclectic approach to community counselling, drawing from systems and ecological perspectives. In recent years this eclectic model has had increasing influence on counselling practice, particularly following the emergence of illicit drug problems in Irish society (Butler, 2003).

With alternate training influences, CAS counsellors became involved in both the provision of ancillary support to prospective and after-care participants in Minnesota Model programmes, and also in providing once-off and ongoing motivational, and harm-reduction counselling on a request basis; in effect integrating both Minnesota Model and public health perspectives, albeit within a system that overall adhered to the disease model ethos, and within which the primary form of alcohol treatment remained psychiatric in-patient. The two quotes below summarise the broadly-based counselling approach:

Our model was very broad. Our view always was: "whatever works with the client we'll run with it, be it AA, [Minnesota Model] or just off the street". There was a relatively broad model that became the eventual model that was used (Jody- CAS addiction counsellor).

....we counsel people who are touched by addiction in any way, that would include people who are addicted, who feel they may have problems and also people who are

touched by it as in family members, we would see anybody over the age of 18, we can't see people under 18 because we are employed by psychiatry which is an adult service. We tend to see people for a minimum of four to six sessions depending on the issues, there is somebody who has been on books for years because of the very nature of the problem people either may be happy where they are, they move on, more problems develop they come back, they do well for years, relapse, come back, there are some people who maybe come and see us as a maintenance thing maybe once ever a couple of months. (Merle- CAS addiction counsellor).

It is clear from these reflections on the development of CASs that in general, addiction counsellors individually exercised quite a degree of autonomy in decisions about training and developing counselling skills. The following exchange between the researcher and a SMT coordinator, Lesley, is instructive in this regard:

ResQ Was any attention given to the skill profile of counsellors?

Lesley No. But, sure who would give it attention? Who would ask the question: 'What skills are needed?' There was no consensus on how to proceed. There was no consistency because there were different services operating out of separate hospitals. The only thing for definite was that the counsellors would be from the ranks of psychiatric nurses (Lesley - SMT coordinator).

From the above paragraphs it can be seen that neither lay management nor clinical management influenced the choice of counselling models adopted by the newly-emerging addiction counsellors. These counsellors were given almost total freedom to exercise their own choice in these matters, with no attempt by management to impose uniformity or the use of evidence-based treatment modalities. Not surprisingly, therefore, counsellors developed idiosyncratic working styles which reflected the

training they had received or their own personal preferences. Some combined motivational interviewing and brief intervention models of practice, which were compatible with the public health approach, with a support role for Minnesota Model facilities, which were obviously underpinned by belief in the disease concept. While such picking and mixing might seem unusual in a large healthcare bureaucracy, its proponents tended to view it positively. This issue is returned to in Chapter 7, when the persistence of individualistic counsellor preferences in relation to treatment options is referenced in a discussion of overall RHB vision and ethos in service development. For the present it is important to highlight that counsellors were given considerable autonomy in deciding their overall counselling approach. It appears that RHB management at the time was happy with this arrangement as were many of the counsellors themselves, albeit to a more limited extent.

TEAM ORGANISATION

In county areas, CAS addiction counsellors are assigned to structured sector multidisciplinary teams, which would also consist of a consultant psychiatrist, who would lead the team, a junior psychiatrist (registrar), psychologist, community psychiatric nurse, family therapist, and the various heads of departments from within the hospital, such as occupational therapy, social work and ward nursing. The way in which addiction counsellors operate this role is variable: some of the functioning has developed over time with both formal and informal communication linkages with

other members of the team and in this way referrals can be received through internal phone calls, everyday meetings or single encounters. In general these constitute variations of a traditional, clinical model. The weekly, traditional routine of one CAS addiction counsellor is described by the following exchange:

I am in [sector 1]. I attend a [sector 1] ward round on a Monday morning and that would be the two acute wards, male and female. But like we would only attend; we don't sit in on the whole ward round. It just gives us an opportunity to meet with the psychiatrist and discuss whatever they need to discuss.. Our structure would be our timetable and where we would be morning and afternoon everyday.That would go on for about half an hour, three quarters of an hour and I would spend the rest of the morning seeing any inpatients from [sector 1]. And on a Monday afternoon I go down to health centre in [town in sector 1], and that is for outpatient counselling, for the whole afternoon. I am in [same town in sector 1] all day in that health centre. [The psychiatrist's] clinic is in the same centre. So I would see a lot of clients. I have a drop in service and anybody that she feels needs to see me, I would see. I would be in [second town in sector 1] on Wednesday and we [other addiction counsellor] both have supervision on a Wednesday afternoon and I would be all day Thursday [in second town in sector 1] and half day Friday. Myself and [....] would meet on Friday afternoon.....Most of [clients] would be attending [psychiatrist] on a weekly, fortnightly, or monthly basis, but some of the people I would be seeing would have no contact with the psychiatrist. They would have been seen in General Hospital, where they presented at some stage and they were seen by our psychiatric liaison person and they would be referred to me, and in that circumstances I would be seeing people that would have very little contact with psychiatrist (Reagan – CAS addiction counsellor).

The sectoral team meeting would be considered as underpinning the work of a mental health team. Usually this would take place weekly within the hospital and the discussion would normally involve a case discussion on new referrals or continuing patients requiring multidisciplinary discussion:

That is our meeting, where we centralise and discuss things that are of importance, every week it happens and we go through referrals or whatever. Outpatients are considered, pre referrals are considered. If a GP has rung us and said: "I am worried about so and so" that is discussed; the proper intervention might be discussed. Maybe it is time to schedule an outpatient appointment or whatever; or someone who has been discharged maybe there is follow up needed so that would be a continuum of care that goes on and would also come up for discussion at a sector meeting. (Ashley- mental health manager)

The sectoral team meeting constitutes the main mechanism whereby CAS counsellors discuss their clients with other members of the team and also receive information on ward patients.

During the [sector] discussion [...] [the consultant psychiatrist] might say: 'right, I am discharging Mr. X but I want him to follow up', and [...] [the addiction counsellor] will take that information and say: 'well, I will offer the appointment or any follow up care'. We then discuss their own work-load during the community part of it, they will say: 'look, I am seeing eight people here and I want to discuss these', so they will go through everything you know and it is discussed and maybe there is another intervention required or whatever but it is all up for discussion. They would always have some people that we [the other team members] wouldn't know at all...they would never come within the ambit of psychiatry at all, but as part of their work load they would just run through them. (Ashley- mental health manager)

While the structure of sector multi-disciplinary teams was not considered necessary for dealing with the general caseload of CAS counsellors, counsellors' association and familiarity with other team members meant they could get relatively easy access to psychiatry, other specialisms within the team, and also access to in-patient admissions, if need be.

Because we work within psychiatry we have access to psychiatrists so if we have somebody who we have concerns about, from a mental health point of view we can actually get them seen and assessed very quickly and that is a massive advantage of being connected to the psychiatric services.....If we had somebody presenting themselves here who was obviously very unwell, needed to stop drinking, [and] couldn't physically do it in the community we couldtake them across [to acute psychiatric ward] and get them admitted (Merle- CAS addiction counsellor).

We find it invaluable that we have the support of our colleagues in the hospital. We have family therapy. We have psychology,... the psychiatrists and the psychiatric team there. We can refer and share resources. There are any number of different courses in the day hospital that we can access quite easily and it saves us having to duplicate that kind of work ourselves (FG: Francis – CAS addiction counsellor).

If you are out in the community and you are trying to make a referral to psychology it could take you months whereas we can just pick up the phone and get an opinion or even a referral if need be at much shorter notice. I suppose some of that would be available in the community because they have a psychology service there but you wouldn't have the same range of services as you would have here (Kelly - CAS addiction counsellor).

SUPERVISION

In addition to the sector team structure, an assigned consultant psychiatrist, who ostensibly acts as team leader, also directly supports each CAS; in one county area where counsellors are not attached to sectoral teams, the assigned consultant psychiatrist plays a more directive role in service development. There are mixed views on the relevance and value of these arrangements; their usefulness was seen as

depending on the attention and interest of the psychiatrist concerned; certainly some counsellors were very positive in relation to specific, named psychiatrists who had fulfilled the leadership role at certain times.

They are always available. If I have a problem here I can contact them, even the consultant on duty. I have access to a consultant at all times (Francis- CAS addiction counsellor)

It is also apparent however, that some consultants felt quite constrained in what they could do in relation to alcohol problems:

Overall up to 50% of the patients I see have some alcohol-related problem. It depends on what way you define it. It is like the “elephant in the sitting room” and all of us are aware of the effect on morbidities. It is there all the time and we are not stepping back to assess this. Yet we don’t have a menu of interventions for alcohol; some (interventions) are made up (Gale – Consultant psychiatrist).

We have no real policy on interventions. It very much depends on the patient. Some might need treatment for mood disorders, or there may be family issues. However, we don’t have a formal menu that we would draw down, it is all on an ad hoc basis (Elisha – Consultant psychiatrist).

There was a view that consultants and other mental-health service management held back from having a too directive role in order not to undermine the CASs’ identity or autonomy. The following comment from a county mental health manager highlights this reluctance to interfere with the operation of CASs:

They would have been set up as alcohol addiction counsellors but have evolved over time into a more generic type of role and would be counselling people not just referred from the clinic route lets say a consultant, and what have you, but

would have evolved into a low threshold type service, you know, an easy access service, like. They certainly weren't restricted in their approach (Alex - mental health manager).

Notwithstanding this reluctance to interfere with the work of CAS counsellors, it appears that in some instances, such loose arrangements did not help consolidate a clear representation of service aims and methods; one counsellor for example commented that in one single CAS there were two distinct services, reflecting two distinct counselling approaches:

Basically you had the [counsellor 1] service and you had the [counsellor 2] service, and the two weren't the same. You had [consultant psychiatrist] who was directing it in a manner I suppose which is quite uninvolved and to a degree I think that informed decisions, say that the other two made. Because I think that the way it grew was: two people working in the same [CAS] and doing completely different things. So when I look back on that I think well there mustn't have been an ethos.... There is no literature over what the ethos is. (Lee - CAS addiction counsellor)

What has been described here is CASs that are relatively structured and formal in the context of their everyday liaison relationships with mental health sectoral teams, but are more loosely structured with regard their alcohol counselling interventions. These loose arrangements inhibited an ongoing structure for support and direction and in general it appears that the major onus was on counsellors to plan, develop and manage the emerging services, drawing from each other for peer support and at times "providing each other with peer supervision", although, because these lacked accountability, such arrangements were perceived as "problematic" (FG: Ali - SMT coordinator). In the absence of structured, in-house supervision or direction, some

counsellors made alternative arrangements to have external, privately-arranged supervision. This researcher was surprised to realize the absence of supervision, as is evident in the following exchange between the researcher and Merle, a CAS addiction counsellor:

- ResQ What supervision do you have?
- Merle Well basically we are supposed to be supervised by the director of addiction services [consultant psychiatrist]These meetings don't often happen and not much is achieved so technically, officially, yes we have supervision but in all honesty we have no supervision.
- ResQ I would consider it quite serious if you don't have a mechanism for discussing your clients in a satisfactory manor.
- Merle There isn't , I pay for my own supervision. When I came here, I couldn't believe it... I was going: "what?" Because I had never worked without supervision, even as a nurse, and when you are counselling people you have to have supervision.
- ResQ But you are paying for your supervision, that is not a form of accountability?
- Merle No.....but for my own sanity I am doing itTo get back to the case load supervision it doesn't happen and my bosses don't know who I'm seeing (Merle- CAS addiction counsellor).

Another CAS counsellor, Lee, was particularly concerned with the laxity towards providing direction and supervision, as indicated by the following exchange with the researcher:

- ResQ Where are you getting this direction?
- Lee I could be.... trying to ram that [Minnesota Model and AA] down peoples throats, and no one is going to know any different. No one is going to have a clue and there is no level of control.
- ResQ So from a professional perspective, it is quite *laissez faire*?
- Lee There is no structure at all
- ResQ Does it have parameters?

Lee The challenge islike in [Minnesota Model] if you don't sit with the programme like you don't get in there. Whereas here you could be someone, like this person I am working with who is waiting to go into [Minnesota Model] because he is going down there and is going to AA and I am talking to him and I am in that model because that is where he is going, right. But I am [also] trying to help him stay out of prison and he has no intention of stopping drinking and I am trying to make sure he doesn't end up in the nick again you know so you have to have some level of flexibility. But when you have no parameters then you go back to ... anarchy reigns. You know, that is the problem within the health board, within this part of the health board addiction service. It is a very quiet form of anarchy (Lee - CAS addiction counsellor).

Another counsellor expressed the general lack of direction as follows:

I would be the first to admit that I am unclear as to where primary responsibility lies: Who leads this service? To whom do we talk to when it comes to looking for changes, improvements funding whatever? I really believe there should be some debate on those issues (Francis – CAS addiction counsellor).

As the following quotes illustrate mental health service managers did not have any undue concern about counselling supervision. One manager explained that counselling supervision is one of three dimensions to accountability, while two managers indicated that the specific issue of counselling supervision was really a matter for the counsellors themselves.

In terms of supervision there are three elements of the supervision. One, there is the clinical responsibility and the actual case specific case supervision, within the mental health service context [with] the consultant psychiatrist and the multidisciplinary [team]. Then [second], there is the supervision in terms of professional counselling and that is provided specifically by a recognized

supervisor for counselling and then [third] there is the nursing supervision which comes to [nursing manager] [Carl – Mental Health manager).

They [medical consultants] allowed a degree of autonomy [for the counsellors], and there was that sort of relationship on a professional level, between our counsellors and our consultants, that permitted that to evolve over time (Alex - mental health manager).

They [counsellors] do it [organize supervision] themselves. I mean if so far they haven't come to us to ask us to do it, if they do we have to do it but they are doing it themselves through their training from whatever but they haven't come to us.....I am surprised they haven't come to us saying: "could you provide us with supervision". I am waiting for it to happen and when it does we have to provide it but obviously wherever they get their training they obviously have their own preferred way of getting their supervision and they will do it themselves and if it costs they have to look after it themselves but as I said I am waiting for them to come and ask us to provide it and I am surprised they haven't.....[They] are accountable for the delivery of care to the medical director, so their clinic work is dictated and supervised. In that sense, they report back what happened I don't feel I have any more input (Drew - mental health manager).

As indicated by the above quote, accountability is provided through overall clinical management; typically this happens through sectoral teams with the consultant psychiatrist giving clinical direction. As pointed out by one manager: counselling supervision is considered one of three dimensions to the overall system of counselling management; in this particular instance the counsellors concerned expressed satisfaction with the support they were receiving through the other two dimensions, but as already outlined it was not universally believed by CAS counsellors that adequate counselling supervision was available through this mechanism and indeed other concerns were also expressed, both in relation to supervision and the prospects of further counselling training and accreditation.

There were lots of people didn't want supervision, they didn't want any further training either.The hospital managers didn't want them getting supervision or getting any kind of legs under them at all.....They didn't want any policy on supervision. They didn't want to be paying money out of their budgets.I was pushing accreditation but I didn't manage to push it as far as I would have like to push it. On the other side of it there is a certain amount of resistance from some people that didn't want accreditation to be quite honest they didn't want to be working to any process where somebody might be looking at them you know (Lesley - SMT coordinator).

In separate discussions held with two psychiatrists in relation to this study both agreed that psychiatry tended to have a hands-off approach in relation to alcohol counselling and perceiving it as being managed and directed by counsellors themselves with psychiatry having a more reserved, referral role. In general this sense of detachment from supervisory relationships by mental health lay and clinical management did, in due course, raise concerns among Community Care managers who subsequently – from late 1990s onwards - took on the role of managing new Substance Misuse Teams (SMTs). Although these latter services were more purposefully framed within a public health model – in this instance in relation to drug problems – at an early stage they emulated CASs in their focus on addiction counselling, although in this particular instance it was not required that counsellors be qualified psychiatric nurses. In due course some counsellors embraced an expectation that their supervision should be arranged off-site, that is through private external supervisory arrangements.

RESOURCE BACK-UP

It is important to note that some CAS counsellors, initially at least, enjoyed their autonomy, their sense of being in control of their own workloads, setting their own direction to service development, and of not being supervised in an ongoing manner; counsellors commented positively about the sense of getting behind a new venture that was exciting and also that was significantly different to the routine of ward nursing; as one counsellor pointedly commented: “it was away from the hospital which would colloquially be referred to as the mental” (Lee – CAS addiction counsellor). However, there was also a strong sense of these CASs operating in isolation; especially for services that continued to be based in psychiatric hospitals:

The service in [Town] is still in the psychiatric hospital and who is going to go into that; it was said you have to be mad or bad to get treatment [there]: mad that you were part of the psychiatric service or bad that you came through the probation service but one way or another you had to see a psychiatrist who may or may not refer you then for counselling (Lesley – SMT coordinator).

The above comment reflects a lingering disparagement towards institutional, psychiatric hospitals, in part explained by a broader frustration among some RHB personnel that many public psychiatric services continued to be provided – twenty years after *Planning for the Future* - from old Victorian buildings. While other, external bases for community alcohol services included a general hospital and psychiatric day centres, the sense of being away from the psychiatric hospital was to a large extent inaccurate; the services remained assimilated within psychiatry although

it is commonly claimed that while they were managed from within this base they lacked direction from it.

CASs also lacked administrative or organisational back-up and in some instances counsellors undertook these tasks themselves, contributing further to their sense of isolation, and this is illustrated by this exchange between the researcher and Merle a CAS addiction counsellor:

Merle Basically we are working for an organization that really does not know what we do.

ResQ Yes, is that very worrying?

Merle It is extremely worrying

ResQ Is it worrying for you because you don't know whether you are being supported in your work?

Merle You are not being supported in your work. When I came first I thought great I [can] make this job up as I go along, but as time went on I thought it is tragic, it is tragic for the clients.

ResQ Can I just check with you, how aware is the organization itself of that particular predicament that you are in at a level say above [consultant psychiatrist]?

Merle It has been said, but you don't know if it is being heard (Merle- CAS addiction counsellor).

While CAS counsellors felt they were part of something bigger, in terms of being members of a sectoral team with good access to psychiatry and other specialists, they nonetheless believed they were having little impact on the overall structure; the limitations of these arrangements, such as in relation to supervision and direction, became more apparent over time. An early indication of these drawbacks focused on access to and use of physical facilities. One former CAS counsellor, now a SMT coordinator, described an initial enthusiasm when he and a colleague viewed the

building in which the CAS was to be located, followed by disappointment to realize the building was to be used primarily as a psychiatric day centre, with the CAS playing a relatively minor, ancillary role:

It was an alcohol service but the alcohol service is actually located within a psychiatric service. I remember [we came] down and looking at the building and we thought it would be a great building to take over for an alcohol service and we would have a plethora of ideas, we would have AA using it we would have NA using it we would have maybe self help groups, I mean other self help groups not just the fellowships. We would run group work, we would look at the whole possibility of structured detox and supervised detox, we even thought at that point of having a bed in there. When we came back [from training] we had kind of the front of the building with three rooms. The rest of the building was a psychiatric day centre and a psychiatric day hospital (Ali - SMT coordinator).

In another area the RHB acquired a house to be used for alcohol treatment but rather than use the house as a non-hospital based community service it was given instead to a voluntary agency who developed the house as a Minnesota Model residential centre, which operated a disease-oriented programme. Three other county services had no direct access to community buildings or facilities: one of these was based in a general hospital while the other two were based in psychiatric hospitals. These arrangements remained in place in the course of this study.

Developments in relation to service accommodation and other apprehensions about supervision raised concerns among some counsellors, and other personnel, as to whether there was a serious intention to develop a new comprehensive, community service. One view was that despite initial enthusiasm for these services, their primary

function was ancillary to inpatient practice, and that this situation would pertain for as long as in-patient admissions for alcohol remained high:

[There was] a very clear message....that the priority was the inpatients, the service was there to serve the hospital, first and foremost and then there was a community base, so it was a community base with this dichotomy of 'you are community-based, but you look after us first' (Lee - CAS addiction counsellor)

There is an internal demand, where people [patients] by virtue of their association with the sector team or as a result of either a planned admission to an admission unit for detox, that is the internal demand. That is where psychiatry says 'look you are a counsellor and I want you to see this person or that person and do whatever work is to be done and we can work together', and that may be because the person has primary addiction problem. (Carl - mental health manager)

Another view was that hospital management, while happy to have community services play an ancillary role, were not prepared to give these services direct back-up resources, support and direction:

The structure here in [...] was that we had two counsellors working to a consultant psychiatrist who was full-time but only part-time in relation to addiction. Psychiatry is poor relation to health and addiction is poor relation to psychiatry. We were running the service on two salaries, a bit of travel, a light bill, a phone bill and ...[little] else. [We had] no admin[istration] and no budget. [It is] very hard when you don't have a full-time boss dedicated to the service. [There was] a very lax attitude towards the service. It never featured as a major issue. Level of input and interest from high-up was not there. We operated in a vacuum. (Jody- CAS addiction counsellor)

Local mental health managers tended to attribute the under-resourcing of CASs to various factors. For example it was argued that CASs were not impacting on in-patient admissions, which if achieved, it was argued, could result in further resources being diverted to community services. This was presented as a chicken-and-egg scenario, so for instance if hospital managers decided to restrict further in-patient admissions as a way of encouraging more focus on outpatient treatment, they were likely to be criticized by psychiatrists, who it is believed, would argue:

‘well look, you resource our community based services, then you will see a real impact on admission numbers, but until you do that don’t expect any performance that will impact on admissions’ (Alex - mental health manager).

IMPACT OF SERVICES

One SMT coordinator, Ali (also, former CAS counsellor), claimed it was considerably difficult for community-based services, aspiring to operate within a broad public health model, to have much impact on in-patient admissions for the reason that they were likely to be attracting and dealing with a different group: “a whole new body of people....who came along because they decided to look at their drink” and usually did not “require going into psychiatric hospitals”. This approach is also supported by Dee, a CAS counsellor, who highlighted that a lot of referrals are consumption-related and arrive from court: potentially in the long-term they may require more in-depth intervention, but for the present the involvement is short-term and outside the mental health care system.

A lot of the people who will come [through court referral] wouldn't have what we would define as a clinical problem with alcohol, but they would have problems that are associated with their consumption. We find it a very interesting experience in terms of [firstly], that is a way of identifying [problems] at an early stage; Is this person going to be a potential client? Maybe in a years time or whatever? Sometimes you can actually address those issues and maybe avert that happening which is what prevention is all about. And, secondly it makes people a little bit more aware that not only have they to go in front of the judge but they have to come and see us as well so you know maybe there is a little bit more thought put into not going down the same road of behaviour again (FG: Dee CAS addiction counsellor).

The basis of the in-patient problem, according to Ali, the above SMT coordinator, was not within community services such as CAS, but lay within both the hospitals and the community more broadly:

.....I would argue that I could go up to the psychiatric unit nowand I would strongly argue that half to three quarters of those people don't need to be there. The difficulty is that there is a mentality in Ireland and if you have a problem go to the hospital, go to the specialist, you know, and you must be dried out. I only recall one or two, literally you could count on one hand in twelve years the people who actually needed a high level of a detox[ification]. Most people are out of it in two or three days, you know. What happens is people wind up in a crisis almost always on a Friday evening, will present for admission, be refused and will come back and say that they are feeling suicidal and will be admitted. Now what happens is that they are admitted then with an alcohol/drug problem. They are not. They are a self-harm problem and they should be listed as such and it is one of the things we try to push for. I think that would change the face of admissions (Ali - SMT coordinator).

The above view has considerable support from among other RHB personnel. One SMT coordinator, Lesley, locates the problem of continued use of in-patient admissions within hospitals and the power relations between hospital managers and psychiatrists:

Lack of an acute unit is what we are told [as explanation for high alcohol admissions in one county psychiatric hospital] but I think it is an ethos – “this is what we always did”. There is something in the staff to keep the beds going [used] because the jobs might go. The hospital managers were grade 7 administrators and had little power over psychiatry and served as a secretariat to the Chief Psychiatrist. The leadership wasn’t there. There were no people there who understood the policy and could bring other people along. There was no planning. There was no systematic approach. Psychiatrists tended not to want to interfere with other people’s patients (Lesley – SMT coordinator).

It is also argued that a persistent, public expectation that alcohol problems be dealt with, not on a community, but on an in-patient basis, ensures that resources are focused on in-patient care and not diverted to CASs or other community or outpatient services: a culture of support for in-patient care has built up and it becomes increasingly difficult through time to change this culture; once in-patient beds were available, the public would automatically assume that their use in treatment was appropriate, irrespective of whether they were really needed. And, as already outlined in Chapter 4 individual hospitals had considerable autonomy in whether or not they used their beds for these purposes, but various internal factors inhibited their ability to reduce bed occupancy, especially given the level of nursing and other employments tied up in hospitals:

Most of our resources are locked into the hospital. A lot of the nursing positions are

tied into the hospital. [RHB] area [is] particularly lagging behind because of old hospitals. These employ a lot of people and there is a lot of resistance to change because of the level of employment. Upgrading is not being done. Some of the nurses will never want to work on a community basis and want to keep the retiring early option. The ones who want to move are not encouraged and are not funded to train-up We have a day hospital up in [...] fully ready, but we can't use it because the resources have not been agreed. Re-locating nurses from [the hospital in this town] is the big problem. The problem has not been resolved (Elisha – Consultant psychiatrist).

Some hospitals however, were able to reduce admissions, irrespective of whether they had CASs and irrespective of the qualities and abilities of those CAS that they did have; as pointed out by a hospital psychiatrist (Elisha) : “Each hospital has a different ethos and variable commitments to enforcing policies”. The following comments from SMT coordinator, Ali expands this argument that the core problem is the way in which in-patient treatment is organized and the effect of this on external expectations.

This [admissions policy to psychiatric hospitals] also has potential negative impact on the community in so far as it reinforces their view of what an alcohol problem is. It reinforces the public's perception of what an alcohol problem is, that it is a problem that gets dealt with up in an acute unit.....The type of admissions to our acute unit, 25 – 27% alcohol, well that has been consistent over quite a number of years. It has been consistent even going back even before [Minnesota Model] opened. So you have had a major residential programme opening; you had a community based service opening and yet the level of alcohol [psychiatric] admissions remains consistent. The message I get anyway is that there is a question about the appropriateness of a lot of those admissions so my understanding is that we are dealing with a lot of inappropriate admissions into our acute unit and why you would ask yourself? I think people misuse the service as much as they misuse a substance. (FG: Ali– SMT coordinator)

The following array of comments highlight the way hospitals are put under pressure

and stress from the external community and individual patients and emphasises the importance of external, cultural influences on in-patient admissions policies.

If someone has a constant problem up the town, then they are sent to us.... they have been brought in as a temporary patient and have been detained or there has been a lot of pressure which can come from politicians, the Gardai, the medics in other services, social workers to take this person in because they are an enormous problem at home or they are walking the streets or they are lying in the streets or whatever. You may know nothing about them and the first that is known about them, and it is not an infrequent occurrence, is where they are literally brought in the Garda car, or an ambulance, or in a private car with a pink form, an order for detention, or they will simply be left and you can get them to sign a voluntary form when then can sober up. (Carl - mental health manager).

In some cases it would mean just someone who hasn't even a bed because they have been kicked out of home because they have created difficulties by going home..... So they are admitted and very often they discharge themselves the following morning. So this is to do with risk management, not to do with what is appropriate for the person at all. It is risk management and we are practicing risk management here and not psychiatry and not counselling..... This then becomes their long term treatment. Once they start the circuit of into the service and out the chances of them making any kind of worthwhile rehabilitation gets less and less because they are provided with a bed when they need it and they know the buzz words for doing this; they know how to get the bed (Dorian – Mental Health manager).

Staff would say so and so is back, are we doing the right thing? A lot of them are afterhours and they come through [out-of-hours GP service] and they [the GPs] will say: 'well suicide was mentioned' and once they hear that they have to come to us. I could have a discussion with the [referring GP]: 'look really hold off until tomorrow, it is a crisis but are there other agencies'. But they will say: 'well he said he was going to, well suicide, that he is going to do this'. So doctors fear that, so they bring them in. (Ashley- mental health manager)

People are very wedded to the disease concept and feel very committed to that whole idea and if you try and broaden that a little you can meet a lot of resistance to it.....I think it [the resistance] comes from society. There is a comfort in saying something is an illness. And for how long have we heard the mantra that a person is an alcoholic, it is ok, it is an illness. There is a cultural thing about that. So I think when you are trying to change perceptions of what a problem is or perceptions of how it should be dealt with, and the structures with which to deal with it, there is a huge cultural shift, which has to take place (Jude – SMT coordinator).

The general difficulties of trying to develop a community service against a background of resources continuing to be absorbed by in-patient admissions are perceived as reflecting a view that RHB management had no real commitment to these services but rather were simply fulfilling the basic requirement of having a CAS in place without making exceptional demands on ongoing service operations. The following comment from a county mental health manager illustrates the sense of frustration, following the departure of two counsellors who had provided a service without a proper structure for almost 20 years.

The total resource provision was two alcohol counsellors, two good people; their posts were created over twenty years ago and they were sent off to do specialist training and then left [alone] to do the job. That is perhaps part of our problem and it is indicative of a lot of service problems - you put people in and say: 'go off and do the job' and twenty years later you say: 'oh they are leaving, what will we do now?' (Carl - mental health manager).

According to one CAS counsellor, Lee, the idea that 2-3 alcohol counsellors could

have the much-needed radical impact on hospital in-patient practices was unrealistic from the outset. It underlined a perceived lack of conviction within psychiatry services more generally that the various problems with which they had been traditionally involved could be dealt with effectively within a community context. In this regard a lack of capacity within psychiatry management for dealing with addiction services is underlined, reflecting a lack of capacity to deal with community services more broadly. There is a general sense among CAS counselling personnel that the development of these services lacked serious investment, in their own right, from the outset and that this lack of investment reflected RHB's lack of general expertise within the field of alcohol and addiction problems more broadly.

The thing is that you have a failure of management in... the [RHB] for years... It is probably lack of knowledge, you didn't have managers in there who had the training or expertise or experiences, who knew what addiction services are and what they need to be. That is why they always get people from the outside to come in, to do reviews.....because, they don't have it within the [RHB] itself (Lee - CAS addiction counsellor).

The lack of investment in CASs is sometimes contrasted to the level of investment made available to residential services that were set up and operated by a voluntary agency that adhered to the Minnesota Model. Counsellors referred into and provided after-care support to these services, as appropriate, and in the context of providing other interventions. However, some concern was expressed at what was seen as this voluntary agency's ability to attract substantial RHB financial support, while the RHB's own services were often perceived as stagnating due to the absence of resources. As already mentioned, a building owned by RHB was given over to the

voluntary agency to operate the Minnesota Model service in preference to using it as a non-hospital base for RHB's own CAS. According to a current SMT coordinator, this decision to support the development of Minnesota Model meant that in effect the RHB was taking very little direct responsibility to manage and coordinate services itself, and in due course this lack of engagement in a coordinating role stored up problems of management and coordination for the future:

It [a decision to set up a coordinating mechanism] certainly never happened. I think it may have occurred to people that it should have happened but what they did you see was.....they found another way around it so what they did was fund a voluntary agency to operate a service.... Instead of sitting down and making a proper plan we give them [Minnesota Model] a house down, which we get a pound a year for, a huge house. The house was bought because there was two [CAS] addiction counsellors going away to be trained, but by the time they came back that house was given away, with funding, and the counsellors ended up on the third floor of the psychiatric hospital and nobody gave a monkeys [cared] whether they ever worked or what they did. So instead of getting heads together and sitting down and getting some kind of policy for the [RHB] it was just ignored, and things went off that way..... Some of the thinking wasn't bad. It was just probably the way it happened. There was a general acceptance....that like, if somebody in my family [for example] had a problem [with alcohol or drugs] I wouldn't ask one of the [hospital counsellors] to see him. I would send them on to that nice place [Minnesota Model] and what psychiatrists wouldn't do in their own services, they did for the nice place. They went along and they assessed their patients and all the rest of it and recommended all sorts of great things for them, but the poor [clients] coming in [to public hospitals] didn't get any of that you know.....So what they went out and got paid for they had a different view on altogether than what they actually should have been doing within their own services I have gone through all [documents] relating to the different issues [on funding Minnesota Model] and I can't see that anyone every took a decision based on some good argument. It was all done. There is no reason for it. It is just done. There isn't paperwork there for it (Lesley – SMT coordinator).

Like many such agencies this Minnesota Model programme invested a lot of energies in supporting its model's diffusion into the wider community, including into practitioner systems and funding bodies such as RHB. Despite the level of investment into the Minnesota Model however, and also despite considerable, widespread support for operating this service at its outset, much of this support seemingly declined over time amidst concerns that the service was far too narrow in its intake policies and lacking commitment or capacity to work in collaboration with external community services. Two SMT coordinators articulated these concerns as follows:

Well I have often said there are residential rehabilitation organizations that require somebody to be problem free before they enter the gates. Well you are going to have a good success rate with that client group, aren't you? Stable non drinkers I am sure do very well in residential rehabilitation. But there are other people that do seem to benefit from that kind of intervention but yet we have got the focus perhaps in the wrong areas (Jude – SMT coordinator).

We have all picked up on people from voluntary treatment who may have not done so well in treatment and then turned up subsequently at community services, whereas maybe if they had turned up at community services first then they might have done better if they had been referred on or sometimes it is not appropriate. With some of the voluntary agencies I would say we have a better relationship, we have a working relationship in that there is a tendency there to make us aware of all clients from our area that are in there irrespective of whether we refer them or not and that does benefit in terms of aftercare and follow up (Ali – community substance misuse coordinator)

In contrast to Minnesota Model the public health approach, which underpinned CASs was not, argued some personnel, well understood; its core philosophy and ideas

lacked diffusion into the wider community, which, it is perceived, continues an expectation that public psychiatric hospitals function “to contain social disruptions attributable to problem drinking” (Schmidt, 1995, 386). Ashley, a mental health manager describes a contemporary “revolving door” event:

With people with alcohol problems it is a revolving door, unfortunately. So just about half an hour ago I had a phone call from someone out in the community about one of our relapsed people and this is a GP so they are ringing to say: “look I am worried about so and so, they are drinking plus the guards have been on to me’. Or the guards will often ring to say: “so and so is on the street and could you send out somebody”. You get a lot of contact pre-admission, and generally it is not straight forward. The CPN (community psychiatric nurse) might be sent out to do a home assessment. We might just get an appointment to see (addiction counsellor) and they might default, and may not come in (for appointment). Eventually they would come in for (in-patient) admission, but we could have a lot of contact from people who are outside. It could be the priest, the family doctor, a concerned neighbour or whatever. Generally these people are ringing to say: “look what can you do about so and so, she is drinking, she is on the street again”. So you have to put your interventions in place and that is where the team comes in and you make a decision (Ashley – mental health manager).

Some counsellors argued that given a choice between continuing with an in-patient admission system and a community-based service, the public would more likely opt for the former. The public health model however, did gather momentum as a result of the emergence of drug problems; this theme is explored in the next chapter.

The initial development of CASs, as already mentioned, however, was approached with great zeal, enthusiasm and a willingness to explore new ideas and to engage with various external community and practitioner interests, and to an albeit limited extent

there was a sense of some achievement in this regard. Across all county areas addiction counselling – as initiated through CASs - was to a large extent perceived as the core resource from which a deeper engagement with community and primary care personnel could be achieved; it was seen as the most likely service discipline with the potential to embrace the twin-pronged approach to service development as outlined in the introduction to this chapter. However, there is a strong sense among both counselling and many management personnel that once the CASs were set up and operating, there was little further attention to their planning and that a focus on community mobilization and on developing primary care capacities within the field of alcohol never really got off the ground. The issue of engaging community is explored later in Chapter 7, in the context of appraising the efforts of both CASs and SMTs in undertaking this task.

SUMMARY

The discussion above focused on progress in the development of community alcohol services during the two decades following the publication of *Planning for the Future*. While there was a major escalation in in-patient admissions for alcohol problems during the period prior to the publication of this report, there is little or no documentation on the type of services and therapies provided; recollections from RHB practitioner and management personnel who used to work in the hospitals suggest that interventions were primarily clinical and focused on detoxification and physical stabilization, with little attention to psychotherapy or social rehabilitation, except through referral to AA, a practice that was utilised in some, but not all

hospitals.

CASs were set up in sub-regional county areas during the late 1980s and early 1990s. Recruitment into staff positions in these services was confined initially, and since, to psychiatric nurses whose primary training and practice was hospital-based; there is no evidence that consideration was given to recruiting other professional disciplines into these positions, for instance social workers and other social care personnel with more experience of working in community-based settings. It appears that recruitment policies were guided primarily by decisions about resource rationalization and there is, for instance, no evidence of planning with respect to profiling required qualifications, skills and competencies. While personnel in new community alcohol services identified the need for training and were able to undertake courses in support of this, it is clear that, initially at least, there was no consistent policy in support of training.

According as CASs developed, a broad model, embracing different interventions, and straddling both disease and motivational treatments, emerged. It seems clear that CAS personnel had quite a lot of autonomy in developing the counselling dimension to their work, even though in most instances they were integrated into sectoral mental health teams. Membership of sectoral teams is seen as providing good access to other specialised services, although there is concern that it reinforces the idea of alcohol counselling as an ancillary service, whose primary function is to support in-patient treatment. Direction, support and counselling supervision, particularly in relation to persons who are not known to mental health teams, is variable and in some instances

non-existent, save through private arrangements.

In one particular county area, following the opening of an acute psychiatric unit in a general hospital, the CAS was structured to support a reduction in in-patient admission, a reduction that was, to a large extent achieved; however, it is contended that continued progress depends on key personnel, who change over time. Elsewhere reductions in in-patient admission for alcohol have been achieved more slowly and unevenly, and the role of CASs in supporting change is not clear.

The relative funding of CASs as compared to expensive in-patient services features as an issue of ongoing importance. Some CAS counsellors expressed concern that a minimum of resources are made available to these services, reflecting a basic commitment to maintaining the service, but little commitment to ongoing service development or investment; it is also suggested that this minimalist approach is reflected in the lack of commitment to providing the CASs with strategic leadership, with the result that some services have foundered, and have been inhibited in supporting and resourcing primary and community care personnel to become involved with addiction issues.

There is a view that lack of support for CASs is linked to a perception that the public is not making demands for this type of service, but requires that in-patient services be continued and that the facility of admitting people who, as a result of their drinking problems, are causing difficulties for other medical and social services, the Gardai and the wider community, be maintained.

The lack of intensive support and funding for CASs is contrasted to the enthusiasm with which senior management supported the opening of Minnesota Model facilities in the region; there is a view that management support for these latter developments reflects continued investment in the disease model and its diffusion into the community. There is also a view that management support for this approach diverted from the need to devise a comprehensive regional strategy.

As is clear from the discussion so far in this study the report *Planning for the Future*, published in 1984 was a major milestone in the development of alcohol services. The report proposed a radical overhaul of these services, one that would potentially locate service provision within the public health model that internationally, at the time, was acquiring research and policy support. One central idea behind the CAS as proposed by *Planning for the Future* was to preserve the key role of psychiatric services in treatment provision so that the facility for in-patient admission would become a back-up to community-based therapeutics. It is clear from the summary of findings in chapter 4 above and in this chapter 5, that the proposed radical overhaul has not been achieved; while in-patient alcohol admissions have reduced, progress has been slow and uneven; while CASs have been set up, and while there are varied views on the success or not of their development, there is a general view that they lack the impact envisaged by *Planning for the Future*.

At a regional level the only management or co-ordinating system envisaged by *Planning for the Future* was that each county area (equivalent to a psychiatric hospital

area) would take direct responsibility for coordinating the changes and developments. From the previous chapter it is clear that each hospital exercised their responsibilities with autonomy; this chapter illustrates that much autonomy was also granted CASs even though they were linked to sectoral mental health teams; the CASs developed with insufficient attention to basic aims, structure direction and ethos. CAS staff, notwithstanding their experience, commitment and interest, had relatively limited qualifications for the developmental tasks required and lacked the ability and support to project a new outpatient, community model of alcohol services development.

Chapter 6 – Emerging drug problems and new drug policies providing a focus for changing alcohol and addiction services

INTRODUCTION

This chapter explores the impact of newly emerging problems associated with the use of illicit drugs, and a new drugs policy, on how the Regional Health Board responded to what could now be generally described as “substance misuse”. As stated in Chapter 1, the aim of the research presented in this thesis was to track the progress of attempts by one regional health board to bring greater organizational clarity and a more evidence-based focus to its management of alcohol-related problems. It was made clear in the literature review that this task was one traditionally assigned to specialist Mental Health services under the rubric of the disease concept of alcoholism, but RHB management - in line with a public health model now being advocated at national and international levels - was attempting to broaden the base of its therapeutic response and introduce services reflecting this public health model. The present chapter is aimed at exploring the impact of newly emerging problems associated with the use of illicit drugs on how the RHB responded to what could now be generically described as 'substance misuse'. It might, of course, be argued that having failed to create a clearly structured response to alcohol-related problems alone, the RHB was unlikely to improve its performance in this regard now that client populations were using a wider range of psychoactive substances. Equally, however,

it might be argued that the challenge of responding to a complex mix of illicit substances and alcohol presented the RHB with a stimulus to rethink its overall strategies and to attempt a root and branch reform of all administrative and clinical activities in this sphere. As will become clear in the findings reported in this chapter, the challenge for the RHB was not solely that its external environment had changed with the advent of a wider range of problematic drugs; it also faced an internal organizational challenge in promoting clearer collaboration between its own Mental Health services (bureaucratically defined as 'Special Hospital' services) and those services traditionally delivered under the rubric of Community Care. The discussion below first provides a background to emerging new policies on drugs and then provides an account of the two separate processes undertaken by the Regional Health Board to bring about a re-structuring of its addiction services within the overall context of these changing policies.

BACKGROUND TO NEW DRUGS POLICIES

When *Planning for the Future* was put into the public domain in 1984, Ireland was already about six years into its first experience of a serious drug problem - Dublin's so-called 'opiate epidemic' (Dean et al., 1985). This referred to the emergence of clusters of injecting heroin users in inner-city and outer suburban areas characterized by high rates of unemployment, poor housing and generalized social exclusion. Epidemiological and social research had, almost from the outset, confirmed that there

was a distinct social or community dimension to Dublin's heroin problem, as well as confirming the wide array of health and social problems created or exacerbated by such drug use (O'Kelly et al., 1988; Cullen, 1993; Cullen, 2003).

Planning for the Future referenced the social and community dimensions of illicit drug problems. It portrayed these problems as symptomatic of “multiple community difficulties and disadvantages” and it advocated a community-based treatment approach, “with inputs from both medical and social personnel together with the voluntary organizations” alongside a close relationship “with probation officers and the Gardai” (*The Psychiatric Services - Planning for the Future*, 1984, 117-8)

As with alcohol problems, *Planning for the Future* questioned the value of costly in-patient residential facilities as a response to these drug problems, pointing out that while physical withdrawal for heroin addicts “may be a simple matter” it was much more difficult to keep addicts abstinent post-discharge, as they are likely to be easily absorbed back into their social networks and into an involvement with crime. The report argued “there is no convincing evidence that highly specialised, costly and sometimes residential approaches to drug problems are cost-effective for the community as a whole” (Ibid).

Planning for the Future noted that while the *Mental Treatment Act* (Ireland, 1945) made provision for psychiatric hospitalization for drug addicts, the use of this provision for non-alcohol drug problems, even following increases in drug misuse, was minimal. However, the report did not spell out a role for sector psychiatric

services in drug treatment and it was not envisaged that drugs be included in the recommendation to develop community alcohol services. Out of concern that opiates and other dangerous drugs prescribed for drug treatment could potentially be leaked into illicit markets, the report argued against the involvement of GPs in the treatment of drug dependence.

In the absence of a well-defined role for GPs or other Primary and Community Care professionals in drug treatment and also in the absence of a developed network of voluntary agencies dealing with these problems at local levels, the management of serious drug problems during the years both immediately prior to and following *Planning for the Future*, was, despite the report's public health rhetoric, dominated by a disease model of addiction treatment. This model as it applies to alcohol is outlined in Chapter 2 and was adopted during the late 1970s /1980s by the then three leading agencies providing treatment services to persons with serious drug problems:

- the National Drug Advisory and Treatment Centre (subsequently re-named the Drug Treatment Centre Board) a psychiatry-led specialist, statutory out-patient treatment centre, with access to a small number of psychiatric in-patient places (Kelly, 1983);
- Coolmine Therapeutic Community a residential programme modeled on American concept houses and therapeutic communities (Broekaert, 2006); and,
- Rutland Centre, which operated a Minnesota Model of addiction treatment (Rowen, 2003).

By 1991, following the publication of the *Government Strategy to Prevent Drugs Misuse* (*Government Strategy to Prevent Drugs Misuse*, 1991), official government policy with respect to drug problems shifted further in the direction of a community approach and towards supporting alternatives to disease model strategies. This report emphasized the necessity of involving GPs and other community professionals and personnel in a harm-reduction model of treatment; it also recommended the designation of regional health officials as coordinators of drugs misuse and the development of pilot community drug teams to coordinate and integrate treatment efforts at local levels. The proposal to designate regional coordinators reflected a concern that, although serious heroin problems were confined to socially disadvantaged communities in Dublin, there was nonetheless an increasing trend in drug use, more widely. By focusing on issues of harm reduction and community-based services the report signalled a move away from a reliance on the disease model towards the public health approach, a move that was motivated by medical, legal and political concerns -particularly arising from the prospective sexual transmission of HIV from drug users to other non-drug using society members. The shift towards a public health approach was supported by emerging networks of drug workers and community bodies (*Community Response*, 1991), and also by new voluntary agencies who already were operating harm-reduction strategies (*Ana Liffey Drug Project*, 1991).

The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) (referred to below as the *First Rabbitte Report* after the Task Force's chairman, Pat Rabbitte TD; both this report and a second report, published in 1997, are jointly referred to as the *Rabbitte Reports*) brought policy focus to the

implications of epidemiological data on the social correlates of injecting heroin use in the Dublin area and made explicit recommendations of a range of public health and harm reduction strategies, aimed at the prevention and management of associated problems, such as environmental decay, educational disadvantage, unemployment and social disorder. The report proposed health interventions in the geographic areas most affected, including the provision of community-based treatment (methadone maintenance) through GPs, local centres, outreach and mobile clinics, an expansion in health board outreach and addiction personnel and the provision of funding support to community groups and user groups who were involved in prevention, treatment and rehabilitation. The report was published in conjunction with a government statement that contained significant funding commitments and also proposed a coordinating, partnership structure - consisting of a National Drugs Strategy Team and Local Drugs Task Forces (for 12 designated areas) – to implement its recommendations. These partnership structures drew in representatives from funding, implementation and community bodies, reflecting a model of service governance at national, regional and local levels whereby various new programmes were jointly set up and managed by collaborative bodies drawn from statutory, voluntary, community and private sector agencies¹⁰.

The Second Report of the Ministerial Task Force on Measures to Reduce the Demand

¹⁰ Social partnership refers to collaborative arrangements between the Irish government and the main societal institutions that set out various economic and social measures, alongside industrial relations agreements, for set periods, usually 3-5 years. The basic principles informing these arrangements were set out by a report from the *National Economic and Social Council (1987) A Strategy for development, 1996-1990: Key points, National Economic and Social Council, Dublin*. following which the first such national agreement was established. The second national agreement extended the national partnership process to regional and local developments; initially this involved the establishment of area-based partnership companies to tackle problems of long-term unemployment in designated areas with concentrated levels of unemployment; in successive agreements both the breadth of this programme and the remit of these companies were expanded and other social partnership developments in relation to poverty, disability, drug problems and so forth were agreed. A full collection of partnership agreements and their review reports is available for download on the Irish government website <http://www.taoiseach.gov.ie/index.asp?ACTIVEGROUP=1&locID=231&docID=-1>

for Drugs (1997) was primarily concerned with education and prevention issues particularly in relation to non-opiate drugs. It recommended extending cross-cutting partnership structures into managing and developing a *Youth Services and Facilities Fund* that would channel funding investment into designated socially disadvantaged urban areas country-wide, thereby ensuring that outside those areas in Dublin where heroin-use was concentrated there would be both structures and resources for developing a response to drug misuse. Several urban areas in the RHB region were named for inclusion in the work of this *Fund*.

The *National Drugs Strategy, 2001-2008* (National Drugs Strategy (2001 – 2008), 2001) consolidated the recommendations of the *Rabbitte Reports* and was issued in the context of a commitment by the governments of EU member states to set out their national policies and priorities on drugs. The policy extended the structures that were utilized as a result of these reports by introducing a new coordinating mechanism at regional health board levels and thereby, potentially improving each of the region's overall capacities to provide community-based treatment and intervention, as required. As with previous reports, the *National Drugs Strategy* emphasized the importance of working with community groups and involving them in devising a range of different responses¹¹.

Under the *National Drugs Strategy*, responsibility for developing drug treatment fell to regional health boards. The discussion in previous chapters has already outlined a lack of progress by health boards in developing community-based alcohol services, as

¹¹ As the *National Drugs Strategy* constitutes continuity from the *Rabbitte Reports*, there is a tendency by many commentators to use the term *National Drugs Strategy* to refer to policy developments from 1996 on; this tendency is continued below.

both a complement, and alternative, to psychiatric in-patient alcohol treatment. However, with the publication of the *Rabbitte Reports* there was a new impetus to developing community-based addiction services as a response to drug problems; for the RHB this interest in developing addiction services included a commitment to focus on both alcohol and drug services together, even though alcohol was specifically excluded from the *National Drugs Strategy*.

REGIONAL COORDINATING COMMITTEE ON DRUGS

Following the publication of the *First Rabbitte Report* the RHB appointed its first Substance Misuse Coordinator; in due course a team of such coordinators was appointed corresponding to one coordinator for each of the county areas and one overall regional coordinator (in this study each of these is referred to as Substance Misuse Team [SMT] coordinator). These coordinators were based in the Community Care Programme. A Regional Co-Ordinating Committee on Drugs (RCCD) was also established. This committee brought together various health board and non-health board stakeholders:

- to act as a forum for co-operation between the various agencies (community, voluntary and statutory) involved in drugs;
- to monitor trends;
- to agree an appropriate range of education and prevention measures; and
- to recommend strategies for the treatment, rehabilitation and ongoing

support of persons who misuse drugs.

Specific issues that dominated the committee's early deliberations are its proposals towards establishing community addiction services, and whether such services should be concerned with *both* alcohol and drugs (RCCD, minutes, 25/06/1996).

Committee members held contrasting positions on the issue of integrating alcohol and drug services. On the one hand, there was concern that the committee's terms of reference arising from *the First Rabbitte Report*, were to focus on drugs only and that a joint focus on alcohol and drugs might make it difficult to draw down new national funds, when these became available. On the other hand, frontline professionals were acutely aware that many drug users commence their use through misusing alcohol, that many prevention and treatment programmes focus on both alcohol and drugs, and also that alcohol misuse was a major problem within the region. It was felt that it would not be appropriate to have an organised regional response for the lesser problem of illicit drugs if alcohol was not also included, or if there was no comparable effort to deal with alcohol as a separate issue.

The Committee sought clarification from the Department of Health on this matter to which the Department responded that the issue of alcohol did "not form part of the terms of reference for the co-ordinating committee" (RCCD, minutes, 17/09/1996). While the Committee decided to inform the Department that the exclusion of alcohol would jeopardize the "effectiveness of our work in the area of drugs", it nonetheless proceeded to submit funding proposals to the Department that were specifically concerned with coordination and new community-based education and outreach

counselling initiatives for tackling drug problems, exclusively.

Despite the absence of new funding from the *National Drugs Strategy* for alcohol service initiatives, the RCCD continued to discuss and process proposals in the direction of more comprehensive, integrated services, and appointed a sub-committee to process this further. This sub-committee included RHB personnel and other service providers and resulted in a proposal, which was adopted by RCCD, that a standardization of treatment services, access and functioning be established across the region, such that each sub-regional, county area would have a service to be known as a "Community Alcohol and Addiction Service". It was proposed *inter alia* that each service "should operate a low threshold, easy to access policy for referrals", and that, in addition to adults, they each receive referrals of persons under the age of 18 years (Regional Health Board, 2003).

The proposal for a Community Alcohol and Addiction Service reflected a growing RHB view that alcohol and drug problems were primarily community and social in orientation, and needed to be dealt with in an integrated manner. As outlined by SMT coordinator Ali, these problems did "not exist in a vacuum" but rather there was a wider context such as "greater affluence, or poor housing or lack of amenities", a position that was also supported, amongst others, by comments from Corey an SMT education officer:

An awful lot of the difficulties that have to be dealt with when someone presents are not [only] the clinical presentations, in terms of damaged cognition or in terms of damaged physical health, but there is also the huge

social impact and how you actually begin to work with the family. So there is a combination: the social consequences [and] how it is damaging their social life and the social fabric of their existence. People often present [in treatment] before it [the problem] is significantly and irreversibly damaging [clinically] but [they present] because of the social consequences of their alcohol or drug addiction (Corey – SMT education officer).

Given this social context, the RHB's view during the period of the RCCD was that proposals for dealing with alcohol and drug problems needed to incorporate the mobilizing of community-based professional and lay interests as part of its general aims.

Before proceeding to discuss the outcome of RCCD proposal, it is useful to provide further context to the involvement of Community Care in these developments. As outlined in previous chapters, RHB involvement in alcohol treatment was traditionally based in Mental Health Services and although the report *The Psychiatric Services – Planning for the Future* recommended that alcohol treatment become more community-based and focused on outpatient as distinct to inpatient care, it nonetheless envisaged that it remain under the direction of Mental Health. At that stage the Community Care Programme had no direct involvement with or management of alcohol services. At the outset of the heroin problem in Dublin during the early 1980s initial management responsibility for these problems lay within Mental Health. In due course, that management responsibility passed over to Community Care. One of the main reasons for this development is that the expanding drug problem in Dublin – and elsewhere - attracted intense interest from community organizations, and consequently, personnel within Community Care engaged with

these various community groups to flesh out and develop community responses. This involvement with community groups was consistent with Community Care's engagement with communities across a variety of social issues, in many different regional health boards. It also coincided - following the publication of the *First Rabbitte Report* (1986) - with an expansion of various government-sponsored programmes that mobilized communities to tackle social problems including unemployment, poverty, environmental decay as well as drug problems (Broaderick, 2002). In an interview, Van, a RHB Community Care manager, outlined Community Care's engagement with these issues as follows:

Community Care would traditionally be engaging with a lot of community groups and would be very much about developing needs. They would be looking at new responses, quite often in the areas of significant deprivation and emerging problems, particularly in child care. Staff were highlighting these problems that they were encountering: if they were trying to address the children's needs and [doing] that on a kind of holistic basis, then they needed to be engaged with the parents; if the parents had a barrier to them engaging with the programme - it may have been drink or it may have been drugs or it may have been both - these were problems that the services were beginning to look at (Van - Community Care manager).

This emerging community dimension is perceived as setting a new agenda to the way in which Community Care managers were assessing and responding to local needs. New funding streams, such as those that emerged through the *National Drugs Strategy*, established roles for community organisations and representatives in the development of health board services. Following the publication of the *Rabbitte Reports* it became clear to Community Care personnel that there was now a new approach: "a new way of doing business" (Lesley - SMT coordinator), and that this

new way required the RHB to bring the various agencies together to formulate a common approach to the problem, and to engage with and involve the community. One Community Care manager describes the process of developing partnership and collaboration as follows:

What emerged was that this *ad hoc* group were beginning to form themselves..... They didn't have a mandate, it wasn't structured, it wasn't official. My view at the time was get them to form something which has some representative structure about it and it was from that that the local coordinating structures came to have true meaning here..... We said: 'look there are various people who have an interest and have a vested interest and we would wish to hear about it'. We have community services, we have the special hospital Mental Health services, we have the community groups and we have the various other statutory agencies that have a role or a responsibility that is the Gardaí, customs, the education side of it and there was a whole variety of people and so from that we pulled the group together with terms of reference.... We had huge success in similar structures in saying: 'lets all get together. What are the needs? Now lets prioritise these; lets try and sign off on it'. (Van - Community Care manager).

While this new partnership way of working was supported through national and regional policies and was also something that local community and other organizations favoured, it gradually underlined difficulties in the relationships between Community Care and Mental Health. It was clear that Mental Health personnel were perceived as having an important role in developing responses to drug problems; they were invited to participate in local consultations and in developing local structures and CAS provision was continually referenced and promoted. Indeed, as already discussed, CAS personnel made an important contribution to the promotion of a new treatment framework at regional level through the work of the RCCD. This contribution notwithstanding, it became apparent that Mental Health was not going to

lead the emerging response and that any additional resources the RHB acquired for drugs, or alcohol, would be channeled through Community Care structures.

By the late 1990s a regional drugs coordinating office was established in order to effect the implementation of the *National Drugs Strategy* and it prioritized allocating resources for new community-organised services. The provision of funds for other health board services was contingent on these being community-based, not only in name but also in terms of engaging community bodies in a more active involvement with service development.

This approach would clearly have implications for the prospective involvement of Mental Health-based CASs in new service developments, for as already discussed in the previous chapter, CASs were generally oriented towards psychiatric hospitals and units and, at this stage, were not perceived as integrated into community-based services or structures. Indeed, as they became involved in drug-related issues, Community Care managers became increasingly aware of the inherent limitations of CASs and of the lack of effective relationships between their own practitioners and their colleagues based in Mental Health. Many such relationships with Mental Health – including CASs - are portrayed as being based around client liaison and referral, involving GPs, social workers and public health nurses, with little attention to planning or policy; it also appears that the referral process was not always clear and is described as being “like referring to somewhere else, like another agency; there was no joined-up approach to it” (Van - Community Care manager).

The fact that CAS referral policies could differ across the region, depending on the hospital catchment area, was also an issue of concern to Community Care managers and personnel. In general CASs had an open-referral system, whereby individuals could self-refer, or be referred by various community personnel. However, in some instances referrals needed to be medically assessed and processed first through GPs, thereby creating a void with respect to problems that were not necessarily viewed as medical and that tended to be primarily social in their manifestation. Increasingly these latter problems were being referred into Community Care services and accessibility was identified as one of the issues needing to be dealt with.

One of the changes that was needed was access. Within a system where you had to go through a psychiatrist to be assessed for an alcohol problem, that was unacceptable to people. Within any modern addiction service you should have easy access and direct access to an addiction counsellor, without having to be referred to a psychiatrist because people didn't want to feel that they had a psychiatric problem because they had an addiction problem (Lee – CAS addiction counsellor)

So an area that was particularly arising as well was how accessible and how appropriate and how responsive the existing addiction service was and how well placed or not it was to respond..... And there is no doubt about it but the communities were beginning to say: "you are not doing enough"....But clearly, in discussions, and in the growing body of wider research that youth groups were doing and communities would be looking at their needs, these [alcohol and drugs] were on the list of other things like poor housing, or income levels, or unemployment, that needed to be looked at (Van - Community Care manager).

Community Care began to rely more on community organizations than their Mental Health colleagues for insights into drug problems; the following exchange between the researcher and one Community Care manager highlights the inevitability of developing new responses within the context of an effective community engagement.

ResQ Were you surprised at the proposal for community-based services?

Dusty Do you mean in terms of the structure that they are putting in there?

ResQ Yes

Dusty No. I think there has to be appropriateness of the services, appropriateness of location, appropriateness of meeting people within their own areas and not hiding the problem in a mental institution or whatever. It is everybody's problem, you know. It is the community's problem and I think the community are part of the solution.

ResQ Are you saying that the emergence of this proposal was consistent with an understanding that you had of these problems as you were beginning to examine them at the time?

Dusty Yes

ResQ And apart from the idea of locating the responses closer to where the problems were being experienced, was there any other rationale in relation to the decision?

Dusty I suppose the whole institution Mental Health thing, the thinking around that whole area was obviously changing and moving away from going to [medical] consultants at the referral process, you know, having to go through this process. First of all you have to go to a GP to be referred into Mental Health and once you got in there not many people would stay the course. I think it [a change] was obvious at the end of the day.

ResQ And when you say it was obvious, does that mean there was a sense in which people were no longer pursuing the Mental Health referrals because there were so many hurdles to go through?

Dusty I know certainly if it was my problem I would want to be pretty far down the road before I engaged in that [referral] process. I think that what that system led to was where people were already caught very much - very addicted - or very much at the end stage, whereas the community based [approach] is more.... conducive to the whole

early intervention, and prevention approach (Dusty - Community Care manager).

Some Community Care discussions with community organizations centred on the non-availability or inaccessibility of existing CASs. As community views were represented and expanded the appropriateness of locating services such as CASs within Mental Health began to be questioned, thus reflecting a growing perception that “Mental Health services were not for them [people with alcohol and drug problems]” and that “not everybody who has a problem of this nature needs to go through psychiatric service..... in actual fact it may be a barrier.” (Van - Community Care manager). It appears indeed that barriers did grow between Community Care and mental Health with respect to these issues

There were problems with developing or providing substance misuse services from within the special hospitals’ programme because of problems with stigma, location, approach, and it was largely focused on alcohol, it was largely focused on adults and it was largely focused on abstinence. So while I am not saying that is true, I am saying that is the rationale given for [changing things]. Some of it is true but it depends on the different areas so that was my understanding of why services needed to be developed within community. I suppose the mistake in it, if there was one, was that it was treated as an either, or thing (Jude – SMT coordinator).

In its work with the RCCD, Community Care personnel anticipated that whatever proposals emerged for further development would include mechanisms for engaging with and maintaining relationships with various communities within which new services or initiatives would be located. The RCCD proposal articulated that alcohol and drug problems were issues requiring more generic, and perhaps less specialist interventions, corresponding to a public health model; it also established a broad

framework for achieving an integration of alcohol and drugs within the context of a community-based service. The proposal was perceived as an evolution of the CAS model as proposed by *Planning for the Future*, one that incorporated both alcohol and drugs together and that also had an outreach, low threshold dimension. The RCCD proposal was also perceived as consolidating RHB's commitment to working with community organizations. At the time the proposal emerged the RHB had – through Community Care - commenced discussions with community organisations to initiate localized, information and prevention response to drug problems. As the RCCD proposal envisaged an expansion, or transformation, of the CAS model, it drew into focus the extant role of the Mental Health services with respect to addiction issues, and more especially with respect to alcohol. It became evident, for example, that the RHB did not have specific Mental Health budgets for dealing with alcohol (or drug) issues and that many of the personnel involved in CAS were tied up in ancillary roles with mainstream Mental Health services (RCCD, minutes 17/12/1996).

In these circumstances, there were two possible options for integrating CAS and any prospective drug-focused service put into place within the context of the *National Drugs Strategy*. The first was that additional resources would be channelled - through Mental Health management - to CASs to expand their role so that they would outreach more into the community, take referrals from under 18s, and become more proactive in responding to drug problems and engaging with local communities. Members of Community Care management, who had overall responsibility for the RCCD process, did not explore this option; some believed that an expanded role for Mental Health with addiction issues, might not resolve issues in relation to appropriateness of location and service accessibility. At the time, some Community

Care personnel believed they were bearing the brunt of criticism from community organizations for what was perceived as a lack of engagement by existing Mental Health services with community bodies. Also, given the variable referral mechanisms operating within CASSs, there was a reluctance by Community Care to use new funds assigned to it to support an expansion of services operating from within Mental Health structures. There was also an underlying fear that additional posts arising from this process could, if assigned to CASSs, become absorbed into mainstream Mental Health services. The following quote from a SMT coordinator highlights Community Care's reluctance:

It came up at the regional committees and our contact with communities that services weren't being provided. Now there was a real frustration around it, from everybody, that if we wanted to get services out there and to get them through the Mental Health services - which is where they were at that particular time - would have taken twenty years..... This [view] was based on the previous twenty years and the intransigence of people: that is about as simple as it was. Even psychiatrists didn't want to talk about it: 'just leave us alone'. So we had to find a way around this and this is where the [Community Youth Drug Projects - CYDPs] came out of. These were a way of getting people out to work with the communities, and I will tell you one thing, only for those [projects] we [the RHB] would have been in real trouble....But if we hadn't done that [invested in CYDPs] I am convinced at this stage that the Mental Health services provision for alcohol and drugs would be exactly the same today as it was then or even further back (Lesley - SMT coordinator).

There is a basis for agreeing with the assessment that Mental Health services lacked the capacity to engage with community stakeholders in the manner envisaged by the *National Drugs Strategy*. The findings as outlined in previous chapters highlight a continued reliance on in-patient admissions and a general inability to give direction

and support to developing CASs; as already mentioned there was the difficulty of variable referral processes and while CAS addiction counselling was described as a community service, most provision was in Mental Health hospitals or at locations on the grounds of hospitals or other Mental Health facilities. While some CAS counselling services would receive self-referrals, in general counsellors did not have an outreach dimension to their work. One SMT coordinator, who was continually the subject of complaints by GPs and other community professionals because of the absence of a service in a particular town, even though an occasional service was provided on the grounds of a Mental Health hospital adjacent to the town, argued that a genuine community addiction service needed to be effectively “linking in with other community services” and “with the regional youth service” getting out of the hospital base and making “better efforts to get into the town more days during the week” (Lesley - SMT coordinator). Meanwhile a CAS counsellor observed that addiction services were not previously well organized and that it would be a mistake to add to this by giving Mental Health management the overall responsibility for service development; this position is summarized as follows:

You can't have the alternative [new community service] being run under the umbrella of the same people who didn't do it; they have had their chance. They have had fifteen yearsThey had their chance and they didn't use it (Lee – CAS addiction counsellor).

The second option for involving CAS in new service developments was that existing CAS counsellors would be deployed to work alongside new Substance Misuse Teams (SMTs), and based in Community Care settings as distinct to Mental Health locations. While there was some discussion of the prospect of proceeding on this basis, this

option was not formally explored at this stage. Mental Health managers were reluctant to factor in their existing CAS resource provision in ongoing negotiations and proposals for service development. It was made clear that Mental Health supported the basic RCCD proposal but this did not go so far as changing the arrangements for managing or deploying CAS personnel.

In reflecting on this period an SMT coordinator recalled that while there was great energy expended from all quarters and particularly from some key Mental Health practitioners in articulating the public health dimension and in establishing that the community-based approach was “the way in which things should be done”, that “nothing actually happened” (Lesley - SMT coordinator). In effect the recommendation for a county-based Community Alcohol and Addiction Service petered out. The RCCD process had succeeded in bringing key personnel together in order to discuss and propose new ideas and policies, but it clearly made no progress in translating its bigger ideas about community-based treatment into practice. Within 18 months the committee became more pre-occupied with the smaller detail of managing the disbursement of funds into new Community Youth Drug Projects and had less time or opportunity to grapple with these wider issues. On the positive side the process had contributed to Community Care developing a more effective relationship with community organizations and these are perceived as strengthening both community and RHB capacities, on these matters, as illustrated by the following quotes from two separate health board managers:

We have the various organizations such as the partnerships [Local Development Programme], such as the CDP [Community Development Programme] who are in contact with the grassroots in the community [and]

who are seeing the problems. These [problems] are articulated back through that sort of mechanism. We haven't been involved in the Mental Health, psychiatry aspect at all and I suppose from a community perspective I would have been hearing a lot through these [other] routes..... The partnerships have been very good on research, you know they were developing projects, but their strong point is research.... They were a font of knowledge really and their sort of feedback is very primary the partnership here set up a project where they identified young vulnerable people who are coming along with a multiplicity of issues, including drugs and alcohol as well (Dusty - Community Care manager).

I think that kind of engagement with community, which was demanded of us in one sense, has been very positive. It is probably one of the positive things that has come out of this in terms of trying to enlist support for what we are doing and in terms of trying to support programmes that communities want to develop. It has been very positive that way and we have interface and work well with communities (Sandy - Community Care manager).

Various CAS counsellors and Mental Health managers were not so positive towards these new developments. Some viewed the Community Care approach as expansionist and were quite critical of the way in which they believed they, CAS services, were being sidelined in the process.

You could ask the question why was the other [community] service set up in the first place. Up to three years ago there were restrictions put in the way of service provision so that when the Mental Health services weren't addressing a need that was out there well then other people said: "well we are going to address that need". I don't see that the other service took anything out of the existing [service]. The only thing it took out was personnel who were prepared to go into it and make that leap away from psychiatry, because any money that has come wasn't going to come to us [Mental Health services] anyway. So there wasn't really a budget for addiction services; there wasn't a defined budget for addiction services under Mental Health (FG: Jody – CAS addiction counsellor).

INTERNAL ADDICTION SERVICES REVIEW

Differences between Mental Health and Community Care came to a head during the late 1990s as a result of the deliberations of an Internal Addiction Services Review (IASR) set up to consider the future direction of addiction services within the health board. The IASR was broadly representative across relevant disciplines, in both Mental Health and Community Care programmes. The IASR emerged out of a sense of frustration that the RCCD proposals on developing a community-based service, involving CAS personnel, had not materialized; there was, as a result, a sense of urgency in driving these same proposals further ahead.

Within two years or whatever we were back around the table again and we said this time: 'look this thing needs to be done, we need to have some kind of a direction on it and we need to get a direction on it fast because as a health board we have no direction because there is nothing, there is no plan there'. So the [IASR] was convened to come up with recommendations (Lesley - SMT coordinator).

The thrust of the IASR's recommendations – which were adopted as RHB policy – was to establish substance misuse teams in each of the sub-regional areas, staffed by a local coordinator, an education / prevention worker and by community addiction counsellors. In its detail the plan was scarcely dissimilar to that already submitted to and agreed by the RCCD in 1997. One difference however is that while the RCCD plan would have required some initial engagement and resources from Mental Health service management, the IASR proposal was built around an emerging substance misuse team in Community Care that was already established with *National Drugs*

Strategy funding, albeit initially dealing with prevention and not with treatment issues. Prevention issues were not perceived as contentious, in terms of being provided either by Mental Health or by Community Care; as argued by one Community Care manager, where a drug education officer is placed “is not really necessarily any challenge to the existing structure”; however this manager also observed that “things really started to diverge in terms of peoples concerns” when “we had new counselling staff in the community” and that with this development some people within Mental Health may “have felt threatened” and that the goodwill towards a community response “flittered away because of [these] growing concerns and objections to [the SMT counselling] service” (Van - Community Care manager).

Indeed, the IASR report understated the prospective role of existing CAS counsellors, except in relation to “co-existing drug misuse and serious mental disorder” (p.8), and it was believed by some, in both Mental Health and Community Care, that the report and the process that brought it about, did not properly acknowledge the previous work undertaken by CAS counsellors nor acknowledge their achievements; the sentiments in the following two quotes were commonly expressed at focus group and interview discussions that reflected on this topic:

The other thing is that there are a lot of people out there working and there are a lot of people doing a lot of very good [things] but there was never any proper assessment of what was working..... And this was never properly acknowledged to the people who were doing a very good job and providing a vital service, but there was no analysis done of that (Carl – Mental Health manager).

ResQ And what do you see as the essential problem in the management approach?

Francis Again we can only talk about our own area I suppose. When the services started out we were doing an outreach clinic in [...]. Now since they have started up community services they...are duplicating [this] service rather than coordinating and working together. It seems to be an all or nothing, rather than partnership - the most recent buzz word. What we are looking for [is] a working partnership but it seems to be an all or nothing.

ResQ What do you mean by all or nothing?

Kelly: It is either take over or close down

ResQ So it is being presented as an either / or?

Kelly: Our experience has been that you know, anything that has happened here, we have initiated it, and we don't have the scope [now] to be able to expand. We are under [Mental Health] and there is only a limited amount we can do. We cannot decide to open up another outreach clinic in some areas. It is up to the [community] co-ordinator, up to management. We are willing to work with any of those areas, but.....

Francis: There is a certain amount of suspicion in that, you know there are unfulfilled promises and stuff like that (FG: Francis – CAS addiction counsellor; Kelly – CAS addiction counsellor)

For some of those involved with the IASR Report, understating the prospective role of Mental Health was no mere omission. A radical overhaul of addictions service provision was being promoted and a previous attempt through RCCD to bring this about had not succeeded as planned. There was a strong sense that change proposals now had a momentum that was coming not from Mental Health services, but from Community Care and that if the former's role was over-stated, the process of change would be further delayed.

The pressures [for IASR changes] in some ways came from the community, came from organizations that were dealing with the client group that weren't gaining access to the treatment system...people would be saying at the regional coordinating committees or county committee meetings that the [CAS] service was inappropriate, that people weren't gaining access to it, that the waiting lists were

too long, that the approach was too structured and rigid in terms of an abstinence base. It [the service] was largely based in [the hospital], Mental Health centres: places that people had a bit of a problem with and didn't really want to go. A lot of people with alcohol problems didn't really want to go there. What happened was that the partnership, the local area partnership front loaded funding for an alternative community counselling service and then was looking to the [RHB] to fund that. Obviously the [RHB] had already espoused that this was the way it was going to use its [new] resources to develop its services so you end up with [these changes] (Jude – SMT coordinator).

In Community Care and within SMTs it was believed that senior management had a current interest in dealing with addiction issues and that this “window of opportunity” might not last, and the momentum could get lost. According to one of those closely involved:

We were very conscious that what we needed to do was to get some recommendations in without too much flesh on them because if we put too much flesh on them we wouldn't have got them through in the first place. So really all we were doing was putting in some brief framework so that we would come back and say: ‘look we have agreed already to do this now how are we going to do it?’ And this is where we actually are now but if that piece of paper [IASR report] didn't exist and if that piece of paper had not been passed by the [RHB] wewould just have rambled on and on. It would have gone nowhere, absolutely nowhere (Lesley - SMT coordinator).

While personnel involved with the IASR report acknowledged that the report lacked operational specifics, they rejected the idea that there was little consultation in relation to its compilation. It is argued that the review group itself was very well represented across all relevant disciplines and that arrangements had been made whereby representatives would report back to their discipline as appropriate, thus ensuring that the main ideas and proposals within the report were fully aired and

understood across the region. However, there was also a belief that whatever the level of consultation, there was an intention to delay anyway:

One of the things we did was brought it down to local level and even far as getting the psychiatric managers to put a nominee on the local committees. They actually nominated somebody on the part of each service and we broke it down into things like bringing people in to talk about treatment and preventionin my naivety I thought that they were all going back to their own [discipline group] but they weren't.But there was also a belief out there from the people in the Mental Health services that their own bosses were saying: 'look don't be doing that, avoid that, it is not going to happen. We'll bury it' and actively I think some of them did that (Lesley - SMT coordinator).

This view is also supported by one of the CAS counselors:.

They [Mental Health services management] can't see anything when it is happening.... So basically, they didn't see the importance of what was going to happen and when it [IASR report] was accepted by the [RHB] and how it was going to inform policy and policy decisions, then suddenly it is like: 'that is not how we wanted it at all'. But that is their problem. When I looked at that [IASR report] and my recollection is that this makes sense, it is covering things from the counsellors' perspective it is covering adults and adolescents, it links in with as many things as possible, it clearly identifies [our role with] probation and welfare and so much of our work is coming from probation. It made sense. (Lee – CAS addiction counsellor).

In general the broad thrust of the IASR report enjoyed support across all areas and disciplines; this had been clear from the outset of the RCCD and there was a strong consensus – as is evident from the discussion in Chapter 5 above – that an adequate community model of service had not been achieved and that further progress in developing such a model was now required. However, while this broad level of

support for a community model was evident, significant difficulties were encountered in trying to translate this support into practical, meaningful change. Although it was not stated, the recommendations in the IASR report envisaged that CAS addiction counsellors who, to date, had operated in the context of Mental Health teams should in future operate within the overall context of new community teams. This indeed proved to be the report's most definitive understatement. A separate document, prepared later, following the publication of the IASR report, spelt out unambiguously the envisaged role of CAS counsellors in prospective service development, as follows:

As services are required to be "locally based and easily accessible" we propose that all substance misuse / addiction counselling staff, in any given Community Care area, be accommodated in community settings outside the area of either a psychiatric hospital or a day hospital setting. Ideally, we would propose that counselling staff currently working under the Special Hospitals Programme [Mental Health] be transferred over to the Community Care Programme, and be managed by the Substance Misuse Coordinator, as part of the Substance Misuse Team (Substance Misuse Teams, Development Proposals, 2002, 11)

This more succinct proposal was unsurprisingly controversial. Although it was qualified by reference to the suggestion that existing counselling staff, "currently employed under [Mental Health] remain under that programme for administration purposes only, such as pay and remuneration" (Ibid), the proposal was nonetheless considered an affront to the integrity of the existing CAS counselling system and its management. Main criticisms of the proposal were derived from a highly supported contention that the proposal was being imposed on the staff concerned, with little, significant consultation and that it represented an attempt by management within Community Care to take control of resources and personnel within Mental Health.

The following selection of quotes from personnel within both Community Care and Mental Health, in both management and practitioner roles, illustrate the depth of negative reaction to the proposal:

We [Mental Health personnel] would have felt ripples of discontent when the other service, the community service [started]. I suppose we would have heard this: "oh the alcohol will move into a different area, a different programme it won't be within the psychiatry service" So this had been going on it had been rippling away and then if they do go to Community Care where do they stay for this that and the other. They [alcohol service] are part of this service, they have a reporting relationship and they have their money from hereI never was quite sure what the other [community] service were doing, I was never quite sure if they are going to eventually marry and develop a service together (Ashley – Mental Health manager).

Counsellors in the special hospitals programme were hearing that they were going to be expected to transfer to these [SMTs]. Now they all had question marks over what their conditions of employment would be. As psychiatric nurses they would be very different to people in the community sector so that immediately raised problems for people with how they viewed this development. But there were other problems as well. The service, at least on paper, from the special hospitals programme was led by a consultant psychiatrist with an interest in addiction - in some areas that is true in some areas it was less true, but it was there in paper and when you moved to the community system that wasn't going to be the case so I think people had a problem with that as well (Jude – SMT coordinator).

Community Care said [to Mental Health personnel]: "you are coming out". They rapped on the door and told them that you will be moving and you will be coming into Community Care you know, we are the structure, we are the group, you will work according to us and that is it. (Jessie – SMT addiction counsellor)

In reality nobody has asked the counsellors in psychiatry are they interested in coming on board or given them an offer.They [CAS counsellors]

will say: 'nobody has come to us, nobody has asked us anything, nobody has put anything on the table to say would you be interested in this package' (Gene - SMT coordinator).

I was told very clearly and above in [health board HQ] that psychiatry was coming into Community Care, end of story. That was it. I was told that, quite clearly: the counsellors in psychiatry were coming over to Community Care. Whether it was a miscommunication or whatever it was, I don't know, but I got it very clear, and I know other counsellors got it very clear, but there was no proper analysis done of what was working and what was needed to be brought in to build up on what was there. (FG: Kerry – SMT addiction counsellor).

The main mistrust arose because the health board developed this whole community [substance misuse] service. Now it was very, I wouldn't say secretive, but it wasn't discussed you know, it came about by stealth, it arrived overnight and at the beginning there was a lot of mistrust around. I suppose ultimatums about how the service was going to develop, where people were going to be, where they were going to end up, that there was going to be no structure within Mental Health for counsellorsthat there would be no money for Mental Health development in addiction services, that all money would come through community services (Dee – CAS addiction counsellor).

I saw that what was needed was someone at management level to be able to come in and sit down and say [to psychiatry managers] 'look we can still give you what you want; if you have someone in a bed that needs to see an addiction counsellor they will be seen'. To be able to say [to CAS counsellors] 'you are working in psychiatry, look, you have everything that you had. You can still go on working for the health board, still retire at 55. You still get tied in paywise and everything else. If there are any pay rises going you will still get one'. So, basically the people could be told come on board in a new system without losing anything and with the potential to gain something..... So what you had was that a bulldozer approach was taken within Community Care and the people in psychiatry dug their heels in and said: 'we are going nowhere'. And that is why there are the problems. That is why there has been such resistance to this. There will always be

resistance. Psychiatrists don't want to lose control, they want to be the top (Lee – CAS addiction counsellor).

In addition to issues about consultation and the prospective difficulties arising from being operationally managed under a new programme, which at the time was perceived as like being managed by a new agency, CAS counsellors were particularly opposed to the idea that while remaining administratively attached to Mental Health services, they would be “line-managed on a day-to-day basisby the Area Substance Misuse Coordinator as part of the Substance Misuse Team” (Ibid). Although, as outlined in chapter 5, various Mental Health practitioners expressed concern about how their work was managed, supervised and supported within the Mental Health structure, most, nonetheless, preferred to remain within this less than perfect arrangement and saw the alternative as even more imperfect.

We have [group] supervision with community services and we have regular contact with community services. I suppose we were a bit disappointed with the progress of community services in that we are quite open to working with them. My problem is I have seen a lot of promises being made but I don't see things actually happening on the ground. You know we see benefits to staying on the sector teams because of the range of supports and the type of work that we do. Like we have two family therapists on site, we have the day hospital which includes a behaviour therapist, psychiatric nursing staff and psychology clinics and psychiatric clinics, so we have access at hand almost all the time. If we need to just check out anything or to refer on to a specialty it makes it that much easier (Kelly - CAS addiction counsellor).

I suppose from their point of view, you know promotion everything, the security of their jobs and everything, it is very defined where they are but they question the fact that if they come over, who they report to? That is the big issue, who they end up reporting to? Now they might complain about

what is going on in there, but the fear of actually not knowing who they are reporting to, they are not happy with that. They look at Community Care and they see us on our own, swinging on our own and they think: 'we don't want any of that' So there is nothing on offer here that they haven't already got, so why would they come over. I can't see them doing it.
(Jessie - SMT addiction counsellor1)

CAS counsellors also perceived the change as involving considerable personal risks from a career perspective. They all had psychiatric nurse training, were members of the union representing psychiatric nurses and were entitled to whatever benefits were negotiated for their psychiatric nursing colleagues at both national and regional levels. Among these benefits was an entitlement to retire at age 55, and although such benefits would be retained in an administrative move, there was always the possibility that the personnel concerned would become increasingly isolated from their professional nursing colleagues, and outside-the-loop in relation to psychiatric nursing career promotions. It was indeed more certain that as they progressed from these community assignments either towards retirement or towards other career positions, their replacements would not retain these benefits. In contrast, psychiatric nurses who were recruited into new community counselling positions, which did not necessarily require psychiatric nursing qualifications, did not have the same benefits as their hospital-based counterparts. In these circumstances, the emerging industrial relations issues were not only the concern of existing CAS counsellors, but also of concern to SMT counsellors and to the union representing psychiatric nurses who saw in these developments the prospect of losing members, or of it operating outside existing personnel agreements.

Like it was just implement this without any proper consultation with the people who are already there and no acknowledgement of what they had

been providing for years, and getting on pretty ok. But like no one sat down with people and now we are sitting down and we are in IR problems or whatever happened It just went all over the shop. Something that should have been really change management isn't easy but this is a classic example of how not to do it (Kerry – SMT addiction counsellor).

I just want to say that equality would have to be one of the things [to be addressed], because there isn't equality. I don't think it can be addressed without equality....like for example some of the people that are coming into Community Care - I am one of them - have psychiatric nursing background and that is not recognized because [they] are Community Care. I don't think you can kind of move within that..... it is almost a boundary around people and what you can do and what your role is. I don't know if I am making sense to you, but there needs to be equality across the board to some degree if people need to work together (Jessie - SMT addiction counsellor).

The dialogue that should have taken place didn't take place and we suddenly found ourselves mired in IR problems..... We [in our county area] had no [provision for] counselling at the time..... An agreement [was reached] in relation to the [new counselling] posts which none of the directors of nursing certainly were aware of. I wasn't aware of it and I knew it had implications for staff I had here. I knew suddenly that there is an agreement to get rid of the service which we had had without any clearance, and without even knowing that this was going to happen and also there was [a] union which is a significant stakeholder who in this area is the biggest union who said: 'hang on you never told us about this. What are you doing to us? You could find yourselves in dispute over this'. So we were at a stage where we were finding ourselves close to dispute over a situation we had no input into, that we were unaware of and which was as it were being done to us (Carl - Mental Health manager).

In due course, the way in which this industrial relations issue was handled and represented, became a critical obstacle to the further development of the proposal to expand community addiction services within the context of a community model. Among some Community Care personnel there is a concern that the industrial

relations dimension to this issue was misrepresented in the sense that claims that CAS counsellors had to move over to Community Care, with the risk of losing benefits, were inaccurate, and potentially formed part of a broader strategy to undermine progress in developing a community model, progress which previously had been eagerly supported by CAS counsellors.

I think that the counsellors on the group, despite what they say, they realized that they were going nowhere, that this [Mental Health] system had forgotten them. I mean they could see that these reports were coming out and there was national directives and that they should have been involved with it ...So the one thing that was being revved up the whole time, and I know it now, I didn't know it then, was that if you [CAS counsellors] make any move here [to go to SMT services] at all you are going to lose all your terms and conditions. This is what they were being fed and constantly fedBut it [terms and conditions of employment] couldn't change. This [change] is not about changing peoples terms and conditions this is about providing a service that is all. There is nobody going to lose anything (Lesley - SMT coordinator).

Another SMT coordinator outlined that in discussions with CAS counsellors that had taken place over a number of years, it had always been envisaged and indeed understood they would become part of a community-based team, located within a single community-based premises. These premises were now established; they were located adjacent to a Community Care health centre that was providing a range of other community and primary care services. It was always envisaged that the centre would become the base for both mental-health-based and community-based addiction personnel, but this simply did not happen. The centre was developing other non-counselling dimensions to the work; meanwhile the CAS counsellors continued to be based in an inadequate and wholly inappropriate suite of offices in a hospital setting.

It was envisaged from the outset that this [community-based centre] was where clients would come to and there would be obviously a fairly major case load here butwe have addiction counsellors who are within psychiatry and to go out and recruit maybe more [counsellors] would be a bit ludicrous... Unofficially it was felt that the services will come together. When they would come together was the question?We were working from the regional plan that things would come together but they still haven't come together, obviously, that is why we are sitting here (Gene - SMT coordinator).

According to another Community Care manager the arrangements for developing a collaborative approach between Community Care and Mental Health services were well developed within the respective county area; there was evidence that the different stakeholders had come together to agree an overall strategy and to identify the critical issues that needed to be negotiated for moving forward; a means for resolving potential differences had also been agreed. However, the pressure of a lack of agreement on these issues elsewhere within the region, together with the growing disaffection among CAS counsellors, resulted in an unravelling of the progress that had been made.

People generally accepted that there would need to be a balanced sense of development provided it didn't hinder them....That was happening here in [...] for quite a while, up to fairly recently, when more or less the union, regionally, I think, they decided well we are not going to cooperate until all of this [IR issues] is dealt with now. So any kind of cosy [local] arrangements can stop. So I got a sense that, despite these difficulties, there was a willingness within most of the existing people to look towards new developments (Van - Community Care manager).

It is clear that the task of developing community addiction services stalled for a considerable time following the IASR Report and an impasse emerged during which little further progress was made in developing a community-based, integrated alcohol and drugs treatment system. In the midst of this impasse the author of this thesis became directly involved with the RHB in an action research process, which was designed to break the impasse and assist the further development of addiction services in the region; this action research process is outlined and discussed in the next chapter.

SUMMARY

At this chapter's outset it was submitted that changes and developments in drug policies could potentially provide a basis for assisting the RHB achieve a more community-oriented, public-health focused alcohol treatment service, within a broader addiction treatment system. The chapter outlines that the early 1980s, the period during which a community alcohol service was first proposed, coincided with the emergence and escalation of a drugs problem, one that was experienced initially in socially disadvantaged, Dublin city neighbourhoods. Community organisations became central to the identification of these problems and in advocating varied preventive and treatment responses; previously community organisations had a relatively scant role in alcohol problems, but as some of these organisations engaged with the drug problem, particularly in the provision of treatment, they also inevitably became concerned with alcohol. In the RHB, which is located outside Dublin, there was a momentum towards dealing with these problems in an integrated manner; while

the regional health authorities were aware that localised drug problems were not anywhere as serious as these problems were in Dublin, they nonetheless were concened to develop appropriate regional and local responses and were also keen to ensure that the issue of alcohol was not marginalised within the context of such responses.

The above discussion has outlined national policy developments in relation to drug misuse. In response to these the RHB, in 1996, set up a regional coordinating committee on drugs (RCCD) which provided a forum for debating appropriate treatment responses and for generating intervention proposals. The RCCD, for example, advocated that alcohol and drugs should be dealt with primarily through new community alcohol and addiction service teams, that would have an outreach, low threshold dimension and especially target young people, who previously were not included in the service remit of CASs. Mental Health personnel played an important role in developing these proposals; however, the possibility of reorganising existing CASs within the context of new service proposals or developments did not arise; alcohol services were deeply embedded within a Mental Health administrative and practitioner framework and they were managed and deployed through separate sub-regional, hospital structures with a continued reliance on in-patient models of treatment; Mental Health management did not countenance the deployment of existing hospital-based personnel to new community services, whatever support they lent, in principle, to the development of such new services. In due course the work of the RCCD became pre-occupied elsewhere, with supporting new investments into local preventive activities provided through community organisations – few of whom had any relationship with existing Mental Health services; moves towards developing

an integrated, community-based approach to alcohol and drug treatment lost much of its initial momentum.

In the late 1990s, the RHB engaged in a new consultative process in order to bring about a restructuring in addiction services. This process, known as Integrated Addiction Services Review (IASR), involved internal and some external addiction practitioner and management personnel. Its central aim was to provide a new direction to addictions services amidst increasing demands from community organizations for a more effective involvement in the response effort, and also an internal RHB commitment to bring about an integration of alcohol and drug services within a single structure. The IASR reflected the RHB's goal of creating and building fidelity to its vision for policy change and development (Beckhard and Pritchard, 1992). It outlined a plan for the future development of substance misuse services within the region and in addition to drawing from the consultative process, this plan is also relatively well-grounded in a public health, harm-reduction literature, which is sketched in broad outline. IASR's proposals are quite similar to those previously prepared and developed by the RCCD.

Having developed this plan, IASR's main proponents sought and received substantial senior-level support within the RHB for its implementation, thereby establishing a basis whereby addiction personnel could be deployed in a manner that was consistent with IASR's main objective. As discussed above, the process of bringing about these changes began to unravel as a result of the RHB seeking to operationally reorganize CAS addiction counsellors from within Mental Health into Community Care. In practical terms, this additional proposal constituted a more direct attempt than

previously to bring about an integration of alcohol and drug treatment within a Community Care structure. It was clear that the proposal undermined both management and practitioner personnel within Mental Health; it also appears the proposal exposed to Community Care personnel a deeply-rooted resistance within CAS to countenance any effective move into a community-care managed role. Although, IASR emerged from a relatively well-grounded consultative process it became clear that opposition to proposals with regard to counsellors based in Mental Health teams was quite substantial, leading to an impasse with respect the broader implementation of IASR's general recommendations.

The general thrust of the above account is that an escalating drug problem, alongside an emerging drug policy, potentially provided a new opportunity to re-focus efforts on developing community alcohol services, operating from relatively well-defined and articulated public health principles. While RHB personnel from across both Mental Health and Community Care services engaged in this process, it was operationally constrained by controversies arising from substantial differences in views about the proposed re-deployment of relevant CAS personnel, thereby creating an impasse in the development of services in this manner. The study reported in this thesis commenced in the midst of this impasse, and indeed this deadlock provided the impetus for the RHB to engage the study's author in providing assistance to it (the RHB) in moving forward from this impasse, within a new consultative framework, that had an action research dimension. This particular process is described and outlined in the next chapter.

Chapter 7 – Action-research process

INTRODUCTION

This chapter is focused specifically on the action research process as used in this study, and provides further insight into issues affecting the RHB's attempts to achieve organisational change. The aim of the research reported in this thesis was to explore the practicalities of introducing a public health model of treatment and management for alcohol problems into one Regional Health Board (RHB): a model which had been formally recommended at national policy level since the mid-1980s and which ostensibly had strong management support within the RHB in question. It is evident from the above accounts however that progress in developing the public health approach within the RHB has been slow, with a continued, inappropriate use of psychiatric in-patient hospital admissions for treating alcohol problems and Community Alcohol Services (CASs) - set up under *The Psychiatric Services - Planning for the Future* (1984) – lacking in overall leadership and direction. These latter services are perceived as functioning primarily as a back-up to in-patient alcohol treatment and with insufficient penetration into the community to deal with changing alcohol and emerging drug problems. Meanwhile internal RHB re-organisational efforts such as Regional Coordinating Committee on Drugs (RCCD) and Integrated Addiction Services Review (IASR) foundered in their attempts to consolidate new community-based Substance Misuse Teams (SMTs) under the direction of RHB's Community Care Programme, as an alternative to these being located within the

overall management of the Mental Health (Special Hospitals – Psychiatric Care) Programme.

Despite the various difficulties summarized above, RHB management and counselling personnel embarked, in late 2003, on a new action research process to develop and re-shape its overall addiction services: in this case to explore if a more effective integration of established CASs – under Mental Health management - and fledgling SMTs – under Community Care management - could, through a bottom-up, collaborative exercise, bring about the comprehensive community model that was envisaged in IASR. The author of this study had a supportive role in this new process, which involved further consultation in relation to the development of addiction services, and also resulted in the author compiling internal reports to assist the RHB in service development. The present chapter reports on this undertaking, which is referred to as the action research process to help to distinguish it from previous developments.

The action-research approach is discussed earlier in Chapter 3. Its key feature is an iterative action-research cycle. This cycle involved the author in a series of regional fora, county-level focus groups, and county and regional level interviews and feedback discussions. The purpose of these discussions was to enquire further into the issues that appeared to impede the RHB in developing a public health / community service approach and to set out, in more detail, recommendations that could assist the process of change. Study findings as discussed above in chapters 5 – 6 are derived in part from this action-research engagement, whereby the author in his discussions with RHB personnel collected and analysed data that provided background to the problems

and difficulties that had previously emerged in implementing a public health approach to service provision.

This present chapter draws from the same bank of data; in this instance the focus is on trying to make sense of factors that continued to facilitate or impede change, thereby providing a basis for further evaluation and recommendations for service development. Various issues having impact on change are explored in this chapter. Initially, the focus is on issues of inter-sectoral frictions that are perceived as hindering RHB's internal change process, and on the prospects of developing a shared vision of change among addiction service personnel. Next, the chapter focuses on the prospective role of mainstream Primary and Community Care professionals in contributing to the development of community-based addiction services, bearing in mind that the utility of this particular approach is linked to the willingness and capacities of these professionals to become involved in the treatment of alcohol and drugs problems. This issue is explored both in terms of the role of GPs and in terms of the involvement of social workers in addiction issues relating to children and adolescents. The chapter then considers external policy developments and their prospective impact on RHB's efforts to bring about organizational change. Finally, before moving to a chapter summary there is a short discussion of key recommendations for future service development; these recommendations are summarized in more detail in Appendix 5.

INTER-SECTORAL FRICTION

At an early stage following ARP's commencement, a regional forum of addiction service practitioner and management personnel was convened to initiate this new process. At this forum, there was a general consensus that IASR's underlying aim of putting into place a county-level system for organizing and developing addiction (alcohol and drug) services was broadly approved; this aim was vocally supported despite evident disaffection, particularly among CAS addiction counsellors, in relation to the manner in which proposals for service development had, to date, been progressed. On the basis of the consensus however, it seemed logical to generate a dialogue at county level between Mental Health and Community Care personnel on the future direction and structure of county-based services. This dialogue actually commenced at the regional forum through the use of sub-groups that were structured on a county area basis. Subsequently it was agreed that these discussions be continued separately, with the researcher's involvement, through county-based focus group meetings and individual interviews conducted by the author with service counsellor, management and other relevant personnel.

At Community Care level there was strong support in having these county level discussions: at this level it was believed that a Community Care-led approach was the ultimate way forward, and there was a need to embrace this approach and deal with whatever underlying problems presented. This position is exemplified by the following quote from a Community Care manager who was anxious that good progress be made in expanding and consolidating Community Care SMT services:

I honestly believe that if the service was restructured under Community Care and a decision was made: “this is where it is going to be and this is the person [who] is going to have responsibility for it”..... that almost creates it’s own momentum. They [counsellors] ... can look then to see well: “what are the responses we need to develop for what is coming at us?” They can grow their own responses in terms of family support interventions and being able to work on a one-to-one with individual families and with practitioners on the ground here, which [they] don’t do at the moment, because they [the CAS counsellors] are not available [on the ground]. Social workers, can’t pick up the phone to [CAS counsellors], and are not meeting them in the canteen... I think that [re-structuring] in itself creates its own momentum.... We need to be able to link them [CAS counsellors] across the services here but you cannot do that unless they are based here (Sandy - Community Care manager).

Ostensibly, there was considerable support across the RHB to the idea of getting both CAS and SMT addiction personnel working together on a county basis, in order to coordinate and integrate their efforts as a further step in bringing forward the model as proposed by IASR. Although, there was some resistance to county-level discussions – outlined below – there was a view that the general approach of having this county-level dialogue was consistent with ideas about proposed structures for achieving interdisciplinary collaboration that were emerging from wider health care reforms (Department of Health and Children, 2004). The following quote from a Community Care manager explains this position further:

No matter what service we run, if you have different disciplines..... and community involved as well, there is a degree of inherent disjointedness. We need to minimize that. The only way we can do that is to concentrate our resources and coordinate it as one system....[with] everyone aware of what each other is doing: What their role is? And what the responsibilities are? To continue operating with people seeing themselves as: “we are the old system....We are part of the medical structure and we are happy to stay here and we are not going to join up with you” is wrong....It shouldn’t be led by a

medical model but clearly the medical input is vital, important and valued. There is no doubt about it, it has to have regard to the community needs and responses. It is cliché stuff but you have to respond to what people want, rather than them having to try and link in with what is a disjointed service right now (Van - Community Care manager).

From the outset of initiating follow-up focus group discussions, it became clear however that the expected support for this process of county level discussions was not extensive. In one county area, for example, there was a persistent delay in hosting a focus group; when the focus group was eventually convened the opportunity was used by some participants to question the action research process's rationale and although further clarifications were offered, the focus group was concluded without collecting data. In fact, very little data was collected from this county area, which naturally limited the overall scope of this study.

Similarly, at another focus group, considerable time was spent questioning the action research process's rationale and purpose, although in this particular instance, the focused discussion continued as planned, following further clarifications. At yet a third focus group, participants initially, were bluntly hostile in their views of RHB central management, who were not present, and were also opposed to the action research process; however it seemed that once these views were openly expressed they were keen to engage in the process further. In general these stances in relation to the action research process reflect disillusionment with RHB in its management of these developments. At a certain level there was the risk of a perception that the researcher would be perceived as part of an RHB management team and in this regard therefore the researcher had to put a lot of effort into explaining that this was not the case, and that there was no specific contractual agreement with the RHB in relation to

the study, and that an internal report on the study would be available to every participant. There was a strong sense of mistrust however, which is evident in the following exchange between the researcher and a CAS counsellor, whose perspective was quite typical of that of many participants from the Mental Health sector.

- ResQ Is what you are saying that if people [CAS counsellors] are to move with the change, you have to pay attention to their own interests?
- Kelly You have to be able to see that there is an improvement in the change and we haven't been certain that that is the case up to this stage.
- ResQ Let's assume that there is a kind of green -field possibilities out there; what are the kind of things that would convince people, you know, that promises can be delivered?
- Kelly But you see you are starting from a negative point already because there is a lack of trust, you know. The green field thing should have been discussed initially. Then you wouldn't have the barriers. Now the barriers are there, so you are starting from a negative position already. Maybe this approach [researcher's consultations] should have been used initially (Kelly – CAS addiction counsellor).

The above quote reflects a mistrust between some counsellors and RHB management. This mistrust had simmered over a long period and had come to a head during the IASR processes. There was also some evidence, as already referenced, that it had spilled over to the ongoing relationships between personnel in the field, and was reflected in positions adopted with respect to each other by Community Alcohol Service (CAS) and Substance Misuse Team (SMT) counsellors. Historically, the former group of counsellors, as previously mentioned, were recruited from an existing pool of RHB psychiatric nurses and were assigned as alcohol counsellors, while retaining their psychiatric nursing status. In due course many of these sought and were

granted counselling accreditation from the Irish Association of Alcohol and Addiction Counsellors (IAAAC).

When the RHB established Substance Misuse Teams (SMTs) during the late 1990s it decided to recruit addiction counsellors with IAAAC or similar accreditation. Certain anomalies in relation to conditions of employment and other benefits arose between CAS and SMT counsellors; as the former were originally psychiatric nurses, they retained this profession's benefits, including the right to retire at the early age of 55, whilst SMT counsellors were not entitled to these benefits, even if they were trained psychiatric nurses. This situation clearly helped reinforce the differences between both groups, as illustrated by the following two quotes, one from a CAS counsellor, Kelly, who referenced the importance of nurse-training in counselling roles and future service development, and the other from a SMT counsellor, Jessie, who, as it happens, was also psychiatric nurse qualified, but not recruited into the service on this basis, but who expressed concern about the unavailability of peer support / supervision with Mental Health colleagues:

There is a staff relations agenda to be considered here in terms of, you know, from the Mental Health perspective we are very much nurse-qualified counsellors, whereas from the community based services that isn't [the case], they don't have that requirement, that doesn't exist. So in terms of integrating the service I suppose there are issues arising for that reason, you know, in the way that we have been operating and the way in which the services have been structured historically (FG: Kelly – CAS addiction counsellor).

When I approached psychiatry [CAS] counsellors for peer support], they approached the consultant and the consultant said: "no, not until all this [difficulties arising from IASR] is sorted out". So that [peer support] has

been blocked. That was blocked because of the times that we are in, and that is fine, I wasn't insulted or anything about it but at the end of the daythat is where the *others* have come into it. I wouldn't have said I was the *other*, but I am becoming the *other*, and that is where it is getting difficult (Jessie – SMT counsellor).

The above quotes illustrate a tension between CAS and SMT counsellors because of the non-resolution of issues arising from IASR. Despite tensions between both sets of counsellors, which were widely acknowledged at the regional forum, it was nonetheless believed that it was possible to overcome these as an obstacle in moving forward with the action research process. Certainly the following quotes provide evidence that some middle management personnel were trying to understand the position from the other side's perspective.

Mental Health clearly feel that they have been left behind: no new monies has gone into Mental Health - that is clear in black and white. Any monies have gone into community service. I feel bad about that because there is a huge resource in Mental Health, and in fact Mental Health have provided this service over the years. They were the pioneers, if you wish, and I thought it was very foolhardy that we didn't embrace that....We have a major uphill battle to restore that confidence, that trust in the system, because we did everything we could over the last three years to run that down and to create that mistrust (FG Sandy – Community Care manager).

The overwhelming focus of the [new] policy development has been to have the substance misuse services not only community based but perceived as being a community service without the stigma, because Mental Health services have a stigma. I think that is quite a reasonable position to have....My point is that we need to maintain some capability to deal with their needs in a more integrated way so that it is less stigmatizing, to deal with it in a community context. Mental health services work in a community context anyway but we need to do that in

terms of [Community Care] substance misuse [services], in a more integrated way. But, we also need to maintain the capability to provide the specialist inputs (Carl - Mental Health manager).

A SHARED VISION?

Organisationally, the prospects of the different RHB sections moving forward with the proposed new approach would of course be hugely improved if they shared a vision of what this new approach entailed. A clearly described vision is a highly valued dimension to organisational change and development. Proehl (2001, 12) emphasizes that a “well-defined” vision can help “chart the course of the change effort by providing focus when competing priorities intrude on the work of the participants”. Miller (2002) and Blumenthal et al., (1993) both separately argue that a comprehensive, integrated addiction service system requires a clear sense of vision and direction and that executive and management structures capable of planning and delivering programmes that are consistent with this vision and of ensuring accountability and compliance with monitoring and evaluation, need to be in place.

Ostensibly the RHB had a vision with respect to organizational change, and this vision was underlined in the IASR; in line with what it saw as government policies and good, evidence-based practice, the RHB wished to integrate alcohol and drug services within a community-based model of care, with SMTs providing primary and secondary preventive services in conjunction with other primary and community-based personnel, and where there would be ongoing liaison with hospital-based

Mental Health services for co-morbid problems as appropriate. It is noteworthy that RHB's vision for service development was quite similar to that subsequently outlined a few years later in the *The Report of the Expert Group on Mental Health Policy: A Vision for Change (2006)*.

On the face of it, both managers and front-line professionals subscribed enthusiastically to this vision of a new public health approach to alcohol-related problems. However, as was made clear in Chapter Six, there were major intra-organisational obstacles to its implementation, particularly in relation to the proposal to relocate addiction counsellors currently based within the Mental Health system to a new base in the Community Care Programme. In the course of the action research process consultations this latter difficulty was never understated and in many instances it was often represented as an industrial relations issue, whereby it was claimed that the personnel concerned were being compelled to work under new, less favourable conditions of employment. It is important to state that RHB management contested the claim there was a threat to the employment conditions of existing members and they also claimed there was a satisfactory management-trade union mechanism in place to resolve any outstanding issues that might arise.

The persistent manner in which, during the action research process consultations, this issue – which had already dominated attempts to implement IASR - continued to be raised and be represented as an enduring obstacle to change undermined the veracity of claims that there was broad, internal support for RHB's proclaimed vision. Indeed, dichotomous views about these change proposals became evident and it appeared that, to a significant extent, the industrial relations issue masked these deeper problems,

which are underlined by the quotes below: the first and second quotes emphasize a belief that Mental Health services perceived they were already community-based and whatever the logic and rationale of a broader approach to addiction, people with these problems tend to end back in Mental Health services anyway, while the second quote reveals a Community Care manager's frustration with what is perceived as Mental Health presumptuousness.

We see ourselves operating in the community more so than on an inpatient basis you know, and I don't think our colleagues in community based services are entirely up to speed with where we are at now in terms of our own thinking and our own strategy and our own operational calendar around this. (Alex - Mental Health manager).

I feel that the structure should still.....be developed within psychiatry. I would be quite happy to see the [SMTs] and us combined but I still feel that psychiatry should take ownership of the whole thing..... If I thought it could work, [that] it would work anywhere else, I would agree with it totally. But I think it will be back because of the Mental Health and the social issues, and the issues that go with addiction. It is always eventually going to be batted back to psychiatry and I am wondering: "why waste time? Why not just set it up within [psychiatry] in the first place?" (Merle- CAS addiction counsellor).

The practical issue is the influence of the [psychiatric] consultantsand trying to get them to even engage meaningfully in developing the service within the present environment.....[It was] said to me at a meeting: "Community Care, you are light years behind, step back and watch us [Mental Health]". You know to me that spoke volumes; you know: this perception of the community. I said [before]: "it is not Community Care. It is not Mental Health. It is a new service we are developing you know". If we look at it that way and look at the person, the rest should follow from there (Dusty - Community Care manager).

Opposition to change proposals, as outlined by IASR, is also manifested in a somewhat negative attitude to the idea of a corporate vision with respect to addiction treatment, in preference to the overriding importance of the individual practitioner's concept of treatment. The strength and persistence of these sectoral perspectives - whereby CAS staff and management continued to see things from a Mental Health perspective and SMT staff and management continued to see things from a Community Care perspective - militated strongly against the action research process, suggesting that both sides were likely to resist the introduction of a new shared vision of addiction treatment for as long as they wished, which is illustrated by the following quotes:

I don't worry too much about the corporate understanding but I would be more interested in the definition of it (addiction) at individual level....My definition is quite simple when it comes to working with people on the ground..... I would feel that while there are presenting problems - maybe one of alcohol or drug dependency or a mixture or both or gambling or whatever - that fundamentally what I am looking at is to see the extent to which the behaviour is interfering with the person's normalized life, and the way it impacts upon them, on society, on their family and so on (Kerry – SMT counsellor).

I have my own understanding which is that a drug and alcohol difficulty becomes a problem if it is presenting legal, social or physical difficulties or a risk of those. That is my sort of working definition of drug or alcohol problem but I have no idea of the [RHB's] definition....I don't know what they believe or what they think.....I don't think there is a coordinated idea of a definition. I don't think people have at the forefront of their minds a clear corporate view.....I wouldn't feel that there is a collective view, or a collective definition of what the problems are (Lee – CAS counsellor).

I would agree that we are all inclined to develop our own understanding of what the problems are and what the responses should be. In fact, I don't understand fully what all the issues are here because this is constantly moving as well and new responses have to be developed on an ongoing basis.....I don't have a sense certainly that there is a cohesive approach and that we each understand what each other is doing. I don't have a sense of a cohesive approach (Merle – CAS counsellor).

The above quotes highlight the absence of an agreed corporate vision in relation to change to which relevant RHB personnel subscribe. The perceived central importance of counsellors' own working definitions is reinforced, suggesting that a corporate, or indeed, external expert view, is not quite as important or relevant to that of the practitioner in the field, who needs to make their own judgement as to the nature of the problems being encountered and the type of responses that are merited. Such views plausibly arise as a result of addiction counsellors – across both CAS and SMT services - operating without coherent organisational structures and although they were relatively unhappy operating in this manner some had become quite used to it and were apprehensive about the idea that significant changes in service provision, however desirable, might also lead to unwelcome changes in their working environments.

However justified RHB claims that there was satisfactory consultation in relation to IASR, and despite the rational basis to this vision, these quotes highlight that the vision lacked shared, collective ownership; the manner in which it was developed and represented resulted in some counsellors feeling vulnerable and isolated. The above views underline that for as long as personnel felt aggrieved by change proposals, the process of change, as it involved them, would be slow.

An important issue raised in regard to this sense of grievance was that although RHB management portrayed IASR as a rational appraisal of addiction services development, the review produced no concrete proposals for changing the way in which addiction services were managed overall. In the absence of such proposals, most attention seemed to focus on the proposal that addiction-counselling staff would operate within the context of new SMTs. The issue of overall structures arose at management levels during both IASR and since, and it appears that a decision to put into place the most appropriate structure for service development was fudged. At the time there was a wider reform process taking place in the health services: a national re-organisation of health structures, which involved *inter alia* a reduction from three to two in service programmes - an Acute Hospitals Programme and a Non-Acute Services Programme. With the latter programme incorporating both Community Care services and Mental Health services, the Special Hospitals (Psychiatric Care) Programme was effectively abolished (Department of Health and Children, 2004).

Structurally, arising from top-down decisions, a new management system within the health services eventually emerged in 2006. In this new system a county-based Local Health Manager took over management responsibility, at sub-regional county levels, for both Community Care services and non-acute Mental Health services, potentially, on the one hand fostering greater and more effective service integration, but on the other hand contributing to further disaffection within psychiatry.

The local health office is giving more priority to community services so psychiatry is bottom of the pile again. The arrangement is not satisfactory and not any more effective. It is still hard to get our needs addressed (Elisha – Consultant psychiatrist).

This new configuration of services management was not decided at the time of the action research process, but it was being considered and anticipated, and it underlined an overall shift in non-acute Mental Health services management from a hospital structure to a community structure. Some Community Care managers expressed frustration with the failure to face up these pending changes, as it was known for some time that they were being discussed and planned, that there would be acute services and non-acute services, and that in due course all addiction service personnel would come under some form of community-based management, irrespective of whether they made that move in the context of present IASR proposals. Sooner or later, it was argued, they would have “to start talking to each other (Sandy - Community Care manager). A Community Care manager summarizes difficulties arising from the fudging of a decision about overall management in the following quote:

I would see the model that we [Community Care] are talking about [is] the community [with] more self referral, [and] less clinical...It is a challenge all right, you know, bringing the Mental Health people into that environment from a very structured environment. The difficulty is there is a perception that we are going - the whole health service is going - acute and non-acute service, and that Mental Health comes within the ambit of non-acute service and in theory then the Community Care manager manages the non-acute service. But in practice that has been very much rejected [by Mental Health]. And that issue hasn't been dealt with and the problems are following from that.....For a while they [three regional managers of General Hospital Care, Psychiatric Hospital Care and Community Care].... went down the road of two-prong structures: acute and non-acute and that was reflected in the regional management structure and so they gave it out to be reflected at local structure but never actually worked through it, and it fell by default through people not accepting it and it went back again to the three managers. And you

know there is still the fall out of that, that I think it is still impacting on what we are trying to do here (Dusty - Community Care manager).

While the issue of overall management of services remained fudged, and in the absence of clarity as to how addiction services were to be managed long term, the most significant outcome in terms of developing structures to emerge from IASR was to suggest changing the operational arrangements for Mental Health field personnel. By focusing on change at practitioner and team levels the IASR, perhaps unintentionally, suggested that it was at these levels that change is most needed. The non-reference to change at other levels was perceived, implicitly, by field personnel as attributing to them responsibility for what was an agreed lack of progress in service development; some practitioners felt that if the solution was to change the way they were to work in the future, then it would be perceived that the problem was the way they had worked in the past. Whatever the truth or logic behind such claims, it was bound to leave some personnel feeling a lack of acknowledgement or affirmation for the work they had undertaken and the achievements they believed had been made, and feeling that they were being scapegoated for broader systemic failures. As a result, and in order to protect the integrity of the services they had worked with, and to protect their own reputations, they felt compelled to oppose RHB's vision, despite some support for its basic precepts.

I think we have been flogged by virtue of the fact that "ah sure you are in Mental Health and you don't provide anything in the community". [Our service] may not be the most ideal but it was a lot better than anything else that was available in 1990 and so we provided open access.....We have done that right from day one: we provided outreach facilities....We provided a service to probation and to the courts to the GPs and all that. But yet we have been

constantly flogged and rapped over the knuckles that we are not doing whatever the community way is (Jody- CAS addiction counsellor).

An acknowledgement by RHB management that the difficulties besetting services development were historically based and rooted in failures throughout the whole system and not a failure at the level of direct service provision, could have helped assuage practitioners sense of grievance and re-assure them that their positions would not be undermined. Indeed, this acknowledgement eventually did come in the course of a second regional forum – held in April 2005 - during the action research process, but for some personnel this acknowledgement was perceived as coming too late to diminish the disaffection that was, by this stage, well established. It appeared furthermore that RHB management continued to lack coherent, satisfactory proposals for changing structures at all levels, or indeed were unable to put these forward - given they were at the time in the midst of a national reform process leading to centralized, national planning in relation to such decisions. RHB management also showed a lack of awareness or assessment of the historical role of Mental Health services in the treatment of alcohol problems; in one exchange with this author, for example, senior personnel were clearly unaware of the longitudinal pattern of in-patient admissions for alcohol problems and the potential impact of these admissions on persistent opposition to change.

In effect, it appeared that RHB management expected existing CAS counsellors to embrace change in the absence of an historical representation of the need for such change and an inadequate assessment of the capacities of alternatives to extant Mental Health addiction services. In the absence of an overview or analysis of existing

service provision, the IASR process lacked a context whereby practitioners could fully assess the changes that were represented by IASR proposals.

[The IASR report] was represented as an attempt to put a shape on things without necessarily naming what the problems were and it didn't really give too much credence to what had been done up to that. ...For some people they would have felt that there was direction without the debate and what happened was, and what is happening still is, that debate is taking place post-direction.....It is highly possible that we would have chosen to do exactly the same thing or chosen to do something entirely different: that is not really the point (FG: Carl – Mental Health manager).

The historical reality was that addiction services were provided through Mental Health and, as outlined by one SMT coordinator, Jude, it would be extremely difficult to expect that such provision could simply close down:

The counsellors within the psychiatric system have got to service the [hospital] sector teams. Politically as much as anything, that has got to happen, because of the historical routes of referral, huge numbers of people come through that way (Jude – SMT coordinator).

The future reality, it appeared, irrespective of proposed changes, was that Mental Health services – as indeed outlined by the 2006 report *A Vision for Change* - would continue to have some role in providing these services for people with co-related addiction and psychiatric disorders. In the absence of a coherent, alternative provision, it was reasonable to expect that psychiatry, irrespective of other developments, would remain the main provider of addiction services:

In the sector teams we have specific clinics and sessions for people who have substance misuse problems and alcohol problems principally. The addiction aspect of their care is dealt with by the team locally and those

people will continue to be dealt with locally....There is also the more residential, inpatient base, where there is a crisis, and it is quite an acute crisis which occurs during the night or at the weekendand because at root is their addiction and once you are associated with a Mental Health service, whether you are mentally ill or not, it is extremely difficult for that tag to be shook off by somebody and another service to say: "well maybe they don't have a Mental Health problem". Once they are associated with the Mental Health services we tend to find that more often than not other services will say: "no it is your problem" (Carl - Mental Health manager).

Some Mental Health personnel argued, that because so many persons had both alcohol problems and co-related psychiatric disorders, it did not make sense to shift the focus of addiction treatment away from Mental Health to Community Care. They argued it would be better to maintain the historical, psychiatric involvement with this issue within a community context, even in instances where this did not involve co-related problems

The policy [not to admit persons with alcohol problems except where there are co-morbidities] is not a good decision. Some people fit in better with the Mental Health services and would get more holistic services with us (Elisha – Consultant psychiatrist).

This position is not consistent with national policy as subsequently outlined in the 2006 report *A Vision for Change* - discussed in Chapter 4 above - where it is proposed that Mental Health services were not to be involved with addiction treatment save in instances of co-related disorders. However, various RHB personnel argue that if the overall intention of the new policy is to shift the focus of Mental Health treatment generally from institutional to community-based care, then the idea of limiting the involvement of Mental Health personnel in addiction treatment within a community

context did not make a great deal of sense, whatever the arguments in support of limiting this involvement within a hospital-based, institutional context. There was a strong sense that among their Mental Health colleagues, addiction personnel had been to the fore in developing a wider, community context, that compared to other areas of Mental Health provision, they (CASs) were in fact an established community service:

It [the Mental Health Addiction Service] obviously has a significant community focus.....it is not recognized that well but it is very significant and it is not a quantum leap to move from where we are today to where we want to get to..... (FG Sandy – Community Care manager).

I think there is a belief within psychiatry that they have been doing community based stuff anyway. So that is why you will hear: “we have been doing this so what?” or “you are going to have a counsellor who goes out and sees people: I am doing that. We are community based. We do see people in the area. We do home visits”. So basically what I am saying is that ideologically it [the service] is community-based.....We are the community addiction treatment service and it is community based, serving the community (Lee - CAS addiction counsellor).

At a certain level there was some perplexity that Mental Health’s traditional involvement in addiction issues did not seem to be perceived by the RHB as a resource to build upon within the context of further service development; the following comment from a Community Care manager illustrates a frustration with the prospect of addiction services developing without a meaningful Mental Health input:

I think the foundation block has been in the Mental Health service and the foundation blocks have not been used in the building blocks of the new service and I think that has been the difficulty that has been there. There has been another foundation set in the [new Community Care

service] perhaps or whatever and that is the other service - it grows. There seems to be two separate services trying to compete against one another. While on the ground people individually are delivering a very good service and I think that then gives rise to the demoralization of the service that seems to be left behind that [it] is not as good as the one that is now growing. And that is the difficulty that is there and you have got to get over that if we are ever going to progress (FG Sandy – Community Care manager).

Support for a more engaged involvement by Mental Health services in Community Care services development was also expressed by a SMT Coordinator, who saw value in developing effective working relationships between Community Care and Mental Health counsellors:

If you look at say the community counsellor and the psychiatric counsellor working say in the same county area or sector, where in their specific separate remits one is dealing with easy access, low threshold, short term interventions and the other is dealing with managing the psychiatry input with people who are coming in through Mental Health mechanisms into their system. They could jointly look at the area of developing specific group supports, specific programmes that can be offered to people, and people can be recruited in on a joint working basis. They could do a specific programme around management of particular behaviour to people who make up their joint case loads and depending on the particular programme that is being offered, people might fit into it in different ways (Jude – SMT coordinator).

In summarising this chapter so far, it is clear that IASR - an attempted reorganisation of addiction (alcohol and drugs) services - has deepened tensions between two RHB operational programmes – Community Care and Mental Health – and limited the prospects that a new action research process could contribute to a more effective integration, at county level, of Community Care and Mental Health addiction services.

The attempted reorganisation focused mainly on restructuring at service provider level and did not address the need for organisational changes at other, higher management and policy levels, although it was clear, in the midst of a wider, national reform process, that some of the proposed changes were pending and unavoidable. The action research process helped to bring about an acknowledgement of previous systemic failures and has also helped to bring focus to the need, despite tensions between Community Care and Mental Health, to build on CASs long-standing involvement with these problems, in developing a new community and public health model of service provision. Indeed, agreed proposals for further service development did emerge from this process and these will be discussed towards the end of this chapter. Meanwhile it is important to address external issues that arose in the action research process and which have influence on the RHB's change efforts. The first of these, which is discussed in the next paragraphs concerns the involvement of mainstream Primary and Community Care personnel in alcohol treatment, and the second, which is discussed later, concerns wider policy issues and developments.

PRIMARY CARE AND THE ROLE OF GPs

The issue of mainstream Primary and Community Care involvement with addiction issues has arisen continuously throughout the action research process. It is important to note however, that the level of Primary and Community Care involvement from non-addiction service practitioners in this process was minimal. There was, amongst addiction personnel who did participate, widespread support for Primary Care

practitioners having a greater role with addiction problems; Primary and Community Care personnel were perceived as being in a “prime position” to engage in preventive work and to direct persons with serious problems to more specialised services as required. It is reported that at an early stage of CASs, there was a commitment to engage with various external Primary and Community Care professionals, and to an albeit limited extent there was a sense of some achievement in this regard. When SMTs were being developed there was similar attention to involving Primary and Community Care personnel; initially this engagement was concerned with issues of education, training and prevention, but in due course there was also some focus on developing relationships with external professionals from a treatment perspective:

I wouldn't say it is ideal.....but we have pretty good relationships with most of the GPs, very good relationships with social work, probation, public health. That structure exists here. It needs to be developed further (FG: Ali – SMT coordinator)].

In general, Primary and Community Care workers are perceived as seeing Mental Health or Minnesota Model programmes as the first port-of-call, in seeking assistance for their clients and not to see themselves as having a more direct, clinical role exercised in conjunction with other community-based colleagues.

I find that the professionals have been trained in a certain way and it is very focused, a lot of the time, on dependency. That is my experience on the ground. And because of that and unless that is being challenged, the manner in which they refer will be very much focused on the knowledge that they have already.....And they refer them into [specialist services] even though a lot of time they [clients] could be at an early stage of substance misuse; they [professionals] could actually work with those issues within their own brief and

it could be probably more effective working with them in their own brief (FG: Jude – SMT coordinator).

One of the difficulties with the primary care workers [is] if they view it as a disease or if they view it that [addiction counsellors] are only dealing with dependency, then a lot of the time they will only refer [persons] when they are in the dependent stage and that I think causes problems.....My sense is that they never realized that if somebody had a problem in the early stage that they could refer on (Kerry: SMT counsellor).

A contributor to one focus group, and an interviewee, considered that there were relatively simple practical, communication and training dimensions to the perceived lack of engagement of Primary and Community Care personnel:

I think that there hasn't been enough selling of what services are available. I think a lot of primary health workers, not necessarily GPs, didn't know where to go with the issues. They might have a phone number but no understanding of what the service at the other end of the line actually does (FG: Terry – SMT education officer).

It is really training. Social workers, child care protection people, ourselves [psychologists], all members of the health board: we need to be involved in training and [to be trained] in the brief [assessment], where you ask four little questions and that will basically give you a lot of information. There are a lot of people on the ground already. [We need] a layer of training so that everybody is tuned in...rather than setting up maybe another track or another separate service, tune up everybody who is working at the moment (Kirby – community psychologist).

An alternative account of the obstacles to a greater community and primary care involvement with these problems is contained in other comments, which put particular emphasis on the need for support to primary care workers and on their fears that if

they got more substantially involved with these issues, they would be left holding these with little if any back-up.

My experience in training days when I am working with them [GPs] and we identify the skills that they have already, saying: “you wouldn’t need an awful lot to build on this to work with them [substance misusers] in the early stage”..... but they [GPs] believe they haven’t adequate knowledge and they say “you would have me working with [persons with alcohol or drug problems] but I’d be left swinging. I am not supported in it.” ... They [GPs] are saying: “we are not supported to work on alcohol or drug related problems so we are going to refer them all, we need to refer them all to a specialist service”.....The same concept holds true for most specialist services....People use what is there unless you have alternatives....I think that GPs can see that if they get involved in this they are going to be left. We all have experience of [being] left swinging here (FG: Corey - SMT education officer).

If we were to look at Primary Care workers or workers in the community ...when it [alcohol or drug use] starts to become a problem then they are thinking: “well maybe I have to deal with it. I have enough on my plate. I have enough to deal with. I have my own caseload. I don’t need to start working with alcohol-related problems or drug related-problems as well”. If you broaden the concept my thinking is that [Community and Primary Care workers] may have to own part of the problem....They like the idea of the specialist service sometimes that they can refer into and they are very reluctant to take on another piece and may not feel adequately trained or supported in taking on that piece (Jude – SMT coordinator).

Despite this broadly-held perception that Primary and Community Care Workers lacked an engagement with addiction issues, it was also reported that some GPs had good contacts with SMTs and that these GPs made meaningful brief interventions with clients and were willing to work collaboratively with counsellors when more serious problems were indicated. It was generally acknowledged, however, that these arrangements depended greatly on the individual GPs involved although it was

claimed that as a group it was difficult to engage GPs in relation to addiction problems. Where GPs were meaningfully involved, however, it was reported they had an important impact on client decisions. The following comment from a focus group contributor highlights the importance of this impact:

I have that experience of working with clients for a number of months and they have gone to their GP for whatever reason and they have talked about whatever and they come back and say well my doctor said this. The temptation is to say well I have been saying the same thing for the last three weeks and you have paid no attention....But the GP is the [person] who has always been there for them.. ..and the message gets across so much better (Lee – CAS addiction counsellor).

Although the involvement of GPs in addiction problems was perceived as positive in some instances, there were no GPs directly involved during any of the action research process consultations; their non-involvement was raised as an issue, both in terms of the negative connotations of the non-involvement of a key Primary Care discipline in promoting the role of Primary Care in addiction problems, and in terms of the difficulties that were perceived as arising generally in trying to get GPs as a group involved in a range of other community health issues, such as suicide prevention and child and adolescent Mental Health problems. Community Care managers and coordinators in two sub-regional areas were optimistic nonetheless that the involvement of GPs in addiction issues could potentially improve, particularly through a screening role and through involving SMT members in the roll-out of new Pilot Primary Care Teams: multi-disciplinary teams that were to be developed within the context of new group GP practices (Department of Health and Children, 2001).

One SMT co-ordinator commented as follows:

It was interesting that when all of the positions [in proposed new Primary Care Teams] were being decided, and they needed a physiotherapist, they needed GPs obviously, they needed public health nurses and they needed psychiatric nurses, and to me the glaring omission was an addiction specialist.....we suggested maybe they would look at us [SMT] providing a service to the Primary Care team. I think it is a way of going [forward], because [it is an] easy access service to GPs. They said finebut I was intrigued that this [addiction specialist] was glaringly omitted (Ali - SMT coordinator).

SOCIAL WORKERS AND CHILD AND ADOLESCENT ADDICTION ISSUES

Aside from GPs, other potential Community Care personnel who could become involved in managing addiction problems included social workers, particularly in relation to dealing with child and adolescent referrals where either the child or the adolescent had an addiction problem or where parental misuse of alcohol and / or drugs was a direct or co-related factor in the referral. Arising from Action 49 of the National Drug Strategy, 2001-8, which underlined the need for a treatment protocol for young persons with serious opiate problems presenting to methadone services, the *Report of the Working Group on Treatment of Under 18 year olds presenting to Treatment Services with Serious Drug Problems* (2005) (referred to below as the *Under 18s Report*) was published and government commitments were made to fund its implementation. The specific needs giving rise to this report arose primarily and almost exclusively in the Dublin region where opiate problems were concentrated.

The *Under 18s Report* drew extensively from a UK report, the *Substance of Young Needs* (Gilvarry, 2001), which was more broadly concerned with substance misuse

and which perceived both alcohol and drugs as pressing problems for young people requiring a substantial, comprehensive response. RHB management and practitioner personnel considered the *Substance of Young Needs* report as being more applicable to substance misuse problems within their region than the *Under 18s Report* which was considered as more applicable to the Dublin region. It was claimed that this latter report was based primarily on views and needs as represented in Dublin – 32 of the 36 members of the working group that compiled the report were based in Dublin-based services, while the remaining 4 represented national offices of government - although its publication provided an opportunity to all regional health authorities to process proposals for dealing with young people's alcohol and drug problems (Harney, 2005).

Both the *Substance of Young Needs* and the *Under 18s Report* advocated a 4-tier model of service delivery, corresponding to primary prevention, secondary prevention, specialist treatment and extra specialist (residential) treatment. The 4 tier model may be summarised as follows:

Tier 1: *Universal – generic and Primary Care services*: provision of primary information/education, general medical screening and screening across lifestyle issues and related risk behaviours, identification of risk, referral and generalised family support and advice.

Tier 2: *Youth-oriented services offered by practitioners with some drug and alcohol experience and youth specialist knowledge*: targeted groupwork and activity programmes for at-risk persons, counselling on lifestyle issues [harm reduction], parenting programmes and risk assessment.

Tier 3: *Services provided by specialist teams*: specialist assessment leading to a planned package of care and treatment that would augment other services already provided or available at Tiers 1 and 2.

Tier 4: *Very specialised services*: Short-period of residential care during crisis; inpatient / day psychiatric or secure unit to assist

detoxification if required. Continued multi-agency involvement across Tiers, 1, 2, and 3.

In addition to this tier outline both reports also draw together key service principles for working with children and young people, highlighting the intrinsic differences between children and adults and the need for services to be designed and operated within a child developmental model. In this sense substance misuse services for children and adolescents should not be simply an extension of existing adult services. It was envisaged that an adolescent framework would contribute to greater integration with other child and adolescent services who would share knowledge and an appreciation of the ethical and legal issues that are underlined in child welfare and child protection legislation.

An understanding of issues concerning consent, confidentiality and the application of protocols for communicating with other agencies and for maintaining case records were all considered important. Service principles concerning comprehensiveness, integration, competence and accessibility were also highlighted; the *Substance of Young Needs* report also suggested that the 4-tier model needed to be dynamic and flexible and coordinated in order that services and interventions be able to adapt to the variable and changing needs of young people and their families. Consequently the tier outline does not define specific disciplines or agencies needed at any particular level, but rather emphasizes the functions at these levels, and promotes integration across different health and social care sectors, agencies and disciplines. Both the *Under 18s Report* and the *Substance of Young Needs* report draw from the public health model, and reflect the stepped-care approach as outlined in Chapter 2 above. In general their

broad principles and strategies provide a concrete opportunity to transmit the public health approach, as it relates to children and young people, into the wider community.

It is important to note, as already referenced in previous Chapter 6, that the need to provide alcohol and drug programmes to adolescents was an important imperative for RHB Community Care managers in developing new community services:

We were saying that from a community perspective we were particularly concerned about adolescence and we were pushing to have something geared specifically for adolescents (Van - Community Care manager).

With the assistance of youth dedicated funds, Community Care managers supported the need for new, community based addiction services for young people. Indeed, from an early stage of their development Substance Misuse Teams (SMTs) were perceived as being primarily concerned with developing services and programmes for young people.

When we looked at the youth at risk services in [...] one of the issues there was access to dedicated counselling for alcohol and drug misuse, so we set that up separately. And that is the one thing, if you ask any of the parents about that service they would say that the one thing that the health board did that was right was introduce a counselling service for these kids. It is just the manifestation of a demand that was identified I would say jointly by the community as well as by ourselves and we met that demand [Sandy – Community Care manager).

As a result of investment, there appears to be general satisfaction with the provision of youth services, operating at a primary preventive (tier 1) level. It is argued for example, that community youth service personnel were able to engage young people,

get to know their patterns of alcohol and drug use behaviour, provide harm-reduction messages as appropriate, and maintain a monitoring, supportive role. Potentially, they could identify the need for more intensive interventions if needed, although some difficulties arose in differentiating the need for support and monitoring and more intensive psychosocial counselling, and it was argued that youth personnel were not always well-positioned to make this distinction. There was concern that there was no consistent triage system to differentiate those adolescents who needed more specialist interventions, and that in some areas there was often a considerable time lag between identifying the need for more specialist services and being able to access these.

A lot of the difficulty...is that there are people presenting [to youth services] who should be dealt with at [specialist] level and are not getting [this] service, and I guess you can end up being left dealing with a particular person while other services are just not available (Gayle - youth worker).

This issue of poor capacity at community level to effectively assess and screen was also identified in discussions of adult persons presenting at community services with alcohol and drug problems.

Despite the new investment into community-based youth projects, it is generally perceived, as already mentioned, that there was both a reluctance and a general lack of capacity for the relevant, existing RHB Primary and Community Care personnel to become involved with these issues. Among other things this reluctance reflects the absence of a coherent Community Care structure to allow Primary Care personnel to work together with addiction personnel and a discontent with the increasing expectation that social workers respond to all, new, emerging social problems, or

older problems that were becoming more socially defined. These points are illustrated by the following comments from a SMT Coordinator and a Social Work Team

Leader:

Periodically, the social work department would [come to us looking for information] if there were substance misuse issues, and they were working on a case. But often we have been involved in a case for six months or twelve months and then we suddenly find out that the social worker is involved in it as well and the social worker will have been involved for two years. It often comes out accidentally: “well my social worker said”I don’t think there is an unwillingness there at all to sit down and engage I just think there is an absence of a structure (Ali – SMT coordinator).

I think [we] are just involved in too many things. In addition to childcare, we now seem to be taking on juvenile justice as well. We are taking on some aspects of school attendance as well. We are involved with asylum seekers, unaccompanied minors. So a whole lot of things we have been signed up to without having the resources to do it. So over time the agency is going to have to retrench back into saying: “what are the core community services to provide?” (Mican – social work team leader).

The reluctance of social workers to engage with addiction and other issues is underlined by a broadly-accepted view that social work services are caught up in child protection issues. For example, it is suggested that if there is “no child protection issue” in a child and adolescent referral, this becomes an “opt-out clause” for the social work team, who tend to be involved only for the “period of time until that problem (child protection issue) is resolved” even though “in real terms the (addiction) problem does not go away”. It is also suggested there are young people

with addiction problems who are considered to be “out of control” but who fall outside a “child protection mandate” (focus group).

Social work services [are] not involved. [It is] not a priority. The whole focus is on child protection. They [social workers] are being crucified by communities, because of very little follow up from case conferences - nothing happens. Very negative feedback from communities. Their perception at community level is extremely poor.....Social work and probation services should ideally know enough to do brief interventions and be able to make appropriate referrals to colleagues at this level. You could have most of the components of a second tier service already in place although there might be some questions around resources and structures (Sidney – SMT coordinator).

In the absence of an involvement by social work services in families with addiction problems, practitioners from local SMTs have tended, to seek the involvement of youth services, outreach services, and various community projects in engaging the young people concerned. The mandate of these services however, is prevention, and they are perceived as lacking the capacity to intervene in an effective manner in relation to drug problems. A contributor to a focus group outlined this difficulty as follows:

Social work service providers do not see themselves as being part of addressing this problem and there's a huge reliance on community based projects to be doing this work but are they able to do it? Can we re-skill them? They need structured supervision and accountability.
(Jamie – SMT counsellor)

A youth work manager explained the situation as follows:

We pick up on people because there is not a comprehensive service at these levels and we end up dealing with them in our project; and they engage with us at this level even though we don't have the facility and we are not equipped to deal with these problems. But there is an absence of other services. So to disengage we are letting them down again....A crucial question is: "should we be providing this service to these individuals"? And if so what happens to the people we are working with in a more preventive way? (Denny – youth work manager)

The difficulty as outlined here was regularly referenced: community projects that were set up to engage young people within a social education model (tier 1) become drawn into providing psychosocial services to vulnerable young people with addiction problems because of the absence of other (tier 2) services. As explained by a SMT Coordinator:

There are [only] a few [addiction] agencies around: you have the [RHB] psychiatric system, the [RHB] community [SMT] system, the [community youth drugs] project. There are only a few bits and pieces around. Other people should be there like child services, social work department, child psychology, child psychiatry adult psychology: whole range of people should have been involved. It is very difficult to bring them into the process [if] when you do actually get them to the meetings, there is nothing really tangible for them to fit into. So I think that is part of the problem (Jude – SMT coordinator).

Across the RHB, adolescents with addiction problems had only limited access to specialised Mental Health services (tier 3), which are based in and managed by Community Care; in general this (tier 3) level of care is considered virtually non-existent (Child and Adolescent Psychiatry Section Irish College of Psychiatrists, 2003, 31) and well below recommended norms (Ireland, 2006). Some SMTs had access to adult psychiatry for adolescents over 16 years. In such situations adult

psychiatry was perceived as a better option than child psychiatry for the reason it had an historical relationship with addiction services. In general, it was felt that adolescent substance misuse has low priority in child psychiatry and that it can take 9-12 months for a person to be seen. It was suggested that external pressures and demands can cause specialized adolescent services – if available - to prioritise around problem areas where there is a lot of public concern. The issue of teenage suicide prevention was referenced in this regard and it was suggested that referral for suicide risk can therefore become a quicker way into the system for adolescents with addiction problems. In some instances specific relationships or arrangements allowed for a child psychiatric involvement:

Effectively we have no link with child psychiatry. They did have a clinical nurse specialist with a background in addiction, so there was a historical relationship there. He kept that link but he has moved on and that link has been lost....We feel we have a bit of back-up from our own [adult psychiatrist]....One of the registrars was based in [addiction service] for half-day a week and there was a 14 year old boy who had been seen with a lot of cannabis use. The registrar had just completed his six months with child psychiatry and so he was able to make that link back [to child psychiatry] on this basis. But it was a once-off – no formal connections (Sidney – SMT coordinator)

Currently, some SMT counsellors across the RHB area accept adolescent referrals from social work, probation and various other sources. The basic idea here is that adolescents can get easy access to a substance misuse service without the necessity of going through a medical or clinical referral, although this too often happens. Essentially this becomes the first point of contact for specialist substance misuse services. The response is primarily a counselling-based assessment with 2-3 sessions of harm reduction. A mixed response is reported, some adolescents making it clear

they do not wish to avail of the service and don't want to come, others coming out of duress because of probation orders, often discontinuing after 2-3 sessions. There is a sense that, in most instances, the response to adolescent addiction problems is modelled on adult services and more careful consideration of an appropriate secondary preventive service component is required, perhaps with a clearer focus on harm reduction and deeper consideration of the co-related issues that surround and contribute to the substance misuse, for example educational and psychosocial problems.

In some circumstances the non-availability of psychosocial services for young people within the community, and the lack of capacity of youth service providers to provide an appropriate, intensive response, has meant that many young people with addiction problems get a relatively early referral to specialist, residential addiction treatment services (tier 4), sometimes in the absence of any prior community interventions, and certainly with no (tier 3) specialist adolescent community addiction service, as none are available. This gainsays the basic principles of the *Under 18s Report* and the *Substance of Young Needs* reports; the latter report in particular highlights the importance of ensuring there is adequate provision of both non-specialist and specialist adolescent addiction services at community levels prior to providing specialist residential services, in order to avoid the development of inappropriate referral practices at the specialist level.

Overall community-based SMT personnel criticised the tendency to refer to residential specialist treatment for young people. They see such specialist services as unnecessarily conferring an adult addiction identity on young people, who often, it is

claimed, end back in the community with much the same problems that gave rise to their admission unresolved. The basic problem, it was argued, was a lack of adequate investment at tier 2 and tier 3 levels, that is in the provision of adolescent workers to provide psychosocial counselling and other interventions to young people at community levels, and more intense, multi-disciplinary provision, within the context of community adolescent Mental Health services: this concern was expressed in relation to residential services across all age groups.

Well I have often said there are residential rehabilitation organizations that require somebody to be problem free before they enter the gates. Well you are going to have a good success rate with that client group, aren't you? Stable non-drinkers I am sure do very well in residential rehabilitation. But there are other people that do seem to benefit from that kind of intervention but yet we have got the focus perhaps in the wrong areas. But at least now we are moving to a situation where it is a community team that are determining access for people to those residential institutions that the [RHB] is paying for, as opposed to the previous system where we grant funding to residential institutions and they made up their minds who they took (Jude – SMT coordinator).

We have all picked up on people from voluntary treatment who may have not done so well in treatment and then turned up subsequently at community services; whereas maybe if they had turned up at community services first then they might have done better if they had been referred on or sometimes it is not appropriate. With some of the voluntary agencies I would say we have a better relationship, we have a working relationship in that there is a tendency there to make us aware of all clients from our area that are in there, irrespective of whether we refer them or not, and that does benefit in terms of aftercare and follow up (Ali – SMT coordinator)

So far the discussion in this action research process has focused on service level issues in the implementation of addiction services. It is also concerned however, with external matters and in this case with the impact of relevant policy developments on RHB's efforts to bring about organizational change. In general the discussion in this study so far has explored RHB efforts at service development within the context of a policy framework that is, in general, perceived as approving a public health approach to both alcohol and drugs. However, the wider policy framework in relation to any particular social issue will rarely be singularly supportive of practice and service developments. The general reorganization of Irish health services has already been referred to above, and it is clear that, for a while, the lack of certainty in relation to the new HSE's intentions to bring together Community Care and Mental Health inhibited the development of working relationships between both sectors with respect the development of addiction services. Other policy developments, particularly in relation to the National Drugs Strategy, the perceived absence of an overall National Alcohol Policy and consideration of the role of alcohol within drugs policy have all, in various ways, had impact on RHB's internal efforts to reorganise its alcohol and drugs services. These wider policy matters are discussed in the next sections below.

NATIONAL DRUGS STRATEGY

The reorganisation of addiction services was, in the minds of many of RHB's counselling and management personnel, derived from developments within the National Drugs Strategy. For some, difficulties in the attempted reorganisation arose

as a result of developments within the Strategy, and it is believed that this Strategy is flawed in relation to the management and treatment of addiction problems in the RHB's geographical area. From its outset in the mid-1990s the National Drugs Strategy was perceived within RHB's senior management as providing an opportunity to apply a strategic approach to developing local services. In addition to its strategic coherence – since 2001 it had five separate pillars: supply reduction, prevention, treatment, research and coordination – the Strategy also offered the prospect of significant new investment. The National Drugs Strategy was perceived as the main mechanism for bringing new funds into the addiction (drugs) field, funding that comes with the condition that there be greater emphasis in developing services through local structures and utilising community models. The National Drugs Strategy was also perceived as bringing a new and important focus on the needs of young people with drug and alcohol problems.

The National Drugs Strategy was, and clearly is, an important engine for funding new developments. By initiating the RCCD and IASR processes the RHB believed it was acting in a manner that was consistent with extending aspects of the Strategy into the regions, thereby attracting new investment. However, there is a strong sense among some personnel that the National Drugs Strategy was represented as the main decider of change for the RHB. This was difficult for people to absorb especially as some of the problems in the service pre-existed the National Drugs Strategy and most of the problems, in any case, concerned the issue of alcohol, which was not part of the Strategy's remit. There was a widespread perception that the National Drugs Strategy's addiction treatment priorities arose from a concern with serious opiate problems and the corresponding need to develop appropriate methadone maintenance

services. As previously discussed, these concerns about opiate use arose primarily in the Greater Dublin area, in communities where these problems were concentrated, and where specific harm-reduction interventions, principally in the form of community methadone clinics, were implemented. For regional authorities outside of Dublin, such as RHB, alcohol misuse, and to a lesser extent cannabis use, were regarded as the most pressing substance misuse problems. Although there were various demands to create appropriate treatment systems for the relatively small, but growing, numbers of opiate users, many front-line personnel believed that such provision should not undermine the operation of services to the broader population of persons with alcohol and drug problems.

As discussed in Chapter 6 above an important implementation mechanism in the National Drugs Strategy was the creation of Local Drugs Task Forces in areas in the Dublin region in which opiate-use problems were concentrated; this later translated into creating similarly structured Regional Drugs Task Forces for each health authority region, suggesting therefore that the issues and conditions giving rise to the need for task forces in particularly vulnerable sub-regional areas in Dublin were replicated across the whole country. This clearly was not the case and although, in principle, RHB personnel did not oppose the central, collaborative ideas behind the formation of Regional Drugs Task Forces, they took issue with what they saw as the imposition onto the regions of a model and structure that was contrived to deal with a particular opiate addiction problem for which there were unique public health concerns. Overall, it was felt that a more open critique of the National Drugs Strategy could have helped build broader support for the proposals for change contained in the IASR. The following views had quite widespread support across RHB personnel:

The national task force [National Drug Strategy Team] is driving this thing and there was a new concept, and we had the strategy, which was a good thing, but.....the strategies were being forced down upon people without looking at the operational aspects and obviously once we started getting into the operational issues all these management issues came up. I think you know we were in trouble before we really got started.....My experience has been [that] the issues in [Dublin] are very different from the issues down [here] - and I think that has to be recognized (Ali – SMT coordinator).

My understanding of the logic is that it comes from a national framework [National Drug Strategy] and it has to be implemented on a regional basis and the regional basis is assumed to do two things: one is to reflect the national framework and the second is to reflect what is happening locally. I don't believe....certainly I don't think, it does reflect what is happening locally. Also I don't believe it takes account.....of what is already there [Carl - Mental Health manager).

NATIONAL ALCOHOL POLICY

In addition to internal difficulties with the attempted reorganisation and concerns about the role of the National Drug Strategy in driving change, RHB personnel also expressed considerable concern with what they perceived as a deeper ambiguity in national policy and societal and community attitudes with respect to the treatment of alcohol problems. Alcohol and drug problems, it was reported, were still widely perceived as different problems, requiring different types of treatment. Despite the RHB's rhetoric in support of integrated, community-based services it was argued that the wider community remained ambivalent about the mechanisms and procedures for

treating these problems. Indeed successive health policy documents since *Planning for the Future* favour a public health approach to alcohol (and drugs), one that broadens the base of both treatment problems and treatment providers, although these are envisaged as separate models for drugs and alcohol. While these policies are coherently stated in official documents, there is both political ambivalence and practical difficulties with respect their application, and in turn this has impact on the ability of service providers such as the RHB to operate coherently.

Politically, the public health approach to alcohol does not enjoy an ongoing consensus, as evidenced by a “two-policy” approach to policy-making: one policy formulated by health agencies and the other by the main stakeholders in the drinks industry (Butler, 2003). Although it is evident that Ireland has one of the highest rates of alcohol consumption per capita of 27 EU countries (fifth behind Luxembourg, Czech Republic, Hungary and Germany), increasing from 11.4 litres in 1995 to 13.4 (peaking at 14.3 litres in 2006), and despite improved research information on alcohol-related harms, there is no single, national structure for coordinating alcohol policies and strategies (Mongan et al., 2007), unlike, for instance, the National Drugs Strategy for drug problems. While alcohol is understood as having public health risks, it is also considered first and foremost a market commodity, forming the basis of large manufacturing, distribution, retail and hospitality industries, providing benefits to many key economic stakeholders: profits for commercial enterprises and tax revenue for governments. This market commodity approach to alcohol is reflected in the remit of the Commission on Liquor Licensing:

..to review the liquor licensing system and to make recommendations for a system geared to meeting the needs of consumers in a competitive market economy, while

taking due account of the social, health and economic interests of a modern society (Commission on Liquor Licensing, 2002, 53).

The Commission, which consisted mainly of representatives from drink and drink-related industries, published a final report in 2003 advocating increased alcohol accessibility, and also suggesting that alcohol problems be tackled mainly through school education measures (Commission on Liquor Licensing, 2003), a position not supported by the Strategic Task Force on Alcohol (2004) which envisaged school education measures as one of a number of strategies that would focus on reducing accessibility and availability, rather than on increasing it: painful measures for both government and industry.

The thrust of the public health approach, as phrased by Babor *et al.*, (2003), and discussed in detail in Chapter 2 above, is that alcohol is *no ordinary commodity* and that measures to control and regulate supply and access must reflect alcohol's contribution to extensive individual, social and economic harm, irrespective of its economic and social benefits. The coherent management and effective treatment of alcohol problems in society therefore will, in public health terms, reflect the existence or not of adequate controls to limit or restrict alcohol consumption. In recent years such controls in Irish society have, on the one hand, been subject to considerable market liberalisation pressures - for example the Intoxicating Liquor Act, 2000 increased alcohol accessibility; on the other hand, this is matched by demands that alcohol restrictions be used in order to control public disorder offences - arising from media coverage of such concerns the Intoxicating Liquor Act, 2008 restricted alcohol accessibility. On the whole it can be argued that in assessing various changes over the last 30 years, demands for liberalisation have been ascendant, as alcohol is more

easily purchased in 2008 than it was 30 years previously, and consumption levels over this period, according to the Strategic Task Force on Alcohol (2004) have almost doubled.

Shifting legislative developments underline the importance of political ideas in shaping alcohol policy. Such ideas may be represented in party political terms, as reflecting particular political aspirations, but they are pervasive in a more general, political sense also, raising questions as to whether policies, such that relate to alcohol, should reflect the individualized nature of risk (Single & Leino, 1998) or whether they should be determined by their aggregate effects on public health (Edwards, et al, 1994; Babor et al., 2003), not forgetting, of course, other commercial demands.

This wider, political issue of alcohol as commodity or public health risk ultimately has impact on the nature and type of treatment for alcohol problems that is provided in society. A society focused on alcohol as an ordinary commodity might tend to favour the disease model whereby it is assumed that individual alcohol problems result more from the individual than the alcohol, whereas a public health conception of alcohol as commodity with inherent dangers, suggests the need for a comprehensive range of interventions aimed at both reducing society's overall alcohol consumption and dealing with its effects on both individuals and society.

People are very wedded to the disease concept and feel very committed to that whole idea and if you try and broaden that a little you can meet a lot of resistance to it..... I think it comes from society. There is a comfort in saying something is an illness. And for how long have we heard the mantra that a person is an alcoholic, it is ok, it is an illness? There is a cultural thing about

that. So I think when you are trying to change perceptions of what a problem is or perceptions of how it should be dealt with, and the structures with which to deal with it, there is a huge cultural shift which has to take place (Kerry – SMT counsellor).

Although *Planning for the Future* and subsequent alcohol policy documents reflect a public health approach, an overriding difficulty affecting the implementation of these policies is that politically, society's leaders are not, except occasionally, engaged by this particular analysis. The National Alcohol Policy (National Alcohol Policy [Ireland], 1996, 37) highlights that treatment interventions can be a lot "more effective" if supported by national policies which help people avoid health damaging behaviour". The frustration arising from the absence of policy coherence with respect this issue is reflected in the following comment from a SMT coordinator:

The [National Alcohol Policy] is worthless because they put absolutely no infrastructure and no resources into implementing it. It has no serious weight..... We have a National Drugs Strategy, which has 100 action plans. We have a review of the national alcohol policy going on at the moment where contrary to every paper written on it, we have the drinks industry around the table, which is bizarre if not insane, so I don't think there is a serious willingness from government level to acknowledge the extent of the problem and to adequately deal with it (FG: Ali – SMT coordinator).

INTEGRATION OF ALCOHOL AND DRUGS IN POLICY

Another dimension to the issue of overall vision and policy is the integration of alcohol and drugs within a single strategy at government and other implementation

levels. This issue continually arises for RHB management and practitioner personnel, and continues to cause difficulty for the HSE. Indeed as outlined in Chapter 6, following the setting up of the RCCD in the mid 1990s, the RHB insisted on focusing on alcohol and drugs together within an integrated prevention and treatment plan, although it was restricted to drawing down new funds for drug-focused proposals. While in practice the RHB – like other regional health authorities (Mongan et al., 2007) - utilised these funds in tackling both alcohol and drug problems it nonetheless raised some confusion and issues of perception in its plans for service development.

The RHB was already dealing with a service separation that was configured on the basis of, on the one hand, CASs based in Mental Health set up following *Planning for the Future*, and on the other community-based SMTs set up as a result of the National Drug Strategy. This configuration tended to suggest that Mental Health services were focused exclusively on alcohol while community services were concerned only with drugs. By so doing it introduced an additional obstacle to the RHB's attempts to bring about an integrated, community-based addiction treatment system, and has also contributed further to the frustration of personnel in the field who see no rational explanation as to why this separation should persist in this manner.

Previously, Chapter 5 referred to an external societal resistance to change from a disease to a public health model of treatment: admitting persons with alcohol problems into psychiatric hospitals had become a useful social control mechanism and if resources were shifted such that the operation of this mechanism was curtailed then, it was suggested, this would cause wider, community unease. This issue was regularly referenced by RHB personnel as “ a cultural thing” and indeed the embedded cultural

expectation that alcohol be dealt with in this manner is reflected in a perceived reluctance by society to accept that the same level of in-patient hospital admission be provided to Illicit drug users.

I see a difference in how problems relating to the drugs and alcohol are responded to, in terms of those people that refer into the service. In the case of alcohol people tend to refer into the service when there are clear problems related to that person's life. Whereas with drugs people who are using drugs tend to get referred in regardless of what the level of problem is, because it is seen as a different type of issue (FG Kerry – SMT counsellor).

The issue of integrating alcohol and drug problems within the context of a single policy and strategy has arisen in the context of a review of the National Drug Strategy (Steering Group for the Mid-Term Review of the National Drugs Strategy, 2005, 55). and the deliberations of a committee of parliamentary members (Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs, 2006). The parliamentary committee has advocated that following the expiry of current National Drugs Strategy in 2008, alcohol and drugs should be dealt with together under a single National Substance Misuse Strategy. On the evidence of the discussions in this study so far, there is an inherent logic to this proposal; the RHB itself has repeatedly advocated this position over the years and it is clear also that the various personnel dealing with alcohol and drug problems would openly welcome it; indeed there is a weariness with the issue:

We are having the same debate in 2004 that we had in 1996: "Is alcohol in or out?" That is insane. Alcohol is our biggest problem. It has to be in" (Gene – SMT coordinator)

I remember there was numerous meetings and arguments over the fact that certain individuals including myself felt that alcohol should be included because you know initially there was no mention of alcohol. It was all drugs, drugs, drugs. I was there going to meetings and thinking hang on, the vast majority of my caseload is more alcohol related, not necessarily so now, but at the time [it was] and it was being overlooked. (FG: Lee – CAS counsellor).

At a national research level the integration of alcohol and drugs is reflected in the decision of the Health Research Board to restructure its Drug Misuse Research Division as the Alcohol and Drug Research Unit (Drugnet, 2007, 32), which in turn reflects similar developments in counterpart research units in other European states (Mongan, 2007, 30). An integration of alcohol and drugs could potentially also lead to some rationalisation in the overall national management of the prevention and treatment of these problems. Currently at government level national responsibility is shared across two departments and within a number of sections. The Department of Community, Rural and Gaeltacht Affairs has responsibility for coordinating the implementation of the National Drugs Strategy (2001-2008), while current overall policy responsibility for alcohol issues in the Department of Health and Children straddles Primary Care and Mental Health sections.

This general fragmentation of responsibilities in relation to alcohol and drugs does not, according to one community care manager “make sense in anyone’s book” (Lesley). Alongside a more effective integration of alcohol and drugs services, the consolidation of overall prevention and treatment within a single central government policy section could potentially reassure RHB personnel, and others, at operation and management levels that a more deliberate attempt than previously was being made to give effective leadership and direction to these issues.

DEVELOPING PROPOSALS

Taking account of the various difficulties outlined above, the prospects of developing a coherent proposal pointing the way forward for addiction services development appeared quite remote during the course of this action research process. Yet, personnel remained enthusiastic about such proposals and indeed a regional dissemination forum held within the context of the action research fully endorsed an outline model for developing a comprehensive addiction service system. This model, which was developed in the course of various consultations and discussions with service personnel, is summarised in Appendix 5 and provides for an enhanced Substance Misuse Team at each county level within the RHB; the Team's core staff would be based at community locations within the general framework of other Community Care personnel. The basic model shows little variation with previous models as developed within the RHB and indeed many of these basics did not appear to be at issue. What was more at issue is the overall structure for giving direction to such proposals, and crucially: Who is in charge of service delivery at this county level?

As already mentioned, operational structures for the delivery of health and social services have changed, quite dramatically, between the start (2003) and finish (2008) of this study. Whereas at the outset, ten regional health boards, such as the RHB, provided independent, overall services management to multiple county areas, varying from 2 to 5 counties and 3 sub-county areas in Dublin, current structures consist of a single national health authority – the Health Services Executive (HSE) which has also

absorbed many of the functions of the Department of Health and Children - with strengthened local-based structures and four sub-national regional administrative units (see Appendix 6).

Currently, Primary and Community care services (all services excluding acute hospital services) have a new national and a county structure. Each of 32 local areas – consisting of 14 single county areas, 6 double county areas and 12 sub-county areas - has an overall chief executive, known as Local Health Manager, for all local Primary and Community Care services (including Mental Health services). In turn these managers carry overall national coordination functions for one of 32 care areas, which are grouped under eight overall care themes. Drugs consist of a care area under the care theme of social inclusion. Alcohol is not identified as a single care area. The logic of the discussion above with respect to national structures suggests that alcohol be included with drugs as one of 32 care areas, thereby providing a coherent structure at both national and local levels for developing and managing alcohol and drug services; it hardly makes sense that for drugs – a lesser overall health problem in society than alcohol – should command a care area, while alcohol does not.

The issue of overall clinical responsibility for alcohol and drug problems has also arisen in discussions in developing this service model. Previously under a Mental Health structure clinical responsibility lay with consultant psychiatrists, who usually carried this function along with other functions. While some psychiatrists developed an interest in addiction issues it is clear that this was variable, and there is a very strong sense that, outside the clinical management of in-patient cases under their direct care, few psychiatrists became more engaged with this issue. Addiction,

according to comments from one psychiatrist (Elisha), is “down the list of illnesses we are trying to keep abreast of” and in general psychiatrists tend to be more focused on “bi-polar disorders and schizophrenia” which are “more demanding of our time and we keep up with developments in these areas”.

Traditionally, addiction services has not attracted much interest within Irish psychiatry as a single area of interest and indeed proposals under a *Vision for Change* to exclude Mental Health involvement with addiction unless there were other co-related psychiatric disorders has lessened further its overall importance within this field. However, a faculty on addictions has been established by the Irish College of Psychiatrists, which has been active in promoting public health principles in tackling alcohol problems (Smyth et al., 2008) and this Faculty has also made clear that it does not agree with the position as outlined in *Vision for Change* (Flannery, 2007, 11). The discussion above moreover suggests that, despite general concerns about the development of addiction services under a hospital-based Mental Health services system, there is still a broad desire to continue the involvement of Mental Health services in prospective service development, particularly now that Mental Health services have come under overall Community Care management.

It is also clear that alternative community service configurations have not dealt with the issue of clinical management. While some aspects of the latter problem may be effectively dealt with through appointing SMT coordinators – which has already happened - there remains the overall problem of clinical management with respect to cases where there is a need for clinical supervision, prescribed medications or where a once-off in-patient admission – either to a general hospital for medical detoxification

or to a psychiatric hospital for intensive assessment - is indicated. The following two comments from Community Care personnel illustrate the importance of retaining a clinical role for psychiatry in the management of addiction problems:

What I saw emerging elsewhere was a sense that Mental Health services were being stripped of resources that were very key to them. So if all of the counsellors went community the consultants were saying: "well hold on ...I have to have direct access [to counsellors] the way I have a psychologist or I have nursing staff. A counsellor is an inherent part of my team and if I have to go cap in hand to somebody else to get my counsellor that is a negative". I could see where that was coming from. Similarly, if there was a sense that counsellors were a resource to be [decided] by the [SMT] coordinator as he or she saw fit that was never going to be appropriate either. The medical side was clearly part of the overall operation. Thirty percent of [clients] had [comorbidities] and were likely to need it [medical intervention]. It certainly wasn't my view that the service was to be led by the (medical) consultant, but it had to be a joined up approach (Van – Community Care manager)

If it [addiction service] is not consultant led, it means....the development of another [community] structure. Something else of that nature will have to be set up and it wouldn't be the consultant, it will be somebody else, isn't that just it?Access to other services is my main concern really, you know psychology the other services. Like if you pull from that [Mental Health managed services] you might have a team manager, who manages the team, but where are the other services? I suppose the bottom line is: is the client better off? That is my main concern: is the client going to be better off if we have this [community] structure? I don't know if they will. The fact is that while the psychiatric [counsellors] are in there [psychiatric hospital] I can at least refer [clients] in. If they [psychiatric counsellors] come out [to community], where do we go [to refer on]? (Jessie – SMT counsellor).

In the greater Dublin region there are three specialist addiction consultant psychiatrists providing clinical support to the treatment of drug problems. Potentially

this approach could be developed in non-Dublin regions also, whereby a single specialist addiction psychiatrist could provide clinical support across two or more local health areas, depending on population, area size and the level of need. In addition to providing clinical support to Mental Health and Community Care service teams in relation to both alcohol and drug problems, the addiction specialists could have policy and development functions through linking with Local Health Managers and the appropriate senior officials dealing with alcohol and drugs at both HSE and Department of Health and Children levels, as well as linking with other addiction-specialist psychiatrists for the purpose of developing treatment protocols and more specific protocols, for dealing with substance misuse and co-related psychiatric disorders and overseeing the development of screening and assessment. They could also assist addiction personnel to develop an overall vision for their work, support training and professional development, and develop liaison mechanisms for working more closely with GPs and other disciplines as well as their respective professional bodies.

SUMMARY

The first part of this chapter, which reports on an action research process, analysed internal factors that continued to inhibit the RHB from shifting the focus of addiction (including alcohol) treatment from a predominantly, specialist model – and one that continued to reflect addiction-as-a-disease concepts, to a model that was more broadly-based and operating from public health principles, within community-based

structures. Internally, some personnel lacked belief in the change proposals and feared some aspects of the new structures; that there was a lack of clarity about the proposed structures at all levels; that there has been too much emphasis on the need for change at service provision levels with an inadequate focus on the need for change at higher management and policy levels; there was also concerns about the impact of change for persons with co-related addiction and psychiatric disorders and it is contended that as psychiatric services need to maintain a capability with addiction problems anyway they should therefore be involved with a broad range of addiction problems in addition to those that are co-related.

The second part of this chapter shifted the focus onto external factors inhibiting change. Previous chapters 4 – 6 have explored wider societal pressures to retain the role of Mental Health hospitals for alcohol admissions, within a popular conception of alcohol as disease. In the second part of the present chapter the discussion has focused on the perceived reluctance of Primary and Community Care personnel to become more directly involved in managing alcohol and other addiction problems. Service provision for young people has been particularly affected, with community youth services finding they have to make up the shortcomings of the non-engagement of RHB social work and psychosocial services, although they – youth services - lack the capacity to do this work. There is also the problem of young people being referred, sometimes inappropriately, into specialist, residential services – who operate out of a traditional disease model of addiction - without any prior community-based assessment or intervention.

The discussion above highlights broad support for locating addiction services within the context and framework of Primary and Community Care services in the new Health Services Executive. However, the practical, external obstacles to realising this objective were substantial and there was little evidence of a coherent strategy for overcoming these difficulties. In this regard the general support of Community Care managers to relocating addiction services within community locations was not mirrored by any substantial intention by existing generic community personnel to become directly involved with these issues and in directly supporting the work of addiction counsellors in the field. Meanwhile community youth workers who are considered to be quite effective in primary preventive activities are increasingly drawn into providing more intensive, psychosocial counselling for which they lack proper training, structures and systems of accountability.

Alongside the various internal and external difficulties summarised above there is the added problem that policy in support of the RHB's efforts at service development are not always as coherent as is often claimed. There is a belief that the National Drug Strategy, which is often represented as key driver in service development and organisational change does not reflect the reality of both alcohol and drug problems within the region and inhibits the development of appropriate structures for dealing with these problems. The National Alcohol Policy is represented as almost, bi-polar: as having a public health approach in relation to various service aspirations but lacking a public health commitment in dealing with alcohol as a commercial commodity. Particular difficulties arise for both the RHB and many other health and social service providers in trying to manage alcohol and drug problems as separate

entities, and it is clear that the absence of policy direction on this matter has caused some confusion.

There is strong, rational support for the public health model - both in and outside of existing addiction services, both CASs and SMTs - and as discussed in Chapter 2 the approach is also highly supported in evidence and policy terms. From a practical perspective however, there is a weak basis for believing the model can, through bottom-up effort alone, be effectively put into place, either in the short- or long-term. Existing Mental Health service providers lack belief that alternative service arrangements will accomplish any more than what *they* have achieved over the previous two decades, in relatively difficult circumstances. At the same time, there is little evidence that, at a community level, apart from personnel already working in SMT services, there is little interest or capacity among other Community Care service providers to provide comprehensive service alternatives. It would seem clear that an integration of both Community and Mental Health capacities in dealing with these issues is warranted; unfortunately, aims at bringing such integration were not achieved during the course of this study, although proposals for the further development of more integration within addiction services were brought forward, and summarised in Appendix 5 below.

Chapter 8 : Conclusion

The overall aim of this study, as set out in Chapter 1, was to evaluate the efforts of one Regional Health Board in Ireland to implement a new approach to health service management of drinking problems within its functional area. This new approach was based on a public health model, which conceptualised the health and social problems arising from alcohol consumption in terms of a spectrum, varying in type and in severity, rather than in terms of a unitary disease known as alcoholism. The practical corollary of this new conceptual approach to alcohol-related problems was that specialist, intensive (and particularly residential) treatment systems should not be seen as the norm but rather as exceptional responses, to be resorted to only when a range of generically delivered, primary care responses have been tried and found wanting.

These efforts by the Regional Health Board in question to refocus its approach to alcohol-related problems were based upon and reflective of recommendations contained in a national policy document, *The Psychiatric Services: Planning for the Future* (1984), which had laid down a template for major reforms of the public mental health system and which had made specific recommendations in relation to alcohol based entirely on the public health perspective. Subsequent health policy documents - e.g. *National Alcohol Policy -Ireland* (1996) and the *Strategic Task on Alcohol* (2004) - have confirmed this support for the public health approach, while more recently the *Report of the Expert Group on Mental Health Policy - A Vision for Change* (2006) has somewhat controversially recommended that the mental health services should only accept responsibility for alcohol-dependent persons with co-existing mental illness, with management of uncomplicated alcohol-related problems

being assigned to community-based services outside the mental health system. All of these high-level policy recommendations have been aimed at reducing, if not completely eliminating, the practice of treating alcohol dependence within in-patient mental health settings, a practice which has symbolically buttressed the disease concept in modern Ireland.

Contemporary debate about public policy is replete with references to *evidence-based* policy and practice, reflecting what would appear to be a global consensus that scarce resources should only be committed to service systems and interventions which are demonstrably effective and efficient. Although the public health model is solidly based on research and would appear, therefore, to exemplify the evidence-based approach to the management of alcohol-related problems, the findings of this study are that the health board in question largely failed in its attempt to introduce this new model of care into an organisational and wider culture in which the traditional disease concept of alcoholism still has considerable currency. The ideal of 'broadening the base', so that family doctors, social workers, youth workers, community psychiatric nurses and others routinely identify and manage alcohol and other substance misuse problems within their generic professional practices, was not realised within this regional health service to any great extent. The aim of this, the final chapter of this thesis, is to reflect upon the study's findings and reach final conclusions as to why this attempt at organisational change had such limited success.

Before proceeding it is important to note the general limitations of this study.

Although it is a detailed case study, and in this sense it draws together data from a good range of relevant sources, it is nonetheless a contextualised study, and cannot be

generalised. The point is made repeatedly that, based on national data on inpatient treatment, the implementation of policy on the management of alcohol varies greatly across locations both in and outside this study area. It is conceivable therefore that different, perhaps contrasting, findings would emerge from a study conducted in a different health board location. Also, while many of the regional-based stakeholders contributed to this study, the contribution of data from some professionals was weak. While this adds further to the study's limitations, it is important to note that some other stakeholders did not perceive this weak participation as surprising, and it is also important to note that many of those who did not participate in initial focus groups or interviews, did find other opportunities to contribute their viewpoints, which were taken into account.

The literature reviewed in Chapter 2 may be summarized as confirming that the traditional disease concept of alcoholism does not provide an evidence-based platform upon which policy makers, service managers and practitioners can build a coherent health service response to alcohol-related problems. On the other hand, the main tenets of the public health approach are strongly supported by empirical research. Alcohol consumers in any given society cannot be divided on any rational basis into two distinct categories - normal drinkers and alcoholics; changes in population drinking habits are reflected in changes in prevalence of a range of social and health problems; outcome studies confirm that specialist treatment technologies are not notably more effective now than at any time in the past, while also confirming that brief, non-specialist interventions can be highly effective with a range of problem drinkers.

The literature review concluded, however, by noting that despite the existence of this strong body of evidence, the international experience of transforming service systems through the implementation of evidence-based interventions has been uniformly poor. Within the United States of America, for example, the disease concept has retained its status, and specialist treatment services - particularly based on the so-called Minnesota Model - are widely regarded within popular culture as representing best practice in this field. Similarly, efforts by the World Health Organisation to persuade primary care physicians or family doctors to improve their identification and management of problem drinkers within this setting have not succeeded, despite compelling evidence that under research conditions this is a highly effective way of dealing with harmful and hazardous alcohol consumers. In short, the literature has confirmed what is a commonplace conclusion within the public policy field, namely that policy making is not necessarily a simple, rational process in which research findings are automatically or quickly given practical effect. In this regard it is important to note that research evidence is but one of many factors that influence policy development: others include political processes, traditional ways of doing things, vested interests and changing events.

Before beginning a final discussion of what could be seen as a failed, or at best limited, action research project, it seems important to refer back to Chapter 1, which introduced the study and set it in a wider social and cultural context, outside of the realms of science and clinical practice which are the dominant themes of this thesis. It was noted at the beginning of this chapter that in Ireland, as in practically all countries in which it is legally consumed, alcohol is an important consumer good albeit one about which there is considerable cultural ambiguity. Edwards (2000) is just one of

many commentators who has written of this 'ambiguous molecule', noting that if we look historically at societal understanding of alcohol or at successive attempts to regulate or control it, we are more likely to find repetitive cycles or waves of policy rather than linear, scientific progress. In applying this insight to the contemporary Irish scene, we are alerted to the fact that the health sector will almost certainly be hindered in its attempts to introduce evidence-based, scientific reforms of its management of alcohol issues by the existence of strongly-held cultural beliefs and values which may run counter to such attempts at reform. Room (2001) has warned against the risk of assuming that because the scientific discourse on alcoholism has virtually disappeared, it no longer is a 'governing image' in popular discourse - including of course discourse of professionals trained in an older regime.

The remaining discussion in this chapter is framed around three interrelated themes that correspond to the challenges presenting to addiction professionals and service managers in setting out to implement the type of changes outlined in *Planning for the Future*, and in subsequent policy developments. The first theme is focused on the role of psychiatric hospitals in creating a disease model that has become embedded in the alcohol treatment system; the second theme addresses the issue of alternative community alcohol services, providing an analysis of a failure to develop comprehensive community treatment systems. Following an overview of these two themes, this concluding chapter takes up the theme of a way forward, identifying recommendations at both policy and practice level, for the further improvement and development of alcohol treatment services.

1 AN EMBEDDED DISEASE MODEL

At the time *Planning for the Future* was published in 1984, the disease model was well established as the dominant policy and practice response for alcohol problems, and over the previous two decades annual levels of psychiatric admissions for alcohol problems had increased by over three hundred per cent, from 1,638 to 7,272. In the main, in-patient alcohol treatment took place in isolation from, and with little or no follow-up contact in, the home or the community of the persons so treated, and there was little expectation that mental health clinicians would have any patient involvement outside of their hospital roles: when patients were discharged, at best a letter of discharge would issue to their general medical practitioner.

Although the disease model dominated treatment, there is a dearth of published literature on the alcohol interventions that were practised in psychiatric hospital settings; information about treatment relied more on oral testimony than written historical or academic accounts. There is a presumption in this governing approach to treatment: a sense that as disease model was ascendant, there was little, if any, need to question its efficacy. Not surprisingly therefore, its main advocates often saw themselves as proponents of addiction 'truths' more than of 'knowledge'. For instance, during the early years of its existence (in the late-1960s and early-1970s), the Irish National Council on Alcoholism publicly and uncritically promoted the disease concept, as part of which it was axiomatically proposed that inpatient

treatment within the mental health system represented the most scientific, evidence-based societal response for individual alcoholics.

It is against this background that slow progress in reducing in-patient alcohol admission to Irish psychiatric hospitals – as proposed by *Planning for the Future* - needs to be assessed. While a national decrease in inpatient admission has been achieved: from 7,345 in 1981 to 2,767 in 2006, it is clear that this rate of decrease has been slow, and the rate of reduction is greater in recent years than previously. In the decade between 1986-1996, alcohol admissions reduced by 24% to 5,432; by 2006 however the 1996 level was reduced by 50% to 2,767 and 60% of this decrease was achieved during the period 2001-6. Alcohol consumption in the general population increased during the period when the rate of decrease was greatest, suggesting paradoxically a potential indirect relationship between alcohol consumption rates and rates of in-patient treatment.

While each and every one of its main tenets came to be scientifically discredited, the disease concept appears to have remained culturally embedded, not only within treatment systems but also within public opinion. Staff in psychiatric hospitals – whatever their individual perspective in relation to respective alcohol models – were, and continue to be, under considerable pressure from Gardai, clergy, GPs, other professionals, families and members of the public, to admit into psychiatric treatment persons with alcohol problems.

Although the pervasiveness of the disease model is evident in the level and extent of in-patient admission, the practitioners concerned do not always proclaim themselves

as ideologically wedded to the model. Throughout this study, for instance, many hospital-based practitioners were vocal in support of an alternative, public health model, yet did not acknowledge some of the inherent contradictions between this support and the continuation of their own rather liberal practice of in-patient alcohol admission. It is possible that the recommendations of *Planning for the Future* with respect to alcohol were not fully understood within hospital practitioner and management systems. Indeed, proposals to change alcohol treatment were often perceived more as a pragmatic than a theoretical imperative. For example, in the Regional Health Board studied, one county area acquired an acute psychiatric unit in a general hospital in recent years (since this study commenced) and closed down admission beds in its public psychiatric hospital. Another county area is still without such an acute unit. The former county area witnessed a dramatic reduction in alcohol admissions once it acquired the acute unit – without, it appears, presenting much difficulties for either practitioners or prospective patients - and in the latter county area the level of alcohol in-patient admissions into the public psychiatric hospital is as high in the year 2006 as 1984 when *Planning for the Future* was produced. These differences reflect a general, pragmatic belief that a reduction in alcohol admissions would follow on from the closure or winding down of psychiatric hospitals. What appears to have been missing however, was an overall commitment to reducing alcohol admissions irrespective of progress in closing psychiatric hospitals.

In some instances, this study showed that leadership and direction was brought to these issues and where there was a determination to change the focus of alcohol treatment, alcohol admissions were reduced, irrespective of other changes. However, progress in this regard was variable and it is apparent that for as long as some

clinicians had access to beds in old psychiatric hospitals, they were prepared to use them for alcohol-related admissions, even in circumstances where it seemed the beds were being used inappropriately as a “revolving door”, providing short-term solutions to immediate problems in response to public demand.

The general absence of management direction and focus on this issue is also evident in health board support for the development of alternative, Minnesota Model residential units. Three such units were set up in the Regional Health Board in recent decades even though the report, *Planning for the Future*, is explicitly critical of such developments; indeed the report strongly suggests that the activities of voluntary organizations, such as those that might set up such ventures, need to be monitored to ensure their adherence to the principles underlying the proposed new, public health approach. In such circumstances, it is remarkable that the Regional Health Board studied should have been willing to provide considerable financial resources and general support for the establishment of Minnesota Model agencies within its functional area. In one instance a health board-owned centre was made available to a Minnesota Model, as an alternative to the health board providing facilities for a new community service, which already had its own newly-deployed personnel.

Hospital practitioners played an important role in assessing prospective residents’ suitability for admission to these centres: all assessments were undertaken during in-patient hospital admission and indeed many such admissions - including it is claimed for persons who lived outside the health board area - were specifically arranged for such purposes. In addition health board Community Alcohol Service (CAS) staff provided ongoing liaison and “aftercare”. It is noteworthy that at an early stage

following the setting up of CASs, some personnel undertook specialist training at Minnesota Model programmes, both in Ireland and in the US and subsequently, their outreach roles included providing referral and post-discharge linkages between hospitals and Minnesota Model programmes. The decision to facilitate training in the Minnesota Model highlights that many health board personnel, at both management and practitioner levels, understood this particular model as constituting a useful alternative to the in-patient hospital model, a position that further highlights that the differences between disease and public health models were not well understood at some health board levels. A general decrease in in-patient hospital admissions for alcohol in the Regional Health Board studied is paralleled by an increase in the utility of these alternative, specialist residential facilities. This suggests that the shift away from specialised, residential treatment that did occur is perhaps not as great as represented by reported reductions in psychiatric admissions; the use of Minnesota Model programmes as an alternative to psychiatric in-patient treatment further reinforces the dominance of the disease model in treatment provision.

In summary, prior to the publication of *Planning for the Future*, the treatment of alcohol problems was dominated by a disease model, as exemplified by the scale of in-patient hospital admissions for alcohol. Although *Planning for the Future* and subsequent reports advocated the alternative, public health approach, in-patient admissions have been slow to reduce. Indeed, it appears that such reductions are more associated with broader hospital developments than with specific, directed efforts to change the focus of alcohol treatment. The reduction has not been radical and the disease model remains embedded in both public expectations and health board practices. It seems fair to conclude then that the slow reduction in in-patient or

residential admissions observed in this study reflects, at the very least, ideological confusion about the status of the disease concept, if not indeed strong continuing support for this allegedly discredited concept.

2 *DEVELOPING ALTERNATIVE, COMMUNITY-BASED TREATMENT*

The Regional Health Board's failure to grasp the conceptual differences between the disease and public health models, as these relate to the use of in-patient treatment, is also evident in the health board's initial approach to setting up and developing alternative, community-based treatment. As time passed, health board management showed some improvement in its understanding of the conceptual and practical implications arising from the alcohol recommendations of *Planning for the Future*; initially, however, it seems that management had little appreciation of what might be entailed in shifting its focus from traditional in-patient treatment to the more broadly-based intervention systems advocated in this report.

Mental Health management's lack of familiarity with the basic tenets of the intervention model that was espoused by *Planning for the Future* is particularly evident in the approach to staffing and training of professionals to work in new Community Alcohol Services (CASs). At their outset, CASs were staffed by redeployed psychiatric nurses whose previous professional experience was based in hospitals or other institutions, and some counsellors, as already mentioned, received

their formative training at Minnesota Model centres. These hospital-based personnel had little, if any, wider community involvements and previously had no meaningful role in mobilising proximal, community supports for patients with alcohol problems, or indeed of working in effective collaboration with community-based agencies. Although generally highly motivated, they lacked the qualifications and practical experiences consistent with their wider community roles.

While some attempts were made, through CASs, to develop outreach into the community, and to engage a somewhat reluctant, Primary and Community Care system into an involvement with alcohol issues, in general these efforts lacked overall direction, focus and resource commitments. In many respects, the hospital system itself, which continued to provide inpatient alcohol treatment, required CAS personnel to provide back-up counselling and other supports to in-patients as a priority: in this sense the focus of CAS work was more hospital- than community-driven. The counsellors were clinically supervised by hospital psychiatrists, who varied greatly in their interest in these services and in most instances were considered as not quite at the helm in taking responsibility for service development and in providing leadership and direction. In some instances counsellors arranged external, private counselling supervision, in order to compensate for what they perceived to be the shortcomings of internal arrangements. In general, CAS addiction counsellors were perceived as alcohol-counselling specialists dealing primarily with persons who were referred by hospital psychiatrists with alcohol disorder diagnosis, and not as persons who would engage with community-based organizations and personnel to coordinate a wider range of alternative interventions to a broader base of persons with alcohol problems.

It is clear, particularly in retrospect, that during the decade following *Planning for the Future*, the overall management of new Community Alcohol Services lacked organisational coherence and focus. An underlying issue was that the health board had not quite grasped the fundamental difference that was espoused by *Planning for the Future* and given the slow pace of reform with respect to inpatient hospital admissions, it appears that the alcohol issue did not really command substantial health board interest, personnel or resources. At the time however, this did not generate much by way of public concern. As already outlined, extant public demands, in so far as these were decipherable, supported the retention of the psychiatric hospital as the primary location for treating alcohol problems and so long as individual hospitals were prepared to continue with this practice, the public was likely to remain content. Although *Planning for the Future* advocated that GPs and social services – which are based in Community Care - have an input into community-based treatment, there is no evidence of significant demand on these services to be so involved, at the time. For all intents and purposes, Community Care continued to function outside the loop with respect to alcohol services, in the sense that generic health and social service professionals failed to develop the level of therapeutic commitment to working with problem drinkers envisaged in *Planning for the Future*.

Community Care's peripheral position on these matters changed with the onset of drug problems during the mid-to-late 1990s. These latter problems were not nearly as widespread as alcohol problems, but given their illegality and their association with disadvantaged communities and youth-at-risk, they constituted a significant policy concern for health professionals, especially for those health professionals who were perceived by the public as operating within community settings, under the

Community Care Programme. Of particular concern to community professionals were the impact of blood-borne viruses, the involvement of minors in drug use and the social risks posed for children with drug-using parents. During the mid-1990s, Community Care came under considerable pressure to become involved with these issues. Given the nature of many other policy developments at the time, Community Care was also required to proceed in accordance with a partnership model, an approach that stood in sharp contrast to previous health board *modus operandi*: for example CASs were set up and managed within traditional, hierarchical health board structures in Mental Health and without any external, community consultation with respect to their aims, focus or methods of working. In contrast, Community Care was required to link in with community organisations and with community-based personnel and services in identifying and quantifying drug problems and in developing appropriate service responses, sometimes within jointly managed community-based structures.

These new developments with respect to drug problems posed a significant challenge to the Regional Health Board. On the one hand, it had an alcohol treatment system that was primarily hospital-based, oriented to a disease model and organised and managed from within the Mental Health Programme. There was little evidence of this treatment system being publicly pressurised, or indeed of it being willing, to become more directly involved with treating drug problems – in community settings. On the other hand, its Community Care Programme was coming under considerable pressure to develop coherent, public health responses to drug problems, even though its personnel had little experience of managing and responding to addiction issues.

Developments in drug policies, however, also presented the health board with new opportunities especially as the *National Drugs Strategy (2001-2008)* provided an overall framework for managing drug problems from a number of perspectives - supply-reduction, education, prevention, treatment, research and coordination – and brought badly-needed resources and energies into the addictions field. Although, there was some concern that the Strategy was overly-focused on the problem of opiate-use – which did not feature as a significant problem in the health board’s functional area - the health board nonetheless viewed it as an opportunity to secure resources for service development, particularly through setting up Substance Misuse Teams (SMTs) and other interventions. Through these developments the health board had an opportunity to fashion a public health, community-based model for drugs, which could potentially, be replicated for alcohol. According as the health board engaged with these developments, it became convinced of the need to bring together personnel across both programmes in an integrated response to both alcohol and drugs. At the time however national policy did not support such integration: government departments with responsibility for drug policy consistently clarified that this responsibility extended to alcohol problems only insofar as illegal, under-age purchase and consumption of alcohol was concerned; otherwise the focus remained on illicit drug problems.

In summary, although the Regional Health Board set up new CASs in the years following *Planning for the Future*, there is a strong sense of CASs being left to their own devices to develop community interventions and also a strong sense that health board management was unclear as to what type of community service it wanted, with the result that services tended to operate in a vacuum with no real job description or

direction for personnel over a period of years. Instead of doing something differently out in the community, the services replicated what was already happening in the hospital albeit at times with a different client group. The onset of new drug problems, together with new policies and funding arrangements, brought about a change in the way in which the health board viewed the public health model. Also for the first time the health board's Community Care Programme was brought into the limelight with some expectation that, with dedicated funding, an alternative engagement with the wider community would commence.

3 *OVERVIEW AND MOVING FORWARD*

This study focused on an attempt to introduce a coherent public health approach to the management of alcohol-related problems in this Regional Health Board. It is clear that this attempt did not succeed. The long-established tradition of managing such problems within residential settings largely survived: as evidenced in the continued practice of admitting substantial numbers of problem drinkers into mental health beds in that part of the region which retained its old mental hospital, and also in the popularity of the free-standing Minnesota Model rehabilitation centres in this region. Alternative, community-based services have been slow to develop and have lacked direction and focus. As in other countries, the study reported here, again came up with little evidence of any enhanced 'therapeutic commitment' on the part of generic, primary care workers. Family doctors, social workers and others who in the new public health paradigm would be expected to see direct work with alcohol problems

as legitimate and within their sphere of competence, by and large, showed no inclination to make this ideological and practical shift. In short, while some managers and practitioners may have shifted ideologically to a public health view of drinking problems, the client population remained largely unaffected by - and probably unaware of - this new perspective. In practical terms, what this means is that service providers were constantly subject to pressure from their client population and the wider community to continue doing what they had always done: to treat drinking problems within specialist, and preferably residential, settings.

So where did it all go wrong? In going back to basics, it is clear that following *Planning for the Future*, the opportunity presented to set-up and develop a whole new approach to the management and treatment of alcohol was not grasped; it was not grasped nationally and it was not grasped regionally. In so far as it was taken on board at county level, this depended on many variables, such as changing leaderships, different hospital management systems, and differences in the extent to which field practitioners were themselves familiar with the public health model; there are compelling indications indeed that many personnel did not quite understand the essential difference between what was being proposed and what was being replaced. It also emerged from the action research reported here that the successful introduction of the new approach was contingent on management identification of the staffing and training requirements of this new approach, and on the identification and resolution of industrial relations problems arising from new work practices necessitated by this shift to a public health approach. In many instances, the difficulties were the predictable problems arising from changing work practices in any large bureaucracy, reflecting worries about pay and conditions of service as well as a reluctance to alter

long-established work practices. The inability to effectively resolve these issues however reflects a fatalist perspective that if the problems were culturally embedded, they were unlikely to be rectified through rational actions.

In their text on managing change in Irish health care organisations Coghlan and McAuliffe (2003, 59), refer to a deeply embedded level of culture, described as “shared tacit assumptions”, which are unstated rules that have grown up in organisations. Members are not necessarily aware of them as being significant, because they take them for granted. These rules get developed at certain times during the organisation’s development, and in due course they are passed on to and absorbed by members. “The way we do things around here” becomes the uncontradicted, established way; suggestions about changing this way are extremely difficult usually because there is an embedded cultural belief that the way of doing things was the successful way, and change would undermine that success. In applying this concept to this study it can be surmised there is an embedded belief, based on “shared tacit assumptions” that alcohol problems are better managed through Mental Health and in-patient admission, even though the evidence for supporting this practice is often not always apparent and even though many of the practitioners concerned have become convinced of the need for an alternative model. Despite such deeply embedded cultural resistance however, there is also evidence of significant effort to bring about change.

From the mid -1990s through to the completion of the fieldwork in this study in 2006, the Regional Health Board engaged in three internal review processes – referred to in the study above as *1. Regional Coordinating Committee on Drugs*, *2. Internal*

Addiction Services Review, and 3. Action Research Process, which, taken together may be represented as a determination to move forward and to establish organisational coherence in the way in which drug and alcohol services were being developed. The determination to bring about change is evident from the support attained at management and Board levels for these initiatives and by the number of personnel, from a variety of perspectives, who participated in the different review processes. For example, at both the commencement and completion of the fieldwork for this study, senior health board executives hosted separate, region-wide meetings for all management and practitioner personnel – numbering about 50 – who had some direct involvement with or interest in alcohol and drug issues, to introduce the process, to explain its basic approach and methods and to outline its findings and recommendations. The open, inclusive approach to involving personnel in this project was also reflected in other review processes.

Separate reports emerged from these processes and again, taken together, their recommendations reflect a resolve by those who were centrally involved to provide a comprehensive development of drug and alcohol services in the region. The reports emphasise the public health model, the community dimension to substance misuse, the need for an overall response to be managed within Community Care-based structures, with the involvement of Primary Care personnel, with locally-based screening and intake systems, and the operation of care-plans for referred individuals. The rationale for these recommendations - which are discussed further below - is well-grounded in public health, harm-reduction literature and the recommendations were generally well received and endorsed as overall policy at the highest level in the Regional Health Board, as well as at regional and county level meetings.

Although there was widespread, stated support for the basic principles and rationale behind a Community Care-based system for service development, it is nonetheless clear that underlying issues have continued to inhibit the Regional Health Board's endeavours to bring about organisational coherence in its management of these problems. Some personnel, based in Mental Health services, in particular, remain unconvinced about the value of proceeding according to this approach. One argument against was premised on a criticism of Community Care's record in other care areas, particularly child protection. It was claimed that social work services operate under considerable pressure and without the various back-up community supports they claim to have been promised over the years. For all its evident shortcomings, the disease model, it was claimed, had at least the outward features of institutional stability and therapeutic certainty, and addiction counsellors working within hospital settings were still able to consult their Mental Health colleagues in their ongoing practice and decision-making. There was a lack of belief among some Mental Health personnel that a Community Care managed service would, in due course, generate its own, separate network of professional supports. For example, it is evident, from the above study, that although some GPs were well linked in with community-based services, the broader profession's overall interest in and commitment to this issue was minimal; indeed GPs were uninvolved in the various discussions and consultations from which health board policy statements had been formulated. Similarly, social workers, who had responsibilities both in the areas of young people at-risk of addiction problems and children and young people in the care of persons with alcohol and drug problems, had a minimal involvement in this review process, reflecting a well-aired general reluctance to become more deeply involved with alcohol issues.

Some Mental Health personnel rue the loss of acute hospital beds for in-patient alcohol admissions and see this loss as symbolic of a gradual undercutting of Mental Health provision for alcohol. There is indeed concern that the proposal in *Vision for Change* that Mental Health services not be involved with addiction issues save where this is co-related with psychiatric disorders, has left some personnel believing that the basic resources necessary to underpin this involvement would, in due course, be withdrawn. Consequently, Mental Health management expressed concern about this issue, highlighting that non-mental health services showed a reluctance to be involved in situations of mild mental disorders, with the result that many of these cases were referred back to Mental Health anyway. They envisaged being required to deal exclusively with many alcohol cases where co-related psychiatry disorder was mild, borderline or unconfirmed and because of this they wished to retain a hospital-based capacity to provide and manage addiction counselling and believed they would lose this capacity once a re-location to Community Care was achieved.

Alongside these reservations a small number of personnel were determined that alcohol services needed to continue to operate under Mental Health management. Although this was a minority view and not publicly advocated in a comprehensive manner, it was nonetheless sufficiently substantial to delay or inhibit implementation of a community-based model. The matter remained unresolved during the course of this study and a resolution was made more difficult because of a standoff between health board management and a group of Mental Health counsellors who did not wish to move to Community Care settings on the basis that this would change their employment conditions. It is noteworthy that broad, practitioner support for the

service proposals was predicated on management achieving a resolution of this particular problem; many personnel believed that as management had neglected the development of these services over the years, it had the main onus to resolve the impasse. For its part, management believed that the main stumbling block was a deeply-rooted resistance to change by some Mental Health personnel who did not wish to make the cultural shift that was required in order to relocate from hospital-based or -managed settings. This impasse continued beyond the time-span of this study.

In some instances, the reluctance to change reflected genuine 'evidence-based' reservations about the wisdom of removing alcohol problems from the mental health domain: given the considerable overlap between substance misuse and mental illness, the insistence that the psychiatric system should continue to play a major role in the management of drinking problems cannot easily be dismissed as merely reflecting a preoccupation by mental health specialists with maximizing power. While the use of psychiatric hospitals for alcohol treatment might face disapproval in the context of a present-day discourse about harm reduction and the public health paradigm, the fact remains that whatever the intentions of those who introduced and sustained the disease-oriented, hospital treatment system, it was a system that was highly used, and there remained high expectations that it continue to be used, and in due course it is likely there will continue to be expectations that psychiatric hospitals – or other institutions - play a role in managing alcohol problems, irrespective of policy and research developments.

In moving towards a conclusion to this chapter, and to the study overall, it is noteworthy, that there is no evidence of stated, fundamental opposition – within the Regional Health Board - to developing a comprehensive system of service provision. While various comments from personnel in both Community Care and Mental Health reflect a lack of engagement with the change process, the overall aims of change continue to be nominally supported. Although there are indications of an embedded cultural resistance to proposals for re-shaping institutional and organizational arrangements for service provision, there is little evidence of stated opposition from within existing service providers, to the main tenets of the public health approach. Even though established arrangements for treating alcohol problems continue to reflect a disease model, there are some straws in the wind, suggesting that while fundamental change is not imminent, it is not to be ruled out.

Specific service development recommendations arising from this study were presented, outlined and endorsed at a regional-wide forum convened by the health board management during 2005. These provide for an enhanced, specialist Substance Misuse Team (SMT) at each county level within the Regional Health Board. The SMT's core staff would be based at community locations within the general framework of other Community Care personnel and with a liaison function between it and Mental Health personnel managing co-related addiction and psychiatric disorders in both hospital and community settings; the establishment of similar linkages between social work and youth services is also proposed.

The intervention model draws from the stepped-care approach, outlined by Sobell and Sobell (1993) and also the four tiers approach outlined by Gilvarry and the NHS

Health Advisory Service (UK) (2001). An important feature of this model is that prospective clients are able to access those services that are most appropriate to their needs and to have a continuum of care according as their situation progresses or remits. For example, on the one hand persons with mild to moderate drinking problems would benefit from brief interventions, consisting of practical advice and information, while on the other, persons with serious dependency problems or who lack social, family or material supports and / or who have co-related psychiatric disorders, would benefit from more intense treatment, either outpatient or inpatient, depending on the severity of the problem. In this stepped-care approach, treatment is perceived not as a set of different treatment programmes but as a system with different treatment components, that could be provided by different agencies (voluntary and statutory) but have an overall coherence, a shared vision and direction and a common system for planning and development. Further details of the model that was agreed at the Regional Forum are summarised in Appendix 5. Importantly, the basic model is not fundamentally different to previous outlines as developed within the Regional Health Board, although, presented as it was, within the context of this study, the model has a sounder basis than previous versions, for setting out a context and background for its main components. An important recommendation from this study is that this model of service provision be implemented in the Regional Health Board and adapted for use in other regions also.

One important difference in the proposals, as compared to previous reports, is that in their presentation to the regional forum it was recommended that while enhanced SMTs be based within Community Care, overall clinical coordination should be provided by a Mental Health based consultant psychiatrist. While this specific

recommendation runs counter to *A Vision for Change* (2006), which recommended that psychiatric services not be involved in alcohol and drug problems except in instances of co-related addiction and psychiatric disorders, it is, nonetheless an important recommendation for providing both organisational and clinical coherence to the change proposals. The *Vision for Change* recommendation was not well received by Mental Health personnel within the Regional Health Board, or more widely, and indeed in the course of this study, various Community Care personnel also raised concerns. Since *A Vision for Change* was published the recommendation that psychiatry cease an involvement with addiction issues has been challenged by those psychiatrists, who in recent years, formed a faculty on addictions within the Irish College of Psychiatrists, which has been active in promoting public health principles in tackling alcohol problems. This suggests a more dedicated future engagement by psychiatrists with addiction issues and one that is not as constrained by the disease model, as previously.

An overriding difficulty with *A Vision for Change*'s proposal that addiction services be provided only within Community Care is that the proposed community model has not yet been implemented to the extent that is suggested in this report, and it is this suggestion that provides the main basis for the proposal. To attempt further implementation without at least some involvement from personnel within statutory health authorities, who have had a history of involvement with these issues over a long period, could have adverse consequences for both the future operation of these services and for the people who attend. It is furthermore, clear from this study, that both management and practitioner personnel from Community Care would not want Mental Health to cease their involvement with this issue, and although concerns

remain about the disease model, there is nonetheless a view that the public health model would not survive in the absence of some clinical back-up, support and direction from psychiatry. Given the findings of this study, the issue of using inpatient treatment for alcohol needs to be dealt with, but this as an issue also needs to be separated out from that of psychiatric involvement in alcohol treatment, and perhaps for too long these have been synonymous. There is clearly a need to reduce further the use of beds in psychiatric hospitals for the treatment of alcohol. That reduction needs to be effectively managed. However, such a development should not be seen as resulting in the ceasing of Mental Health involvement with addiction treatment. This study recommends that Mental Health personnel remain closely involved in the ongoing development of SMTs and that addiction specialist psychiatrists be appointed to provide overall clinical direction.

A positive harbinger for the future development of services is that since the study was completed new organisational arrangements were put into place as a result of national health care reform. Under these new arrangements, non-acute mental health services (including CASs) were effectively integrated within a single sub-regional, county level structure with services that were traditionally based in Community Care (including SMTs). It appears that the integration that was being sought – and resisted - through various processes of consultation, discussion and agreement has arrived by default as a result of other external developments.

The broader policy issue also shows some recent positive signs. There are wider policy dimensions to the public health model than the issue of treatment, and as discussed in Chapter 7, although national policy on alcohol incorporated a

comprehensive range of proposals on dealing with population-wide prevention issues, many health board personnel had serious misgivings about the lack of mechanisms for their effective implementation, particularly in relation to supply control measures.

The National Drugs Strategy is often juxtaposed with National Alcohol Policy: the former is perceived as succeeding in mobilising cross-departmental interest, resources and structures, while the latter is often seen as stumbling, without direction, focus or political interest. The question has been justifiably posed in the course of this study: How could it be possible to implement the less important treatment dimension to an alcohol policy if there was continuous equivocation and uncertainty about the more important supply-control and prevention dimensions?

Some health board personnel adopted a pragmatic, tactical approach in dealing with this issue and advocated, from the outset of the National Drugs Strategy in 1996 that alcohol should be included as part of this Strategy's remit. In turn this position was officially adopted by the Regional Health Board and in its continued efforts to bring organisational coherence to these matters, it maintained its commitment to an integrated alcohol and drugs response, despite the absence of funding and other supports for such integration at a national level and also despite the inherent impact of this lack of support on efforts to develop a unified, cross-programme vision for service development.

Along with other health care bodies, the Regional Health Board made a number of submissions to government advocating an integrated alcohol and drugs national strategy. In 2006 a Parliamentary Committee dealing with these matters also

supported an integrated approach in a report. However government remained resistant to this idea.

Shortly after the completion of this study it was reported that the Government had changed its mind on this proposal and on March 31st, 2009 it announced that alcohol and drugs were to be integrated into a new National Substance Misuse Strategy¹². This is an important positive development for the future. The integration of alcohol and drugs within a single national strategy is not only important for bringing some organizational coherence to the work of addiction managers and practitioners, it also potentially symbolizes that the problem of alcohol is being taken more seriously by central government, and gives impetus to the practical efforts of personnel in the field. As a result of this change-of-heart in government, this study recommends that alcohol and drugs should now become a single care area under health management structures, where currently there are 36 such care areas, one of which is drugs.

Finally, in the US the failed experience of alcohol prohibition in the early-20th century was commonly referred to as the 'noble experiment' and it is tempting to conclude this study by seeing this failed attempt to introduce a public health approach to the management of alcohol problems in the same way. If nothing else, this study has revealed that public policy and practice are not notably rational or 'evidence-based'. This is not to say, however, that the Irish health system can never make this transition, nor indeed is it to suggest that the evidence model is without fault. What was especially noble about this attempt was that while it strove to implement recommendations contained in national policy documents, it did so largely through

¹² <http://www.pobail.ie/en/PressReleases/htmltext.9777.en.html> (downloaded April 24th, 2009).

the efforts of regional and Community Care management and without the consistent support and encouragement of central government. Whether the new Health Service Executive has the motivation to introduce change of this kind remains to be seen, but bottom-up initiatives within a single region – or county area - seem likely to fail should they ever be repeated in the absence of a coherent national policy, together with structures and revenues for effective implementation.

References

- Advisory Council on the Misuse of Drugs (1982) *Treatment and rehabilitation*, HMSO, London.
- Agar, M. H. (1986) *Speaking of ethnography*, Sage.
- American Medical Association (1967) *Manual on Alcoholism*, American Medical Association, Chicago.
- American Psychiatric Association (1968) (2nd edition) *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, Washington DC.
- American Psychiatric Association (2000) (4th edition text revision) *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, Washington.
- Amsterdam Group (1993) *Alcoholic beverages and European society : a report by The Amsterdam Group, 1993*, The Amsterdam Group, London.
- Ana Liffey Drug Project (1991) *Annual Report, 1990*, Ana Liffey Drug Project, Dublin.
- Anastas, J. W. (1999) *Research design for social work and the human services*, Columbia University Press, New York; Chichester.
- Anderson, D. J. (1981) *Perspectives on treatment*, Hazelden, Center City, MN.
- Anderson, P. (2006) Responding to alcohol problems, *Addiction*, **101**, 750-752.
- Anderson, P. and Baumberg, B. (2006) *Alcohol in Europe: A Public Health Perspective - A report for the European Commission* Institute of Alcohol Studies, UK
- Anderson, R. (1992) For the record: A history of the IAAAC *Newsletter of the IAAAC [Irish Association of Alcohol and Addiction Counsellors]*.
- Anonymous, A. (2001) *The Big Book (Online)*, Alcoholics Anonymous World Services, Inc.
- Armor, D. J., Polich, J. M. and Stambul, H. B. (1978) *Alcoholism and Treatment*, Wiley, New York; Chichester.
- Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E.,

- Rehm, J., Room, R. and Rossow, I. (2003) *Alcohol: No Ordinary Commodity - Research and Public Policy*, Oxford University Press, Oxford.
- Babor, T. and Grant, M. (1994) A randomized clinical trial of brief interventions in primary health care: summary of a WHO project, *Addiction*, **89**, 657-660.
- Baldwin, S. (1987) Old Wine in Old Bottles: Why Community Alcohol Teams Will Not Work In *Helping the Problem Drinker: New Initiatives in Community Care* (Eds, Stockwell, T. and Clement, S.) Croom Helm, London.
- Bandura, A. (1977) *Social learning theory*, Prentice-Hall, Englewood Cliffs; London.
- Barber, J. G. (2002) *Social work with addictions*, Palgrave Macmillan, Basingstoke.
- Beckhard, R. and Pritchard, W. (1992) *Changing the essence : the art of creating and leading fundamental change in organizations*, Jossey-Bass Publishers, San Francisco.
- Bentz, V. M. and Shapiro, J. J. (1998) *Mindful inquiry in social research*, Sage, Thousand Oaks, Calif. ; London.
- Berger, P. L. and Luckmann, T. (1967) *The Social construction of reality. A treatise in the sociology of knowledge*, pp. 249. Allen Lane, The Penguin Press: London.
- Berridge, V. (1990) The Origins and Early Years of the Society 1884-1899, *British Journal of Addiction*, **85**, 991-1003.
- Bien, T., II, Miller, W. R. and Tonigan, J. S. (1993) Brief interventions for alcohol problems: a review, *Addiction*, **88**, 315-335.
- Blumenthal, L., Hunter, F. and Sawka, E. (1993) A comprehensive and integrated system for treating alcohol and drug problems in Alberta In *Addictive Behaviours Across the Life Span: Prevention, treatment and policy issues*(Eds, Baer, J. S., Marlatt, G. and McMahon, R.) Sage, London.
- Boog, B. W. M., Keune, L. and Tromp, C. (2003) Action research and emancipation, *Journal of Community & Applied Social Psychology*, **13**, 419-425.
- Broadening the Base of Treatment for Alcohol Problems* (1990) Report of a study by a Committee of the Institute of Medicine, Division of Mental Health and Behavioral Medicine, National Academy Press, Washington, D.C, pp. viii, 629.
- Broekaert, E., Vandeveld, S., Soye, V., Yates, R. (2006) The third generation of therapeutic communities: The early development of the TC for addictions in Europe, *European Addiction Research*, **12**, 1-11.

- Broaderick, S. (2002) Community development in Ireland - a policy review, *Community Development Journal*, **37**, 101-110.
- Bronfenbrenner, U. (1979) *The ecology of human development : experiments by nature and design*, Harvard University Press, Cambridge, Mass. ; London.
- Bruun, K., Edwards, G. and Lumio, M. (1975) *Alcohol Control Policies in Public Health Perspective*, The Finnish Foundation for Alcohol Studies, Helsinki.
- Bryman, A. (2004) *Social research methods*, Oxford University Press, Oxford.
- Bryman, A. (2008) *Social research methods*, Oxford University Press, Oxford.
- Butler, S. (2002) *Alcohol, drugs and health promotion in modern Ireland*, Institute of Public Administration, Dublin.
- Butler, S. (2003) Doing Drugs from an Ivory Tower: Reflections on Twenty years of Addiction Studies at Trinity College Dublin, *Studies*, **92**, 249-257.
- Butler, S. and Jordan, T. (2007) Alcoholics Anonymous in Ireland: AA*s first European experience, *Addiction*, **102**.
- Caetano, R., Tam, T., Greenfield, T., Cherpitel, C. and Midanik, L. (1997) DSM-IV alcohol dependence and drinking in the U.S. population: A risk analysis, *Annals of Epidemiology*, **7**, 542-549.
- Cahalan, D. (1970) *Problem Drinkers: A National Survey*, Jossey-Bass, San Francisco.
- Campbell, D. T. (1969) Reforms as experiments, *American Psychologist*, **24**, 409-429.
- Carlin, N. (2006) Presentation on National Drugs Strategy to Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs, Wednesday March 1, *Houses of the Oireachtas Parliamentary Debates*, **46**.
- Census 2006: Vol 1 - Population classified by area* (2007) Central Statistics Office, Government of Ireland, Stationery Office, Dublin.
- Chalke, H. D. (1970a) Alcoholism: A Major Public Health Problem, *Alcohol and Alcoholism*, **5**, 117-132.
- Chalke, H. D. (1970b) The role of voluntary organisations in combating alcoholism, In *Modern trends in drug dependence and alcoholism* (Ed, Phillipson, R. V.) Butterworths, London, pp. xiii, 311.
- Cherpitel, C. J., Tam, T., Midanik, L., Caetano, R. and Greenfield, T. (1995) Alcohol and non-fatal injury in the U.S. general population: A risk function analysis, *Accident Analysis & Prevention*, **27**, 651-661.

- Chia, R. (2002) The production of management knowledge: Philosophical underpinnings of research design, In *Essential skills for management research* (Ed, Partington, D.) SAGE, London, pp. xxiv, 282.
- Chick, J., Lloyd, G. and Crombie, E. (1985) Counseling Problem Drinkers in Medical Wards - a Controlled-Study, *British Medical Journal*, **290**, 965-967.
- Child and Adolescent Psychiatry Section Irish College of Psychiatrists (2003) *Submission to the expert group on mental health services*, Irish College of Psychiatrists, Dublin.
- Chisholm, D., Doran, C., Shibuya, K. and Rehm, J. r. (2006) Comparative cost-effectiveness of policy instruments for reducing the global burden of alcohol, tobacco and illicit drug use, *Drug & Alcohol Review*, **25**, 553-565.
- Chisholm, D., Rehm, J. and Ommeran, M. v. (2004) Reducing the Global Burden of Hazardous Alcohol Use: A Comparative Cost-Effectiveness Analysis, *Journal of Studies on Alcohol*, **65**, 782-93.
- Coghlan, D. and Brannick, T. (2005) *Doing action research in your own organization*, Sage, London.
- Cohen, M., Liebson, I. A. and Faillace, L. A. (1971) The modification of drinking in chronic alcoholics, In *Recent Advances in Studies of Alcoholism*, Vol. Publication No./HSM/71-9045, (Eds, Mello, H. K. and Mendelson, J. H.) US Government Printing Office, Washington DC.
- Commission on Liquor Licensing (2002) *Second interim report*, Stationery Office, Dublin.
- Community Response (1991) *Community response: a report of a seminar on drug problems in the south inner city held in Kevin Street College of Technology on November 3rd, 1990*, Community Response, Dublin.
- Cook, C. C. H. (1988) The Minnesota Model in the Management of Drug and Alcohol Dependency: miracle, method or myth? Part I. The Philosophy and the Programme, *British Journal of Addiction*, **83**, 625-634.
- Cullen, B. (2003) *Community and drugs: a discussion of the context and consequences of community drug problems in Ireland*, , Addiction Research Centre, Trinity College, Dublin.
- Cullen, K. (1993) *Community and drugs: a case study in community conflict in an inner city community in Dublin*, Unpublished M.Litt thesis submitted at Trinity College, Dublin.

- Currie, E., Duroy, T. H. and Lewis, L. (2003) Qualitative explorations of adolescents in treatment, , *Journal of Drug Issues*, **33**, 769-776.
- Curry, J. (2003) *Irish social services*, Institute of Public Administration, Dublin.
- Davies, D. L. (1962) Normal drinking in recovered alcohol addicts, *Quarterly Journal of Studies on Alcohol*, **23**, 94-104.
- Davies, H. T. O., Nutley, S. and Smith, P. C. (2000) *What works? Evidence-based policy and practice in public services*, The Policy Press, Bristol.
- Department of Health and Children (2001) *Primary care: a new direction: quality and fairness - a health system for you* Stationery Office, Dublin.
- Department of Health and Children. (2004) *Health service reform programme : composite report*, Dept. of Health and Children, [Dublin.
- DePoy, E. and Gitlin, L. N. (1998) *Introduction to research: understanding and applying multiple strategies*, Mosby, St. Louis ; London.
- Drugnet (2007) Changes at the HRB, *Drugnet, Ireland*, **21**, 32.
- Durrant, R. and Thakker, J. (2003) *Substance use & abuse: cultural and historical perspectives*, Sage, Thousand Oaks, [Calif.] ; London.
- Eden, C. and Huxham, C. (2002) *Action Research*, Sage, London.
- Edwards, G. (1980) Alcoholism treatment: Between guesswork and certainty, In *Alcoholism treatment in transition* (Eds, Edwards, G., Grant, M., Alcohol Education Centre. and University of London. Addiction Research Unit.) Croom Helm [for] the Alcohol Education Centre and [the] Addiction Research Unit, London, pp. 327.
- Edwards, G. (1984) Drinking in Longitudinal Perspective: Career and Natural History, *British Journal of Addiction*, **79**, 175-183.
- Edwards, G. (1987) *The treatment of drinking problems : a guide for the helping professions*, Blackwell Scientific, Oxford.
- Edwards, G. (1994) *Alcohol policy and the public good*, Oxford University Press, Oxford ; New York.
- Edwards, G. (2000) *Alcohol : the ambiguous molecule*, Penguin, London.
- Edwards, G. and Gross, M. M. (1976) Alcohol dependence: Provisional description of a clinical syndrome, *British Medical Journal*, **1(6017)**, 1058-61.
- Edwards, G., Gross, M. M., Keller, M. and Moser, J. (1976) Alcohol-related problems in the disability perspective: A summary of the consensus of the WHO group

- of investigators on criteria for identifying and classifying disabilities related to alcohol consumption, *Journal of Studies on Alcohol*, **37**, 1360-62.
- Edwards, G., Marshall, E. J. and Cook, C. (2003) *The treatment of drinking problems: a guide for the helping professions*, Cambridge University Press, Cambridge.
- Egan, C. (2007) Foxford house of HOPE, In *Mayo News* Castlebar.
- Emrick, C. (2001) Alcoholic Anonymous and other mutual aid groups, In *International handbook of alcohol dependence and problems* (Eds, Heather, N., Peters, T. J. and Stockwell, T.) John Wiley, Chichester, pp. xvii, 892.
- Emrick, C. D. (1987) Alcoholics Anonymous: Affiliation Processes and Effectiveness as Treatment, *Alcoholism: Clinical and Experimental Research*, **11**, 416-423.
- Emrick, C. D., Tonigan, J. S., Montgomery, H. and Little, L. (1993) Alcoholics Anonymous: What is currently known?, In *Research on Alcoholics Anonymous: Opportunities and Alternatives* (Eds, McCrady, B. S. and Miller, W. R.) Rutgers Center of Alcohol Studies, New Brunswick, NJ.
- Fals-Borda, O. and Rahman, M. A. (1991) *Action and knowledge: breaking the monopoly with participatory action-research*, Intermediate Technology Publications.
- Farren, C. (2006) Presentation on National Drugs Strategy to Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs, Wednesday March 1, *Houses of the Oireachtas Parliamentary Debates*, **46**.
- Fetterman, D. (2005) Empowerment evaluation principles in practice, in D. Fetterman & A. Wandersman (Eds.), *Empowerment Evaluation Principles in Practice*, New York: The Guilford Press.
- Fingarette, H. (1988) *Heavy Drinking: The Myth of Alcoholism as a Disease*, University of California Press, London.
- Finn, J. L. (1994) The Promise of Participatory Research, *Journal of Progressive Human Services*, **5**, 25-42.
- Finney, J. W. and Monahan, S. C. (1996) The cost-effectiveness of treatment for alcoholism: A second approximation, *Journal of Studies on Alcohol*, **52**, 517-40.
- First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996) Pat Rabbitte, TD (Chairman), Stationery Office, Dublin.
- Flannery, W. (2007) Faculty of Addiction Psychiatry, *Irish College of Psychiatrists Bulletin*, **2**.

- Fletcher, A. M. (2001) *Sober for Good: New solutions for drinking problems - advice from those who have succeeded*, Houghton Mifflin, Boston.
- Frankfort-Nachmias, C. and Nachmias, D. (1996) *Research methods in the social sciences*, Edward Arnold, London.
- Freire, P. (2000) *Pedagogy of the oppressed*, Continuum, New York.
- Frost, N. (2002) Evaluating practice, In *Critical practice in social work* (Eds, Adams R., Dominelli, L. and Payne, M.) Palgrave, Basingstoke, pp. xxii, 358.
- Gambrill, E. (1999) Evidence-based practice: An alternative to authority-based practice, *Families in Society: The Journal of Contemporary Human Services*, **80**.
- Gilvarry, E. (2001) *The substance of young needs: review 2001*, Health Advisory Service, London.
- Gomm, R. and Davies, C. (2000) *Using evidence in health and social care*, Sage, London.
- Goodwin, D. W. (1991) Inpatient treatment of alcoholism – New life for the Minneapolis Plan, *New England Journal of Medicine*, **325**, 804-806.
- Goodwin, S. (1997) *Comparative mental health policy : from institutional to community care*, Sage, London.
- Government Social Research Unit (UK) (2007) Background paper 7: Why do social experiments? Experiments and quasi-experiments for evaluating government policies and programmes, In *The Magenta Book: Guidance notes for policy evaluation and analysis* HM Treasury, London.
- Government Strategy to Prevent Drugs Misuse* (1991) Department of Health, Dublin.
- Grant, M. and Litvak, J. (1998) *Drinking patterns and their consequences*, Taylor & Francis, Washington, DC.
- Greene, J., Caracelli, V. (1997) Defining and describing the paradigm issue in mixed-method evaluation, *New Directions for Program Evaluation*, **1997**, 5-17.
- Greenwood, D. J. and Levin, M. (2007) *Introduction to action research: social research for social change*, Sage, London.
- Greenwood, D. J. and Levin, M. (2000) Reconstructing the relationships between universities and society through action research, in N. Denzin and Y. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd edition), London: Sage.
- Guba, E. G. (1990) *The Paradigm dialog*, Sage Publications, Newbury Park, Calif. ; London.

- Gusfield, J. R. (1996) *Contested meanings: the construction of alcohol problems*, University of Wisconsin Press, Madison, Wisconsin.
- Hall, B. L. (2001) I wish this were a poem of practices of participatory research, In *Handbook of action research: participative inquiry and practice* (Eds, Reason, P. and Bradbury, H.) Sage, London, pp. xlii, 468p.
- Harney, M. (2005) Press Release on Report of the Working Group on Treatment of Under 18 year olds Presenting to Treatment Services with Serious Drug Problems, Department of Health and Children.
- Heather, N. (1995) Brief Intervention Strategies, In *Handbook of Alcoholism Treatment Approaches: Effective alternatives (2nd Ed.)* (Eds, Hester, R. K. and Miller, W. R.) Allyn & Bacon, Needham heights, MA.
- Heather, N. (2007) A long-standing World Health Organization collaborative project on early identification and brief alcohol intervention in primary health care comes to an end, *Addiction*, 679-681.
- Heather, N. and Robertson, I. (1997) *Problem drinking*, Oxford University Press, Oxford.
- Hodgson, R. (1994) Treatment of alcohol problems, *Addiction*, **89**, 1529-1534.
- Holder, H., Longabaugh, R., Miller, W. R. and Rubonis, A. V. (1991) The cost-effectiveness of treatment for alcoholism: A first approximation" 52 (6), 517-540., *Journal of Studies on Alcohol*, **52**, 517-540.
- Holder, H. D. (1998) *Alcohol and the community : a systems approach to prevention*, Cambridge University Press, Cambridge.
- Howlett, M. and Ramesh, M. (2003) *Studying public policy : policy cycles and policy subsystems*, Oxford University Press, Don Mills, Ont. ; Oxford.
- Hughes, J. A. and Sharrock, W. W. (1997) *The philosophy of social research*, Longman, London.
- Humphreys, K. (1999) Professional Interventions That Facilitate 12-Step Self-Help Group Involvement, *Alcohol Research & Health*, **23**, 93.
- Institute of Medicine (U.S) (1990) Broadening the base of treatment for alcohol problems : report of a study by a committee of the Institute of Medicine, Division of Mental Health and Behavioral Medicine, (Ed, Committee for the Study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse, N. I. o. A. A. a. A. U. S.) National Academy Press, Washington, D.C, pp. viii, 629.

- Ireland (1945) [Acts of the Oireachtas]. Mental Treatment Act, 1945, Stationery Office, Dublin, pp. 337.
- Ireland (1970) Health Act, Stationery Office, Dublin.
- Ireland (2004) Health Act, Stationery Office, Dublin.
- Ireland (2006) A vision for change : report of the expert group on mental health policy, (Ed, Children, D. o. H. a.) Stationery Office, Dublin, pp. 284.
- Irish Medical Organisation (2005) *Doctors' group condemns drink ads watchdog: press release from Irish medical organisation (IMO), december 15th.*
- Irish National Council on Alcoholism (1973) *Alcoholism: Report to the Minister for Health*, Irish National Council on Alcoholism, Dublin.
- Jellinek, E. M. (1952) Phases of alcohol addiction, *Quarterly Journal of Studies on Alcohol*, **13**, 673-84.
- Johnson, P. and Duberley, J. (2000) *Understanding management research: an introduction to epistemology*, Sage, London.
- Johnson, S. P., Greenfield, T. K., Giesbrecht, N., Kaskutas, L. A. and Anglin, L. (2004) The role of research in the development of U.S. federal alcohol control policy, *Contemporary Drug Problems*, **31**, 737-758.
- Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs (2006) *Ninth report: the inclusion of alcohol in a national substance misuse strategy*, Stationery Office, Dublin.
- Katz, I. and Pinkerton, J. (2003) *Evaluating family support : international lessons for policy, practice & research*, Wiley, New York ; Chichester.
- Kazi, M. (2003) Realist Evaluation for Practice, *British Journal of Social Work*, **33**, 803-818.
- Keene, J. M. (2001) An International Social Work Perspective on Drug Misuse Problems and Solutions: Reviewing Implications for Practice, *Journal of Social Work*, **1**, 187-199.
- Keller, M. (1986) The old and the new in the treatment of alcoholism, In *Alcohol Interventions: Historical and Sociocultural Approaches* (Eds, Strug, D., Priyadarsini, S. and Hyman, M.) The Haworth Press, London.
- Kemmis, S. (2001) Exploring the relevance of critical theory for action research: Emancipatory action research in the footsteps of Jurgen Habermas", In *Handbook of action research : participative inquiry and practice* (Eds, Reason, P. and Bradbury, H.) SAGE, London, pp. xlii,468p.

- Kendell, R. E. (1979) Alcoholism: a medical or a political problem?, *British Medical Journal*, **1**, 367-371.
- Klingemann, H. (2001) *Promoting self-change from problem substance use : practical implications for policy, prevention, and treatment*, Kluwer Academic Publishers, Dordrecht ; London.
- Leane, M., Powell, F. W., University College Cork. Social Policy Research Unit. and Aiséirí. (1994) *Courage to change : an evaluation of an Irish addiction programme*, Social Policy Research Unit University College Cork, Cork.
- Lender, M. E. and Martin, J. K. (1987) *Drinking in America : a history*, Free Press ; Collier Macmillan, New York; London.
- Levin, M. and Greenwood, D. (2001) Pragmatic action research and the struggle to transform universities into learning communities, In *Handbook of action research : participative inquiry and practice* (Eds, Reason, P. and Bradbury, H.) Sage, London, pp. xlii,468p.
- Levine, H. (1993) Temperance Cultures: Alcohol as a Problem in Nordic and English-Speaking Cultures, In *The Nature of Alcohol and Drug-Related Problems*. (Eds, Malcom Lader, Griffith Edwards and Drummon, D. C.) Oxford University Press, New York, pp. 16-36.
- Levine, H. G. (1978) The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America, *Journal of Studies on Alcohol*, **15**, 493-506.
- Levine, H. G. (1984) The Alcohol Problem in America: From Temperance to Alcoholism, *British Journal of Addiction*, **79**, 109-119.
- Lincoln, Y. S. (2001) Engaging sympathies: Relationships between action research and social constructivism, In *Handbook of action research : participative inquiry and practice*(Eds, Reason, P. and Bradbury, H.) SAGE, London, pp. xlii,468p.
- Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*, Sage Publications, Beverly Hills (Calif.) ; London.
- Makela, K., Room, R., Single, E., Sulkunen, P. and Walsh, B. (1981) Alcohol, society, and the state, Vol. 1: A comparative study of alcohol control, Addiction Research Foundation, Toronto: .
- Mann, R. E., Smart, R. G. and Anglin, L. (1991) Reductions in cirrhosis deaths in the United States: associations with per capita consumption and AA membership, *Journal of Studies on Alcohol* v. 52 (July 1991) p. 361-5.

- Marlatt, G. A. and Donovan, D. M. (2005) *Relapse prevention : maintenance strategies in the treatment of addictive behaviors*, Guilford Press, New York ; London.
- Marsh, J. (1866) *Temperance Recollections*, Scribner, New York.
- Maxwell, M. (1950) The Washingtonian Movement, *Quarterly Journal on the Study of Alcohol*, **11**, 410-452.
- McCrary, B. S. (2000) Alcohol use disorders and the Division 12 Task Force of the American Psychological Association, *Psychology of Addictive Behaviors*, **14**, 267-276.
- McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H. and Argeriou, M. (1992) The fifth edition of the addiction severity index, *Journal of Substance Abuse Treatment*, **9**, 199-213.
- McNeece, C. A. and DiNitto, D. M. (2005) *Chemical dependency : a systems approach*, Pearson/Allyn and Bacon, Boston, Mass ; London.
- McNiff, J. and Whitehead, J. (2002) *Action research : principles and practice*, RoutledgeFalmer, London.
- Medico-Social Research Board (1980) Report of the inspector of mental hospitals for the years, 1977-9, Stationery Office, Dublin.
- Medico-Social Research Board and Health Research Board (1965-2005) Activities of Irish psychiatric hospitals and units, Medico-Social Research Board / Health Research Board, Dublin.
- Mello, H. K. and Mendelson, J. H. (1971) Drinking patterns during work contingent and non-contingent alcohol acquisition In *Recent Advances in Studies of Alcoholism*, Vol. Publication No./HSM/71-9045, (Eds, Mello, H. K. and Mendelson, J. H.) US Government Printing Office, Washington DC.
- Mental Health Commission (2004) Annual Report 2003, MHC, Dublin.
- Meyers, R. J. and Miller, W. R. (2001) *A community reinforcement approach to addiction treatment*, Cambridge University Press, Cambridge.
- Meyers, R. J. and Slesnick, N. (2002) Establishing and maintaining evidence-based treatment in community programs, In *Changing substance abuse through health and social systems*(Eds, Miller, W. R. and Weisner, C. M.) Kluwer Academic/Plenum, New York ; London, pp. xviii, 259.
- Midanik, L. T. and Tam, T. W. (1996) Risk functions for alcohol-related problems in a 1988 US national sample, *Addiction*, **91**, 1427.

- Miller, W. R. (2000) Rediscovering fire: Small interventions, large effects, *Psychology of Addictive Behaviors*, **14**, 6-18.
- Miller, W. R. (2002) Is 'treatmentt' the right way to think about it?, In *Changing substance abuse through health and social systems*(Eds, Miller, W. R. and Weisner, C. M.) Kluwer Academic/Plenum, New York ; London, pp. xviii, 259.
- Miller, W. R., Andrews, N. R., Wilbourne, P. and Bennett, M. E. (1998) A wealth of alternatives: effective treatments for alcohol problems, In *Treating Addictive Behaviours, (2nd ed.)*, (Eds, Miller, W. R. and Heather, N.) Plenum, New York.
- Miller, W. R. and Baca, L. M. (1983) Two-year follow-up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers, *Behavior Therapy*, **14**, 441-448.
- Miller, W. R., Brown, J. M., Simpson, T. L., Handmaker, N. S., Bien, T. H., Luckie, L. F., Montgomery, H. A., Hester, R. K. and Tonigan, J. S. (1989) What works? A methodological analysis of the alcohol treatment outcome literature, In *Handbook of alcoholism treatment approaches : effective alternatives*(Eds, Hester, R. K. and Miller, W. R.) Pergamon Press, New York, pp. xiii,292.
- Miller, W. R., Brown, J. M., Simpson, T. L., Handmaker, N. S., Bien, T. H., Luckie, L. F., Montgomery, H. A., Hester, R. K. and Tonigan, J. S. (1995) Handbook of alcoholism treatment approaches : effective alternatives, Allyn and Bacon, Boston, pp. xiii,292.
- Miller, W. R. and Hester, R. K. (1986a) Inpatient alcoholism treatment: Who benefits?, *American Psychologist*, **41**, 794-805.
- Miller, W. R. and Hester, R. K. (1986b) The effectiveness of alcoholism treatment: What research reveals?, In *Treating addictive behaviors : processes of change*(Eds, Miller, W. R. and Heather, N.) Plenum Press, New York ; London, pp. xix, 464.
- Miller, W. R. and Hester, R. K. (1989) Treating Alcohol Problems: Toward an Informed Eclecticism, In *Handbook of alcoholism treatment approaches : effective alternatives*(Eds, Hester, R. K. and Miller, W. R.) Pergamon Press, New York, pp. xiii,292.

- Miller, W. R. and Kurtz, E. (1994) Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused, *Journal of Studies on Alcohol*, **55**, 159-166.
- Miller, W. R., Taylor, C. A. and West, J. C. (1980) Focused versus broad-spectrum behavior therapy for problem drinkers, *Journal of Consulting and Clinical Psychology*, **48**, 590-601.
- Miller, W. R. and Weisner, C. M. (2002) *Changing substance abuse through health and social systems*, Kluwer Academic/Plenum, New York ; London.
- Miller, W. R. and Wilbourne, P. L. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders, *Addiction*, **97**, 265-277.
- Miller, W. R., Zweben, J. and Johnson, W. R. (2005) Evidence-based treatment: Why, what, where, when, and how?, *Journal of Substance Abuse Treatment*, **29**, 267-276.
- Mongan, D. (2007) European drug policies - extending beyond illicit drugs?, *Drugs, Ireland*, **21**, 30.
- Moos, R. H., Finney, J. W. and Cronkite, R. C. (1990) *Alcoholism treatment : context, process, and outcome*, Oxford University Press.
- Moos, R. H., Finney, J. W., Ouimette, P. C. and Suchinsky, R. T. (1999) A Comparative Evaluation of Substance Abuse Treatment: I. Treatment Orientation, Amount of Care, and 1-Year Outcomes, *Alcoholism: Clinical and Experimental Research*, **23**, 529-536.
- Morgan, D. L. (1997) *Focus groups as qualitative research*, SAGE, London.
- Morgenstern, J. and Longabaugh, R. (2000) Cognitive behavioral treatment for alcohol dependence: a review of evidence for its hypothesized mechanisms of action, *Addiction*, **95**, 1475-1490.
- Morse, J. (1999) Myth # 93: reliability and validity are not relevant to qualitative inquiry, *Qualitative Health Research*, **9**, 717-18.
- Moskowitz, J. M. (1989) The primary prevention of alcohol problems: a critical review of the research literature, *Journal of Studies on Alcohol*, **50**, 54-88.
- Mulford, H. A. (1994) What if alcoholism had not been invented? The dynamics of American alcohol mythology, *Addiction*, **89**, 517-520.
- Musto, D. F. (1999) *The American disease : origins of narcotic control*, Oxford University Press, New York ; Oxford.

- Nace, E. P. (2005) Alcoholics Anonymous, In *Substance abuse : a comprehensive textbook*(Ed, Lowinson, J. H.) Lippincott Williams & Wilkins, Philadelphia, Pa. ; London, pp. xxiv, 1421.
- Najavits, L. M. and Weiss, R. D. (1994) Variations in therapist effectiveness in the treatment of patients with substance use disorders: an empirical review, *Addiction*, **89**, 679-688.
- National Alcohol Policy [Ireland] (1996) Department of Health, Stationery Office, Dublin, pp. 90.
- National Drugs Strategy (2001 – 2008) (2001) Stationery Office, Dublin.
- National Economic and Social Council (1987) A Strategy for development, 1996-1990: Key points, National Economic and Social Council, Dublin.
- O'Farrell, T. J. (1993) *Treating alcohol problems : marital and family interventions*, Guilford Press, New York.
- O'Hagan, M. and McGovern, T. (1987) The alcoholism / drug dependency counsellor, health care professional in the US and Ireland, In *Health for all - meeting the challenge : proceedings of the 12th World Conference on Health Education, 1-6 September 1985, Dublin, Ireland*(Eds, Crawley, H., D'Ardis, M., Duffin, H., Harkin, A. M., O'Neill, C. and Redmond, A.) Health Education Bureau, Dublin, pp. xviii, p 471-946.
- O'Kelly, F. D., Bury, G., Cullen, B. and Dean, G. (1988) The rise and fall of heroin use in an inner city area in Dublin, *Irish Journal of Medical Science*, **157**, 35-37.
- Oakley, A., Strange, V., Toroyan, T., Wiggins, M., Roberts, I. and Stephenson, J. (2003) Using Random Allocation to Evaluate Social Interventions: Three Recent U.K. Examples, *Annals of the American Academy of Political and Social Science*, **589**, 170-189.
- Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., Fryer, K., Handforth, L., Alwyn, T., Kerr, C., Thistlethwaite, G. and Slegg, G. (2006) The clients' perspective on change during treatment for an alcohol problem: qualitative analysis of follow-up interviews in the UK Alcohol Treatment Trial, *Addiction*, **101**, 60-68.
- Orford, J., Oppenheimer, E. and Edwards, G. (1976) Abstinence or control: The outcome for excessive drinkers two years after consultation, *Behaviour Research and Therapy*, **14**, 409-418.

- Ouimette, P. C., Finney, J. W. and Moos, R. H. (1997) Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness, *Journal of Consulting and Clinical Psychology*, **65**, 230-240.
- Ovretveit, J. (1998) *Evaluating health interventions : an introduction to evaluation of health treatments, services, policies and organizational interventions*, Open University Press, Buckingham.
- Parry-Langdon, N., Bloor, M., Audrey, S. and Holliday, J. (2003) Process evaluation of health promotion interventions *Policy and Politics*, **31**, 207– 16
- Pattison, E. M., Sobell, M. B. and Sobell, L. C. E. (1977) *Emerging Concepts of Alcohol Dependence*, Springer, New York.
- Pawson, R. and Tilley, N. (1997) *Realistic evaluation*, SAGE, London.
- Peele, S. (1995) *Diseasing of America : how we allowed recovery zealots and the treatment industry to convince us we are out of control*, Lexington Books, New York.
- Peele, S. (2001) Whose spirits have been broken anyway? Review of Broken Spirits: Power and Ideas in Nordic Alcohol Control, *Nordic Alcohol and Drug Studies*, **18**, 106-110.
- Peele, S., Brodsky, A. and Arnold, M. (1991) *The Truth About Addiction and Recovery*, Simon & Schuster, New York.
- Plant, M. A., Single, E. and Stockwell, T. (1997) *Alcohol : minimising the harm : what works?*, Free Association Books, London.
- Porter, R. (1985) The Drinking Man's Disease: The 'Pre-History' of Alcoholism in Georgian Britain, *British Journal of Addiction*, **80**, 385-396.
- Preskill, H. S. and Torres, R. T. (1999) *Evaluative inquiry for learning in organizations*, Sage Publications, Thousand Oaks, Calif. ; London.
- Prochaska, J. O. and DiClemente, C. C. (1986) Toward a comprehensive model of change, In *Treating addictive behaviors : processes of change*(Eds, Miller, W. R. and Heather, N.) Plenum Press, New York ; London, pp. xix, 464.
- Prochaska, J. O., DiClemente, C. C. and Norcross, J. C. (1992) In search of how people change: Applications to addictive behaviors, *American Psychologist*, **47**, 1102-1114.
- Proehl, R. A. (2001) *Organizational change in the human services*, Sage, Thousand Oaks, Calif. ; London.

- Project Match Research Group (1998) Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment, *Journal of Studies on Alcohol*, **59**, 631-9.
- Raistrick, D., Heather, N. and Godfrey, C. (2006) *Review of the effectiveness of treatment for alcohol problems*, National Treatment Agency for Substance Misuse, London.
- Rasmussen, S. (2000) *Addiction treatment : theory and practice*, Sage Publications, Thousand Oaks, Calif. ; London.
- Reason, P. (1988) *Human inquiry in action : developments in paradigm research*, Sage, London.
- Reason, P. and Rowan, J. (1981) *Human inquiry : a sourcebook of new paradigm research*, Wiley, Chichester.
- Regional Health Board (2003) Overview of the regional Co-ordinating Committee on Demand Reduction Measures for Drugs, 1996-2003.
- Rehm, J. and Ashley, M. J. (1996) On the emerging paradigm of drinking patterns and their social and health consequences, *Addiction*, **91**, 1615.
- Reinarman, C. (1988) The social construction of an alcohol problem, *Theory and Society*, **17**, 91-120.
- Report of the Commission of Inquiry on Mental Illness* (1967) Department of Health,, Stationery Office, Dublin.
- Report of the Inspector of Mental Hospitals for 2001* (2002) Stationery Office, Dublin.
- Report of the Inspector of Mental Hospitals for the Year 1992* (1995) (Ed, Medico-Social Research Board) Stationery Office, Dublin.
- Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems* (2005) Health Service Executive, (Ed, Department of Health and Children) Health Service Executive, Dublin, pp. iv, 80.
- Robinson, D. (1979) *Talking out of alcoholism : the self-help process of Alcoholics Anonymous*, Croom Helm, London.
- Robson, C. (2002) *Real world research : a resource for social scientists and practitioner-researchers*, Blackwell, Oxford.
- Room, R. (1972) Comments on the 'alcoholologist's addiction', *Quarterly Journal of Studies on Alcohol*, **33**, 1049-59.

- Room, R. (1985) Dependence and Society, *British Journal of Addiction*, **80**, 133-139.
- Room, R. (1992) The impossible dream?--Routes to reducing alcohol problems in a temperance culture, *Journal of Substance Abuse*, **4**, 91-106.
- Room, R. (2001) Governing images in public discourse about problematic drinking, In *International handbook of alcohol dependence and problems*(Eds, Heather, N., Peters, T. J. and Stockwell, T.) John Wiley, Chichester, pp. xvii, 892.
- Room, R., Agar, M., Beckett, J., Bennett, L. A., Casswell, S., Heath, D. B., Leland, J., Levy, J. E., Madsen, W., Marshall, M., Moskalewicz, J., Negrete, J. C., Rodin, M. B., Sackett, L., Sargent, M., Strug, D. and Waddell, J. O. (1984) Alcohol and Ethnography: A Case of Problem Deflation? [and Comments and Reply], *Current Anthropology*, **25**, 169-191.
- Room, R., Bondy, S. J. and Ferris, J. (1995) The risk of harm to oneself from drinking, Canada 1989, *Addiction*, **90**, 499-513.
- Rowen, S. (2003) The treatment of alcohol dependence in Ireland, *Studies*, **92**.
- Royce, J. E. (1981) *Alcohol problems and alcoholism : a comprehensive survey*, Free Press ; Collier Macmillan, New York; London.
- Rubin, A. and Babbie, E. R. (2005) *Research methods for social work*, Thomson Learning, Belmont, CA.
- Rudy, D. R. (1986) *Becoming alcoholic : Alcoholics Anonymous and the reality of alcoholism*, Southern Illinois University Press, Carbondale.
- Rush, B. (1785) *Inquiry into the effects of ardent spirits upon the human body and mind*, Tract Association of Friends, Philadelphia.
- Sackett, D. (2000) *Evidence-based medicine : how to practice and teach EBM*, Churchill Livingstone, Edinburgh.
- Sands, R. and McClelland, M. (1994) Qualitative research in social work, In *Qualitative research in social work*(Eds, Sherman, E. and Reid, W. J.) Columbia University Press, New York ; Chichester, pp. xii, 520.
- Sayer, A. (2000) *Realism and social science*, Sage, Thousand Oaks, Calif. ; London.
- Schmidt, L. A. (1995) The role of problem drinking in psychiatric admissions, *Addiction*, **90**, 375-389.
- Scocozza, L. (2005) The Randomised Trial, A Critique from the Philosophy of Science In *Evaluation research [i.e. research] methods. Sage benchmarks in social research methods*(Ed, Stern, E.) SAGE, London, pp. 4 v.

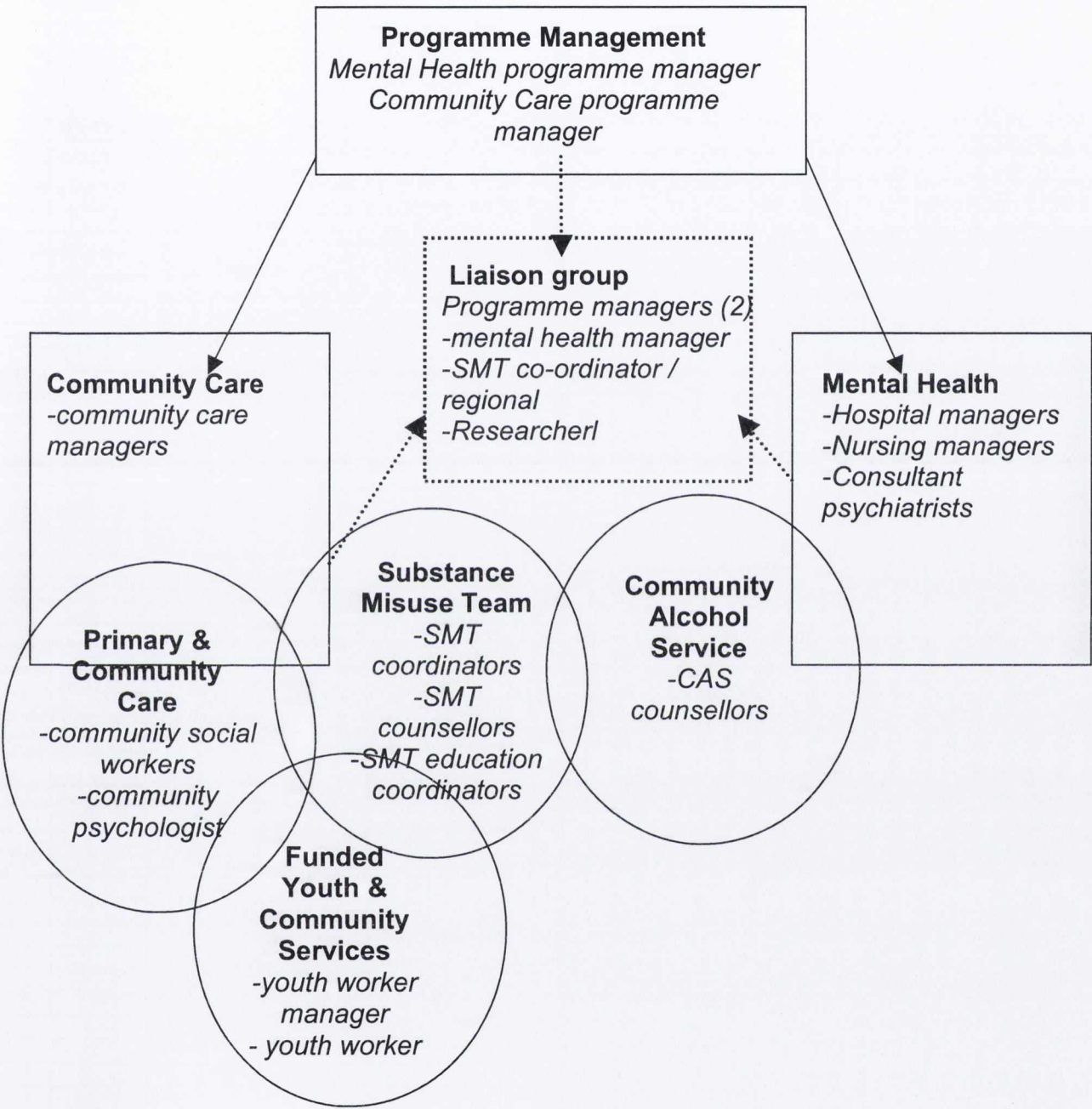
- Scriven, M. (1994) The fine line between evaluation and explanation, *Evaluation Practice*, **15**, 75-7.
- Second Report of the Ministerial Task Force for Measures to Reduce the Demand for Drugs* (1997) Pat Rabbitte, TD (Chairman), Stationery Office, Dublin.
- Seiden, R. H. (1960) The use of Alcoholics Anonymous members in research on alcoholism, *Quarterly Journal of Studies on Alcohol*, **21**, 506-9.
- Sellman, D. (1994) Alcoholism: development of the diagnostic concept, *Australian and New Zealand Journal of Psychiatry*, **28**, 205-211.
- Shani, A. B., Albert, D. and Willson, C. (2004) Collaborative research, alternative roadmaps, In *Collaborative research in organizations : foundations for learning, change, and theoretical development*(Eds, Adler, N., Shani, A. B. and Styhre, A.) Sage Publications, Thousand Oaks, Calif. ; London, pp. xxiii, 383 p.
- Shaw, S. (1979) A Critique of the concept of the Alcohol Dependence Syndrome, *British Journal of Addiction (to Alcohol & Other Drugs)*, **74**, 339-348.
- Shaw, S. (1985) The disease concept of dependence, In *The Misuse of alcohol : crucial issues in dependence, treatment & prevention*(Eds, Heather, N., Robertson, I., Davies, P. and New Directions in the Study of Alcohol Group.) Croom Helm, London, pp. 284.
- Shaw, S., Cartwright, A., Spratley, T. and Harwin, J. (1978) *Responding to drinking problems*, Croom Helm, London.
- Sheron, N., Olsen, N. and Gilmore, I. (2008) An evidence-based alcohol policy, *Gut*, **57**, 1341-1344.
- Single, E., Leino, V. E. (1998) The levels, patterns, and consequences of drinking. In M. Grant & J. Litvak (Eds.), *Drinking Patterns and Their Consequences*. Washington, DC: Taylor & Francis.
- Skog, O.-J. (1985) The Collectivity of Drinking Cultures: A Theory of the Distribution of Alcohol Consumption, *British Journal of Addiction*, **80**, 83-99.
- Sobell, L. (2006) Natural Recovery / Self Change: How it works and implications for treatment In *Eleventh International Conference on Treatment of Addictive Behaviours*The Eldorado Hotel Santa Fe, New Mexico, USA.
- Sobell, L. C., Cunningham, J. A. and Sobell, M. B. (1996) Recovery from Alcohol Problems With and Without Treatment: Prevalence in Two Population Surveys, *American Journal of Public Health*, **86**, 966-966.

- Sobell, M. B. and Sobell, L. C. (1993) Treatment for problem drinkers, In *Addictive Behaviour Across the Lifespan: Prevention, Treatment and Policy Issues*(Eds, Baer, J. S., Marlatt, G. A. and Mc Mahon, R. J.) Sage, Beverly Hills, CA, pp. 138-157.
- Sobell, M. B. and Sobell, L. C. (1999) Stepped care model for alcohol problems: An efficient method for planning and delivering clinical services In *Changing addictive behavior : bridging clinical and public health strategies*(Eds, Tucker, J. A., Donovan, D. M. and Marlatt, G. A.) Guilford Press, New York ; London, pp. xx, 387.
- Steering Group for the Mid-Term Review of the National Drugs Strategy (2005) Mid-term review of the National Drugs Strategy 2001–2008, (Ed, Department of Community, R. a. G. A.) Department of Community, Rural and Gaeltacht Affairs, Dublin.
- Stern, E. (2005) *Evaluation reseach [i.e. research] methods*, SAGE, London.
- Stewart, D. W., Shamdasani, P. N. and Rook, D. W. (2007) *Focus groups : theory and practice*, SAGE Publications, Thousand Oaks, Calif. ; London.
- Stinchfield, R. and Owen, P. (1998) Hazelden's model of treatment and its outcome, *Addictive Behaviors*, **23**, 669-683.
- Stockwell, T., Hawks, D., Lang, E. and Rydon, P. (1996) Unravelling the preventive paradox for acute alcohol problems, *Drug and Alcohol Review*, **15**, 7-15.
- Strategic Task Force on Alcohol* (2004) Second report, Department of Health and Children, Dublin, pp. 62.
- Stringer, E. T. (2007) *Action research*, SAGE, London.
- Sulkunen, P. (2000) *Broken spirits : power and ideas in Nordic alcohol control*, Nordic Council for Alcohol and Drug Research, Helsinki.
- Susman, G. I. and Evered, R. D. (1978) An Assessment of the Scientific Merits of Action Research, *Administrative Science Quarterly*, **23**, 582-603.
- The Psychiatric Services - Planning for the Future* (1984) Report of a Study Group on the Development of Psychiatric Services,, In [No. Z.33](Ed, Health, D. o.) Stationery Office, Dublin, pp. xv, 191.
- The Report of the Expert Group on Mental Health Policy: A Vision for Change* (2006) Department of Health and Children, Stationery Office, Dublin, pp. 284.
- Thom, B. (1999) *Dealing with drink : alcohol and social policy : from treatment to management*, Free Association Books, London ; New York.

- Tonigan, S., Connors, G. J. and Miller, W. R. (2002) Participation and involvement in Alcoholics Anonymous, In *Treatment matching in alcoholism*(Eds, Babor, T. and Del Boca, F. K.) Cambridge University Press, Cambridge, pp. xvi, 275.
- Townend, P. A. (2002) *Father Mathew, temperance, and Irish identity*, Irish Academic Press, Dublin ; Portland, OR.
- Trice, M. and Staudenmeier, W. J. (1989) A Sociocultural History of Alcoholics Anonymous, In *Recent Developments in Alcoholism (vol. 7) Treatment Research*(Ed, Galanter, M.) Plenum Press, London, pp. 11-35.
- Trotter, T. and Porter, R. (1988) *An essay, medical, philosophical, and chemical on drunkenness and its effects on the human body*, Routledge.
- Vaillant, G. E. (1983) *The natural history of alcoholism*, Harvard University Press, Cambridge, Mass. ; London.
- Vaillant, G. E. (1995) *The natural history of alcoholism revisited*, Harvard University Press, Cambridge, Mass. ; London.
- Valle, S. K. (1981) Interpersonal functionin of alcoholism counselors and treatment outcome, *Journal of Studies on Alcohol*, **42**, 783-790.
- Van Wormer, K. S. (1995) *Alcoholism treatment : a social work perspective*, Nelson-Hall, Chicago.
- Waclawski, J. and Church, A. H. (2002) *Organization development : a data-driven approach to organizational change*, Jossey-Bass ;, San Francisco, CA.
- Walsh, D. (1987a) Alcohol and Alcohol Problems Research 15. Ireland, *British Journal of Addiction*, **82**, 747-751.
- Walsh, D. (1987b) Recent trends in mental health care in Ireland, *International Journal of Mental Health*, **16**, 108-117.
- Weisner, C. (2002) What is the scope of the problem and its impact on health and social systems?, In *Changing substance abuse through health and social systems*(Eds, Miller, W. R. and Weisner, C. M.) Kluwer Academic/Plenum, New York ; London, pp. xviii, 259.
- Weisner, C. and Matzger, H. (2003) Missed Opportunities in Addressing Drinking Behavior in Medical and Mental Health Services, *Alcoholism: Clinical and Experimental Research*, **27**, 1132-1141.
- White, W. L. (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, Chestnut Health Systems: Lighthouse Institute,, Bloomington, IL.

- Whyte, W. F. (1990) *Participatory action research*, Sage Publications, Newbury Park, Calif.
- Williams, L. (1956) *Alcoholism: Drink, Temperance and Legislation*, E. & S. Livingstone, Edinburgh.
- Williams, M., May, T. and Wiggins, R. D. (1996) *Introduction to the philosophy of social research*, UCL Press, London.
- Winter, R. and Munn-Giddings, C. (2001) *A handbook for action research in health and social care*, Routledge, London ; New York.
- World Health Organization (1977) (9th edition) *Manual of the International Classification of Diseases, Injuries and Causes of Death*, World Health Organization, Geneva.
- World Health Organization (2000) European Alcohol Action Plan, 2000-2005, Geneva, , WHO Regional Office for Europe, Geneva.
- World Health Organization [Europe] (2006) *Framework for alcohol policy in the WHO European Region*, World Health Organization, Copenhagen.
- Zinberg, N. E. (1977) Alcoholics Anonymous and the Treatment and Prevention of Alcoholism, *Alcoholism: Clinical and Experimental Research*, **1**, 91-102.
- Zuber-Skerritt, O. and Perry, C. (2002) Action research within organisations and university thesis writing, *The Learning Organization*, **9**, 171.

Appendix 1: organizational map for action research study



Appendix 2: Personnel roles, sex, and participation in data events

Code: CAS=community alcohol service; SMT=substance misuse team; LG=Liaison Group; RF=Regional Forum; FG=Focus Group; IV=Interview; UA =Unavailable for interview; UC= Uncontactable for interview		Stage 1		Stage 2		Stage 3		Stage 4		Stage 5	Late discuss- ions (LDs)
		LG 1	RF 1	LG 2	FGs 1-3	LG 3	IVs	LG 4	FGs 5-8	RF (2)	
		Sex	Oct '03	No '03	Jan '04	Feb- May' 04	June '04	July- Sept' 04	Oct '04	Oct- Dec '05	
Cluster 1¹³		FG1=16 (M=5;F=11)						FG5=9 (M=3;F=6)			
A - CAS counsellor (01)	F		✓		✓		✓		✓	✓	
A - CAS counsellor (02)	M		✓		✓		✓		✓	✓	
A - CAS counsellor (03)	M		✓		✓		✓		✓	✓	
A - CAS counsellor (04)	F		✓		✓		✓		✓	✓	
A - Mental Health Manager (1)	F		✓		✓		✓			✓	
A - Mental Health Manager (2)	F		✓		✓		✓			✓	
A - Mental Health Manager (3)	M		✓		✓		UC			✓	
A - Consultant psychiatrist (1)	F		✓		✓		UA			✓	
A - Locum CAS counsellor	F		✓		✓		UC				
A - Locum consultant psychiatrist	F		✓		✓		UC				
B - Community Care manager (1)	M		✓		✓		✓		✓	✓	
B - SMT coordinator (1)	F		✓		✓		✓		✓	✓	
B - SMT counsellor (1)	F		✓		✓		✓		✓	✓	
B - SMT education officer (1)	F		✓		✓		✓		✓	✓	
B - Child Care manager	F		✓		✓		UA		✓	✓	
B - Child psychiatrist	M		✓		✓		UA			✓	
Cluster 2		FG2 = 7 (M=4;F=3)						FG6 = 5 M=4;F=1)			
A - CAS counsellor (05)	M		✓		✓		✓		✓	✓	
A - CAS counsellor (06)	M		✓				✓		✓	✓	
A - Mental Health Manager (4)	F		✓		✓		✓			✓	
A - Mental Health Manager (5)	M		✓		✓		✓			✓	
B - SMT coordinator (2)	M		✓		✓		✓		✓	✓	
B - SMT counsellor (2)	M		✓		✓		✓		✓	✓	
B - SMT education officer (2)	F		✓		✓		✓		✓	✓	
B - Locum SMT counsellor	F		✓		✓		UC				
Cluster 3		FG3=not continued						FG7 = 6 (M=6)			
A - CAS counsellor (07)	M		✓				UA		✓	✓	
A - CAS counsellor (08)	M		✓				UA		✓	✓	
A - Mental Health manager (6)	M		✓				UC		✓		
A - Consultant psychiatrist (2)	M		✓				UC		✓	✓	
B - Community Care manager (2)	M		✓				✓		✓	✓	
B - SMT coordinator (3)	M		✓				✓		✓	✓	
Cluster 4		FG4 = 7 (M=4;F=3)						FG8 = 6 M=3;F=3)			
A - CAS counsellor (09)	F						✓		✓	✓	
A - CAS counsellor (10)	F						✓		✓	✓	
A - Mental Health Manager (7)	M	✓	✓	✓	✓		✓		✓	✓	
A - Mental Health Manager (8)	F		✓		✓		✓			✓	
A - Consultant psychiatrist (3)	F				✓					✓	✓
B - Community Care manager (3)	M		✓		✓		✓			✓	
B - SMT coordinator (4)	M		✓		✓		✓		✓	✓	
B - SMT counsellor (3)	M		✓		✓		✓		✓	✓	
B - SMT education officer (3)	F		✓		✓		UA		✓	✓	
Cluster 5											
A - Consultant psychiatrist (4)	M										✓
A - Consultant psychiatrist (5)	F		✓								✓
B - A/Principal social worker	F										✓
B - Social work team leader	M										✓
B - Community psychologist	F										✓
B - General practitioner	M		✓				UA			✓	
C - SMT coordinator	M	✓		✓		✓	✓	✓		✓	
C - CC Prog Manager	M	✓		✓		✓		✓		✓	
C - MH Prog Manager	M	✓		✓		✓		✓		✓	
D - Youth work manager	M										✓
D - Community youth worker	M										✓
Total personnel = 50 (M=28;F=22)		Tot RF1=		Tot RF1 & /or FG1 = 44;NR= 2M				Tot RF2 = 39			
A - Mental Health = 25 (M=12;F=13)		50+		Tot identified for interview = 42				(M=23;F=16)			
B - Community Care = 21 (M=13;F=8)		Tot A&D=38		Tot IV = 27(M=15;F=12);				LDs = 8			
C - Exec management = 3 (M=3). D=Non-RHB=2M		M=21;F=17		UC=6(M=3;F=3); UA=9(M=4;F=5)				M=4;F=4			

¹³ Clusters 1-4 include personnel who participated in at least one of two area-based focus groups. Cluster 5 includes personnel who did not participate in area-based focus groups and who either attended regional forum or late interview; this cluster also includes executive management personnel (3)

Appendix 3: Focus Group question schedule

Focus Groups 1-4 (Focus groups were tape-recorded and later transcribed)

Each of these focus groups were structured around three key questions as follows:

Overriding question 1

Policy can play an important role in the development of health care services, in this case, in the development of addiction services within this region. A good policy can suggest the health board has a vision of service development. To what extent do you believe the health board has a vision for the development of addiction services, in this region?

Prompt Qs:

- Where does the health board get its vision? Does it take it from central government policy, from research, from bottom-up consultation?
- What are the key components of the health board vision for service development within this region?
- To what extent do you believe service plans in this region reflect the public health as distinct to the disease models?
- To what extent do you believe these distinctions are understood across the health service system, including management and practitioner levels?

Overriding question 2

The health board has indicated a desire to develop addiction services according to a public health, community plan, putting more emphasis on a broader base of problems and with more of an involvement from Primary and Community Care personnel. What do you consider to be the main personnel implications of this proposal?

Prompt Qs

- What are the training needs for personnel working in these roles?
- Do you believe Community Care people are ready or willing to take on these new roles?
- What new roles would Mental Health personnel have in relation to these service developments?
- Who needs to give clinical direction to these services at a local level?

Overriding question 3

The health board's plans require some level of integration between Community Care and Mental Health personnel. What type of structure do you believe needs to be in place to give shape to this proposed integration?

Prompt Qs

- Does the health board have a record of success in trying to integrate other service areas? If so, what has helped make these work?
- Are there particular obstacles in the way of achieving integration?
- What do you think needs to happen in order to help achieve improved integration?

Focus groups 5-8 (handwritten notes summarising issues that arose were taken of these groups)

These focus groups were structured first, to provide a response to a preliminary data analysis, which included reference to the following:

- (1) a strong sense of failure by the health care system in dealing with the issue of alcohol since *Planning for the Future*
- (2) a fear that field personnel being blamed for the failure
- (3) new change attempts will also fail unless learning from past mistakes
- (4) proposals for service development need to acknowledge role of Mental Health
- (5) also need to acknowledge that Community Care personnel lack interest and engagement with addiction issues
- (6) there are still policy barriers to change and development in addiction services.

Q1 To what extent to you believe that these preliminary findings reflect the reality of addiction service provision within the region?

The focus groups were also structured to generate comment and discussion in relation to updating proposals for enhanced SMTs in the region (see Appendix 5)

Q2 To what extent to you believe that these proposals represent a way forward for the development of addiction services within this region? What are the strengths of these proposals? What are their weaknesses? Can these proposals be improved, prior to bringing them to the next scheduled regional forum for further discussion and decision?

Appendix 4: Individual interview schedule

Interviews proceeded according to main headings, using questions as prompts. A lot of flexibility used in this schedule, depending on the interviewee and the general direction in which interviews went.

(Interviews were tape-recorded and later transcribed and analysed)

- 1 **Your background and involvement with addiction issues:** Start with your background. How did you become professionally involved with addiction issues? What is your history with this job? When? Why? What was your early expectations? Hopes? What do you consider to be the main aims of addiction interventions? How are these achieved? What is your training / qualification?.....How did the issue of addiction first represent as a serious issue for you in your ongoing management (other work)?
- 2 **Pre-Planning for the Future:** For persons with a history of addiction work prior to mid 1980s: Can you describe your work – and the work of the hospitals - with persons with alcohol problems, at the time? What was the procedure for admission? What contact was there with family, external professionals? What therapeutics were used? Counselling models? Groupwork?
- 3 **Impact of Planning for the Future:** What is your sense of the envisaged impact of the proposed changes in PFTF for the work around alcohol, at the time? What impact did PFTF have on staff, in terms of their professional expectations, professional development? What exactly did happen as a result of PFTF. What is your sense of the decisions that were taken within Mental Health management in responding to PFTF?
- 4 **Relationship between Mental Health and the wider community:** How would you describe the relationship between Mental Health and the wider community? Does Mental health promote itself into the wider community? What perceptions do community members have of Mental Health services? What expectations does the community have of Mental Health services in relation to alcohol?
- 5 **Relationship between Mental Health and Community Care:** How would you describe the relationship between Mental Health and Community Care? What mechanisms are in place whereby personnel from both programmes can meet and agree matters in common? To what extent have personnel from both programmes put in place mechanisms for joint working with shared clients?
- 6 **The development of CASs :** When did you first hear about the development of these services ? What expectations were there in relation to these services? Did people feel hopeful? What changes do you believe people envisaged as a result of setting up these new services? Was there any uneasiness about change?

- 7 **The development of SMTs :** When did you first hear about the development of these services ? What expectations were there in relation to these services? Did people feel hopeful? What changes do you believe people envisaged as a result of setting up these new services? Was there any uneasiness about change?
- 8 **For counsellors who are working with either CASs or SMTs:** How did you become involved with CASs / SMTs? What training did you have? What was / is your typical daily routines in these services? What supervision do you have? Explain to me the procedure you would normally adopt for receiving a new referral? How does this get managed? How are decisions taken to work with a client? Who gets assigned the case etc. Are you part of a team? How does this team function and work? How does it go about making decisions? What procedures are in place for monitoring clients progress? What is your expectation of working with clients? What therapeutic goals do you pursue? What do you believe to be the most appropriate models of care? Describe your direct work with hospital admission / ward personnel? Describe how you work with voluntary agencies, such as Minnesota Model programmes? Describe how you work with community bodies, such as local prevention projects?
- 9 **Demands from the Community:** Have community bodies or community members made direct representations to you or your colleagues in relation to the future development of addiction services? What has been the nature of such representations? What information has been brought to your attention through these representations? What expectations do community representatives have in relation to the development of addiction services? What is your attitude and that of your colleagues in relation to working closely with community bodies?
- 10 **National Drug Strategy:** What are your thoughts / reflections in relation to the National Drug Strategy and its likely impact on the development of services within this health board region? Do you believe the Strategy reflects addiction problems as experienced within this region? What improvements, if any, would you like to bring to the Strategy?
- 11 **National Alcohol Policy:** What are your thoughts / reflections in relation to national alcohol policy? Do you believe we have a coherent alcohol policy? Are you affected in your work by the existence o not of an alcohol policy? What, if any, policy changes would you like to see happening?
- 12 **RHB and change management:** What are your thoughts / reflections on how the health board has set about changing the focus of addiction services in recent years, and in managing the change process? Do you agree with the changes that are being proposed? Do the change proposals pose any particular difficulties for you in your work? Would you envisage changing these proposals? What would you recommend by way of change?

- 13 **Confidence for Future:** How confident are you that the health board can bring together a coherent plan for future service development? What do you believe needs to happen to ensure there is coherence in service development? What confidence do you have that Community Care and Mental Health personnel can develop good working relationships and arrangements for the future?

Appendix 5

AN OUTLINE OF COUNTY-LEVEL SUBSTANCE MISUSE TEAMS

A regional forum held within the context of this study fully supported a proposal to provide, at county levels, Substance Misuse Teams, that would have a range of services, with varying levels of intensity, corresponding to the severity of problems encountered. This forum, which had an attendance of over 70 persons, was attended by senior executive management, straddling both Mental Health and Community Care, various Community Care and Mental Health Managers, personnel from Community Alcohol Services and Substance Misuse Teams, and other personnel with a direct practitioner and management involvement with addiction issues.

The proposal was seen as consistent with the stepped-care model as outlined by Sobell & Sobell (1993). A similar model, based on four tiers of intervention, was outlined by Gilvarry and NHS Health Advisory Service (UK) (2001) and this was also adopted by the *Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems (Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems, 2005)*.

In this treatment model prospective clients are able to access those services that are most appropriate to their needs and to have a continuum of care according as their situation progresses or remits. For example, on the one hand persons with mild to moderate drinking problems would benefit from brief interventions, consisting of practical advice and information, while on the other, persons with serious dependency problems or who lack social, family or material supports and / or who have co-related psychiatric disorders, would benefit from more intense treatment, either outpatient or inpatient, depending on the severity of the problem. In this stepped-care approach, treatment is perceived not as a set of different treatment programmes but as a system with different treatment components, that could be provided by different agencies (voluntary and statutory) but have an overall coherence, a shared vision and direction and a common system for planning and development.

The following table summarises levels and interventions within a treatment system as discussed and agreed by the RHB forum.

Level	Interventions
<i>1. Self-change</i>	No intervention – availability of information
<i>2. Assisted self-change</i>	Brief advice intervention, encouragement to participate in self-help groups or to link in with community / voluntary project, GP or other community-based projects / personnel
<i>3. Community care / primary care: psycho-social programme</i>	Short-term counselling intervention, integrated with advice / information on co-related issues (housing, finance, employment, education, relationships, etc) + detox and medical intervention (e.g. methadone programmes), as needed.
<i>4. Specialist, outpatient intervention</i>	Daily (or 2-3 times per week) attendance for pre-designed, short duration programmes, drawing from best evidence,(behaviour, social learning, community reinforcement) + detox and medical intervention (e.g. methadone programmes) as needed.
<i>5. In-patient treatment</i>	Intensive, residential, pre-designed programme combined with detox (or maintenance) as needed.

These intervention levels are not as easily differentiated as may appear in the table above. Obviously it would be necessary to develop a system of information that would allow for this differentiation and in due course it was envisaged that such information would be derived from caseload practice and management. To develop and implement the model in the RHB it was suggested there would be three key dimensions to service provision at county level – which could mean twin-county or sub-county depending on area and population – as follows. These dimensions are:

- intake / assessment community team;
- outpatient treatment facilities; and
- inpatient treatment facilities.

INTAKE / ASSESSMENT COMMUNITY TEAM

Each county area, it was suggested, should have a core team of drug and alcohol caseworkers / counsellors who would provide outreach contact, intake assessment, who would intervene as appropriate at the lower levels of treatment intensity and who would continue to function as a keyworker or case coordinator in circumstances where a person remained in the treatment system, at other levels. Clearly these caseworkers would need facilities for conducting assessments with persons who should be either able to self-refer (walk-in) on the basis of self-identification of problems, or be referred by professional personnel in community or primary care settings.

Assessment would likely involve enquiring into drug and alcohol use (CAGE or AUDIT (where this has not already been used) to establish whether an addiction problem exists and whether further assessment is necessary; the provision of a brief, motivational intervention where early stage, mild to moderate problems are indicated, or if the problem is more serious taking a full alcohol and drug use history, for example using Addiction Severity Index (McLellan et al., 1992), and a social history and assessing entry to short-term psychosocial programme and /or referral to GP for home detox, or referral to higher level of intensity service

The essential idea behind a walk-in service was that persons who are in distress or who have become concerned about their problems would be able to access advice, counselling and / or assessment within a short period of requesting it. The service therefore would obviously need to be provided in accessible locations and these most likely would need to be able to develop and expand according to the needs and demand of areas. It was envisaged that any request to the service system for an intervention be channelled through this intake team and that protocols for intake assessment would need to be devised and agreed for dealing with co-related disorders, re-referral and coordination.

Although team could undertake most of their work in different community locations it was considered important they be assigned a specific community base in which they

could assemble as a team and undertake administrative and other organisational duties relating to their work. Ideally the base should be located as part of or adjacent to existing Community Care services, but not part of or adjacent to psychiatric hospitals. In addition to having easy access to Primary Care and Community Care social services, it was believed that such co-location would also assist in the much necessary mobilisation of natural community supports and resources in promoting self-change, assisted self-change and in developing community-based psycho-social programmes.

It was also envisaged that team members would allocate clients for short-term interventions on a team basis, although it would be expected that in most instances, where indicated, a short-term intervention would be provided and managed by the same intake person. Short term interventions are possibly best structured around motivational enhancement techniques and indeed, keyworkers should continue a role in motivational enhancement with their clients that enter other programmes at higher levels of intensity.

In addition to their work in undertaking assessments, short-term interventions and as case keyworkers, members of the intake team would obviously have a role in developing relationships and networking with primary and community care personnel, promoting screening and brief interventions, and explaining the overall functioning of the drug and alcohol treatment system. They would obviously also need to be involved with personnel at the next two levels of intervention: outpatient specialist and in-patient specialist.

It was suggested that each intake / assessment community team would have a team leader who would provide guidance, leadership and clinical direction to the team. This should involve one to one supervision of individual cases as well as direction in relation to other aspects of the work, for example linking in with community bodies, with other professional groups, developing assessment skills, procedures etc.

As an intake team would be likely to operate in a variety of different settings, albeit with the same assessment / intervention protocol, it was suggested that the team have a diverse range of staff skills and competencies, drawing in personnel from social work / youth services in addition to addiction counsellors and other health care

workers. The idea, of staffing community intake services with “alcohol” or “addiction” counsellors exclusively would need to be set aside to incorporate a more generic model consisting of personnel who have the appropriate skills and training to both manage individual cases across a range of community-based disciplines and community agencies, and who are also able to engage Primary and Community Care service personnel in an involvement with these issues. It is difficult to envisage such roles fitting the brief of practitioners whose primary focus is counselling. It was considered important that the team have a social worker assigned to deal specifically with cases involving child welfare issues and also that it be assigned a liaison professional from Mental Health services to facilitate assessment and / or intake to the Mental Health system, where co-related psychiatric problems are indicated, as appropriate.

OUTPATIENT TREATMENT FACILITIES

At the time of writing the RHB has no specialist day programmes that involve daily or regular attendance, for persons with drug and alcohol problems. It was envisaged that such programmes were needed and should be provided either directly by health board personnel and in health board premises, or alternatively by way of contract to external, not-for-profit bodies. It was perceived that voluntary organisations could bring an important vision and mission to the development of such programmes, provided they operated within the parameters of an overall service plan. It was envisaged that a variety of programme types - incorporating educational, vocational elements as well as psychotherapy – could be provided. It was suggested that particular attention be given to programmes that are based on social skills development, cognitive – behavioural therapy and community reinforcement therapy. As a way of proceeding with developing day programmes it was suggested that RHB management invite proposals, both internally and externally, for the development of such programmes on a county basis and also that the probation service / courts be drawn into the funding and development of such programmes.

INPATIENT FACILITIES

It is clear from the discussion throughout this study that the RHB has substantial current capacity for in patient treatment both in Mental Health services and through non-psychiatric services operated by voluntary bodies. It was considered that these forms of provision needed some restructuring in order to establish proper continuity with other services, particularly so that in-patient services would be seen as an important stage for the treatment of persons who have not been able to respond to non-residential treatments or whose problems are particularly severe. It was envisaged that all inpatient and residential facilities would need to be planned, developed and monitored in the context of consistency with overall policy and a continuum of care, and with adequate mechanisms and protocols to achieve integration with outpatient and intake services.

Appendix 6: HSE administrative areas

■ Location of HSE's Four administrative Areas and 32 Local Health Offices

Figure 2: HSE's Four Administrative Areas and 32 Local Health Offices

