

Discourses in drug treatment

'Exploring the meaning of drug treatment in the Crinan Youth Project'

By

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To

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Dedicated to the memory of

Uncle Tom

1924-1993

Abstract

The Crinan Youth Project is a systemic treatment programme for young people in Dublin who have developed personal, social, learning, economic and legal difficulties as a result of their use of heroin. This qualitative research inquiry examines the meaning of drug treatment in this project through the lens of adult and community education. The research methodology involved in-depth interviews, theatrical workshops and participative observation. The research looks critically at the discourses of medicine, therapy and education through which the Crinan Youth Project is constructed. Theatrical language is used at times to present the complexity of drug treatment as a drama and point of convergence between conflicting scripts, languages and discourses played out by the actors and stakeholders of drug treatment.

The research found that this drug treatment drama is dominated by a medical discourse and the prescription of methadone. The medical discourse secures and maintains its powerful position in the drug treatment services through the concept of hegemony. Medicine through psychiatry has become a powerful institution and controlling influence in defining and shaping addiction and mental health services in Ireland.

The research also found that psychotherapy supports this medical dominance in the treatment of addiction in return for its own script and central part in the drama of drug treatment. Furthermore the research highlights critically the position adopted by community development within the educational discourse in failing to perceive or challenge this medical hegemony in drug treatment.

What has developed as a result is a range of medical led services treating what is primarily a social problem, with a medical solution that is clearly not working. In this context vulnerable young people are construed as heroin addicts and prescribed methadone based solely on a medical definition of addiction. A medically dominated approach to drug treatment is failing to facilitate young people in becoming the authoritative authors of their own script as empowered citizens.

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Chapter 1

Introduction

Introduction

By the mid 1990s the drug heroin had taken root in the northeast inner city of Dublin where a number of young people had died tragically as a result of their drug use (Butler, 2002b). The community had grown intolerant with the lack of Government action and a new wave of street protests were galvanized by the anti drugs movement coordinated by the community network Inner City Organisations Network (ICON). The consensus expressed by ICON at the time was that there was a lack of treatment options available for young people who wanted support to stop using heroin. The community lobbied for extra resources to provide treatment and prevention programmes as well as new community structures to tackle the drug problem systematically. The Health Board in partnership with the community developed the blue print for a specialized treatment programme for young people experiencing problems associated with heroin use. This project came to be known as the Crinan Youth Project.

The Crinan Youth Project

The Crinan Youth Project was established in 1996 in response to the increasing need for a specialized treatment option for adolescents with a range of behavioral, educational, legal, and health problems, associated with opiate dependency. The Crinan Youth Project employs a multi-disciplinary team of professionals who managed in partnership with the community and the Health Board (Crinan Youth Project, 2001).

The Crinan Youth Project understands the problem of opiate dependency not only as a problem concerning the individual or the individual family but also as a profoundly social problem with roots in the socio-economic and historical realities of the north inner city of Dublin. Consequently the project offers a therapeutic, educational and recreational response, which integrates personal, group and family therapy with models of community development.

Particular attention was given to designing a programme that would be attractive to adolescent drug users presenting with a wide range of needs, compounded by opiate dependency. The project takes referrals as young as 15 yrs of age from the north inner city area. Assessment is carried out by the therapeutic team, with the focus is on the needs of the young person and their families. The programme runs from 10.00am to 4.00pm, from an inner city community based premises staffed by a multi disciplinary team catering for their medical, psychological and social/ educational needs.

Medical

The young people attending the programme are under the care of a sessional general practitioner for medical assessment and when required methadone stabilization and detoxification. When the project was established, it was thought that any methadone detoxification would be of sufficiently short duration to ensure that the young person does not become addicted to methadone. Yet, it was also understood that they would have to be given enough methadone to successfully detoxify them.

Psychological

The young people attending the programme will be seen by an addiction counsellor on a weekly basis and by a family therapist monthly basis with relevant family members. Two project workers provide psychological and emotional support to the young people on a daily basis supporting them with a wide range of social, educational and employment issues. The premises, is suitably designed to facilitate one to one therapy, family therapy and provide a safe therapeutic environment where the team can build a trusting therapeutic relationship.

Social/ Educational

One third of the young persons time in the project is spent between occupational, educational and social learning activities. As a general principle the occupational and educational component targets the talents and skills that are innate in each individual. Working in

collaboration with local community educational and training project the Crinan Youth Project seeks to address the underlying causes of drug use and dependency. The young people are linked into local recreational services to give them alternative and constructive ways to use their leisure time.

The projects mix of occupational, recreational, educational, therapeutic and medical input aims to be of sufficient variety and intensity to engage the young people in the programme. Every effort is made to make the programme attractive to young people and to tailor it to meet their needs. The programme blends educational and recreational activities and includes; literacy, art and design, yoga, computer skills, personal and social education, physical training and a range of health education. The young people participate in the designing of the programme and help in regular programme evaluations.

The project has contributed hugely to the local community and to our knowledge about drug treatment and rehabilitation of young people. This research sets out to explore that learning in more detail, while looking critically at aspects of the programme that contribute to the further medicalization of this vulnerable section of our society.

Starting point for this research

As one of the key players involved in the establishment and early management of the Crinan Youth Project, I maintained an interest in the project's development. As time passed I became concerned with the project's increasing dependence on methadone and critical of the dominant position methadone had secured within the treatment programme. I felt the educational component had become marginalized and underdeveloped as a result of the project's dependence on methadone. So when the opportunity arose for me to conduct a PhD through research I decided to examine the dynamics and meaning of treatment in the Crinan Youth Project. Why had methadone come to dominate drug treatment for heroin users and addicts? Why was education not having more of an impact in the Crinan programme and life of the young person in treatment? Asking these questions, I set out to examine the meaning of drug treatment in the Crinan Youth Project.

I came to this inquiry with my own set of assumptions about drug use, addiction and treatment. I believed in the potential of adult and community education to transform, enable and empower individuals and communities to solve the heroin problem. I assumed a key role for adult and community education in the treatment and rehabilitation of young people seeking help with their drug problem. I believed that the input from the community educator in drug treatment was as important as that of the doctor and therapist. This input needed to be researched, understood and articulated in order to add credibility to the role of the community worker and educator and those who valued adult education in drug treatment.

Chasing the wrong dragon

There is a strong belief echoed in this research that heroin is not the real problem that many of these young people experience. The heroin problem may in fact be a myth. A myth is a collective story repeated over time and eventually people believe it to be true. By constantly focusing on heroin as the problem we avoid confronting the social and economic conditions in which the drug takes root. The heroin problem is a symptom of the social and economic history of the northeast inner city of Dublin. The decimation of the inner city from years of government neglect created the conditions in which heroin would take root. Young people growing up in this situation are deeply affected by the experience of poverty, social exclusion and educational disadvantage. There are many in the Crinan who feel that they are treating a social problem with a medical solution and it is clearly not working.

The drug treatment drama

John Watson co-editor of 'The Double Helix' (Watson and Stent, 1980) recently gave a lecture in Trinity College Dublin. There he described DNA as messengers carrying the instructions for living. The human book he suggested was made up of 35,000 genes, messengers or actors with the instructions and scripts that make the human drama possible. Comparing this human drama with its 35,000 actors to a film he said he could only follow about five actors in a plot without getting confused. The simple bacteria have about a 1,000 genes. So the play in the life of bacteria involves a 1,000 actors interacting in a large variety of ways.

The analogy of life as a play involving thousands of actors is a useful one when exploring in more detail, aspects of the human drama. This research is concerned with the drama of addiction treatment and the lives of young people who use heroin in the northeast inner city of Dublin. It is a drama involving many different actors each with their own script and part to play in this theatre of drug treatment. A different script informs each part of the play with certain actors seeking to dominate the outcome of the play as the story unfolds.

The actors

The young person

The young people are the chief protagonists and performers in this drama. The drama centres on them at all times. There is a conflict between the young person who uses heroin and the State who made its use illegal. The young people in this play come from the northeast inner city of Dublin, a community besieged by decades of economic and social decline.

The community

The northeast inner city of Dublin is a resilient community that has organized itself to fight economic and social decline. Inner City Organisations Network (ICON) is the central player and voice of the community on issues of unemployment, education, housing, culture, young people and fighting the drug problem. ICON played a central role in the establishment of the Crinan Youth Project.

The doctor

The doctor is one of the main antagonists in the treatment drama. The antagonist plays the opposing role to the protagonist in any play. There is usually a conflict between the protagonist and antagonist. They want different things. It is this conflict that is at the heart of this treatment drama. The doctor approaches drug use and addiction through the paradigm of biomedicine. Biomedicine sees drug addiction primarily as a biological disease and treats it medically. In this case the treatment for heroin addiction is methadone.

The therapist

The therapist is another key antagonist empowered by the project to help the young person to give up using heroin. The therapist sees drug addiction through the paradigms of psychology and the social sciences. Within psychology and psychotherapy there are multiple theories and models for interpreting addiction. The role of the therapist is to support the drug user in their choice to stop using heroin and reduce the risk of relapse. The therapist and doctor have an aligned relationship in the treatment drama.

The community/youth worker

The community/youth worker dominates the play with their energy and commitment to the project and the goal of enabling the young people to come off heroin. Professionally the community/youth worker, works the hardest, is the most versatile and creative but earn less pay and status than the doctor or therapist. The community/youth worker is strongly aligned to the community (ICON) and to the young people and their families.

The scripts

A script usually refers to a text of a play. In the Crinan Youth Project the term 'script' also refers to a persons methadone script or prescription. I use the term script here metaphorically to describe the various texts and narratives that inform drug treatment. The Crinan Youth Project was designed to integrate several scripts that could enable and empower young people to come off heroin and remain drug free. The dominant scripts in the Crinan play are shaped by medicine, therapy and education. By combining these scripts Crinan believed it could significantly influence the young person choice to stop using heroin and remain drug free.

The focus of the inquiry

The research examines these scripts in more detail exploring their epistemological assumptions. The dominant scripts in this play are shaped by the discourses of biomedicine, psychotherapy and education/development. The identity of the young heroin addict is constructed through a series of discourses, which act to dominate, control, disempower, oppress and sedate the person. The research will seek to decode these discourses, decipher their epistemological assumptions and explore how they function in the construction of the heroin dependent identity. The research also seeks to shed new light on the epistemological framework of the Crinan treatment programme and its effect on its participant's identity, self-knowledge and sense of agency, using qualitative methods to deconstruct the oppressive

discourses at the root of dependency and facilitate participants to become the authoritative authors of their own script.

The research takes place in a context where medical and therapeutic knowledge dominates the conversation when it comes to defining solutions to heroin addiction among young people in the North East Inner City of Dublin. According to Ivan Illich, 'Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people' (Illich, 1977: 13,14). This research examines this conversation and looks at other sources of knowledge in particular from the field of adult and community education.

The epistemology of treatment and rehabilitation of young drug users in inner city Dublin remains the central focus of this inquiry. This research will show that treatment for heroin users is dominated by the use of methadone as a substitute and that this policy reflects the ascendancy of the medical discourse in drug treatment.

Conclusion

This thesis draws together the threads of the research from the concepts that shaped the focus of this inquiry, its research methodology, the data and its analysis to its findings, implications and conclusions. Chapter two examines in brief the substance at the heart of this drama – heroin, the concept of addiction and the various treatments used in the treatment of heroin addiction. Chapter three looks at the discourse of adult and community education and its perspectives on heroin use and its treatment. Chapter four examines critically the biomedical discourse on drug treatment and asks how did medicine come to dominate the field of heroin addiction. Chapter five examines the literature on psychotherapy and its role in the treatment of addiction. Chapter six looks at the research methodology used to conduct this inquiry. Chapter seven presents a summary of the data reconstructed after data analysis as a script for the play that this drama is trying to understand and present in a new light. Chapter eight introduces the findings and Chapter nine examines the main finding of this research – the existence of a biomedical hegemony in the treatment of heroin addiction in Ireland. Chapter ten takes a critical look at the role of psychotherapy in drug treatment and asks why it supports the existence of a biomedical hegemony. Chapter eleven finally looks at the drama of drug treatment from the perspective of adult and community education. This chapter presents the challenges and opportunities facing adult and community education if it is to become a legitimate source of critical knowledge in this area. Finally the thesis concludes with a summary and reflection on the main findings.

Chapter 2

Heroin, addiction and its treatment

Heroin

Heroin is a drug surrounded by myth. No drug has been more argued over and legislated against and no drug has been subject to misinformation and moral panic than heroin (Carnwath & Smith, 2002). The most persuasive myth about heroin is that once you've tried it you become addicted. Connected to this myth is that if you want to stop using heroin you will need to be prescribed the substitute drug, methadone. This research questions these myths and examines the drug and its treatment in detail. A brief look at the history of heroin will set the scene for a more detailed examination of treatment for those who develop problems with the drug.

Heroin is made from morphine, the principle active ingredient found in the opium plant, which has been used for its psychotropic qualities for centuries. Walton (2001) suggests that intoxication has formed an integral part of human cultural development since classical Graeco-Roman times. Modern use of opium for medicinal and recreational purposes began in Europe in the sixteenth century. Until the Pharmacy Act of 1868 opium could be bought and sold by anybody in Britain. In 1803 Freiderich Serturner isolated morphine from opium, but it was not until the invention of the hypodermic syringe in 1856 that morphine injections were used to treat American civil war casualties already accustomed to opiates. In 1874 British chemist, C. R. Alder Wright found that boiling morphine with hydride produced diamorphine. By 1898 diamorphine or heroin as it became known was marketed and used in patent medicine remedies for the treatment of chest pain, pneumonia and tuberculosis (Carnwath & Smith, 2002: 18).

By the end of the nineteenth century the medical community began to see the growing seriousness of opiate addiction. Morphine addiction was widespread in the United States and Europe. The opium wars had introduced opium to China from Britain and between 1852 and 1870 many of 70,000 Chinese who came to America to work on the railroads and in the gold mines smoked opium (Courtwright, 2001). There was growing public concern about the

increased number of opium addicts. The prohibitionist movement in America was at the forefront of highlighting these concerns at the time.

Significant changes occurred when in the United States the Harrison Act in 1914 banned the use of all narcotics, except for medical purposes. Although the Act was intended to licence and tax the importation, manufacture and sale of opium, it was used to prosecute drug addicts, distributors and doctors who prescribed to addicts (Fernandez, 1998: 28). The British Dangerous Drugs Act was passed in 1920. These new laws meant heroin use was driven under ground and became associated with those already on the margins of society. Heroin came to be demonised and credited with an increase in society's problems.

In 1923 as part of the Geneva Convention a system of licensed manufacture and of export and import licenses was introduced. Heroin continued to be produced and sold until after the Second World War when the United Nations introduced international controls for the manufacture and supply of the drug for medical purposes only. World production of heroin dropped as it became illegal to import, produce or sell heroin in most countries.

Illegal factories emerged across the world to meet the needs of the heroin market. The demand for heroin increased under the conditions of the black market. In the United States Harry Anslinger led the fight on drugs relying on a simple principle, 'get rid of drugs, pushers and users' (Courtwright, 2001). He had some success in reducing the numbers of opiate addicts from 200,000 in 1924 to 20,000 in 1945. Courtwright argues that this fall in the numbers of addicts could be attributed to changing medical practices and the disappearance of an older generation of medical addicts. Despite these facts Anslinger's approach became the template for the war on Drugs policy initiated by Nixon and the Criminal Intelligence Agency.

In Courtwright's history of Opiate addiction in America *Dark Paradise*, he argues that it is impossible to separate the social history of drug use from its political history. His principle conclusion:

Shows that a shift in the addict population, from one that was predominantly middle-class, female and medical to one that was lower-

class, male, and non-medical, served as the critical precondition for the criminalization of American narcotics policy. (Courtwright, 2001: xi)

This trend was later reflected in Britain and Europe and eventually in Ireland when confronted with its own heroin crisis in the late 70s and early 80s. Heroin only took a serious hold in Europe in the 1970s. In Britain there were 1,299 registered addicts in 1967. The rate continued to increase in the seventies, spiralling from 5,000 in the 1980s to 50,000 in the late 1990's and the figure continues to rise by about 20 per cent per year (Carnwath & Smith, 2002).

In 1966 a policy document on mental illness in Ireland concluded that Ireland had as yet avoided serious drug use and addiction problems. The first clinical evidence of amphetamine dependence was reported in 1966 (Walsh, 1966). There was no clinical evidence for heroin until 1980 when there was a sudden and dramatic rise in its use by young people from the inner city areas of Dublin (O'Brien & Moran, 1997).

Today there is an estimated 14,450 heroin-users in the Republic, of whom 12,456 are in the Dublin according to the National Advisory Committee on Drugs (The Irish Times, 7th May 2003). The number of people (aged 15-64) with a drug problem in Europe varies from two to ten cases per 1,000 head of population. The Netherlands, with its liberal stance on cannabis, shows the lowest rate of problem drug use in the EU, at 2.6 cases per 1,000. Ireland falls into the upper percentile, with 5.7 cases per 1,000 (European Monitoring Centre for Drugs and Drug Addiction, 2001).

Heroin addiction

Peele (1985) argues that the biological model for understanding heroin addiction is disputed by a vast array of evidence.

Every naturalistic study of heroin use has confirmed fluctuations, including switching among drugs, voluntary and involuntary periods of abstinence, and spontaneous remission of heroin addiction (Maddux and Desmond 1981; Nurco et al 1981; Robins and Murphy 1967; Waldorf 1973, 1983; Zinberg and Jacobson 1976). (Cited in Peele, 1985: 8)

These variations make it difficult to define a point at which a person can be said to be addicted. There is evidence to show that large numbers of people have used heroin and did not become dependent or addicted (The 1999 National Household Survey on Drug Abuse). The US National Household Survey on Drug Abuse found that over 3 million people had used heroin at some time in their lives, but only 208,000 had used during the last month. Put simply, 93 per cent of those who had used heroin, had either given it up or were no longer using dependently. It seems many people can use heroin for a while and give it up without ever requiring treatment.

Robins et al.'s (1975) research on Vietnam veterans who had been addicted to narcotics in Asia found that only 14 per cent became re-addicted when they returned home. Harding et al. (1980) reported on a group of addicts in the United States who had all used heroin more than once a day who were now controlled heroin users. Waldorf (1983) found that former addicts who quit on their own, used the drug later without becoming re-addicted (Peele, 1985: 8).

The media and drug commentators in the United States seemingly feel obligated to conceal the existence of controlled heroin users. (Peele, 1985: 9)

By portraying heroin use in the most dire light at all times, the media apparently hope to discourage heroin use and addiction. Our ideas about heroin have up until recently been coloured by the fact that most of our knowledge comes from those users who cannot control their habits. McIntosh and McKeganey (2002) argue that the perception of addiction as a fixed endpoint characterised by personal and social dissolution, fails to recognise that many dependent drug users manage to overcome their dependence without the assistance of helping agencies. Indeed, it has been suggested that the proportion of addicts who manage to overcome their addiction without formal treatment may either match or be greater than the proportion who recover following treatment for their addiction (Waldorf and Biernacki 1979, Stall and Biernacki 1986, Cunningham, 1999).

In reality it is the combination of factors such as quality of drugs that are taken, frequency with which they're taken, how rapidly they're taken and the general state of emotional and mental health of the individual concerned, that determine whether addiction develops or not

(Haskings, 2003, 117). A brief look at the literature on addiction will help to locate my argument in the broader context of addiction research.

Addiction

The conventional idea of addiction, that a substance or an activity can produce a compulsion to act in a way that is beyond the individual's self-control is a powerful one. Stanton Peele in *The Meaning of Addiction* (1985) challenges the popular belief about addiction where by:

An entire set of feelings and behaviours is attributed to the unique result of one biological process. Only compulsive consumption of drugs and alcohol – conceived as addictions is believed to be the result of a spell that no effort of will, can break. (Peele, 1985: 1)

In reality addiction affects every one of us. The use of addictive substances, from sugar, caffeine in tea, to alcohol and cigarettes is part of everyday life for most.

Number of people dependent/addicted (Holford, 2003: 264)		
(% of UK population)		
Nicotine	15 million	(25%)
Caffeine	12 million	(20%)
Alcohol	4.6 million	(8%)
Tranquillisers	1.5 million	(2.5%)
Heroin	150,000	(0.25%)
Cocaine	16,000	(0.0003%)

The mythology surrounding heroin use and addiction distracts attention away from the substances that are costing society more in social, economic and health terms.

The cost of the Irish drug habit (*Sunday Independent*, 24th August, 2003)

Alcohol	Tobacco	Illegal Drugs
€2.5 Billion 1.9 per cent of GDP	€1.5 Billion 1.6 per cent of GDP	€350 Million .27 per cent of GDP

Alcohol consumption in Ireland rose by 41 per cent between 1989 and 1999. Ireland now tops the EU drinker's list. It is estimated that alcohol is costing the Irish economy €260 million on lost productivity, in the extra cost of dealing with increased public disorder and in extra health care costs, as half of all causality admissions are linked to excessive alcohol consumption (*Sunday Independent*, 18th May 2002).

It is difficult to identify the full scope of the problem of drug use. The very nature of drug use means that people will tend to hide evidence that they are users. In America in 1997 70 per cent of those people who used illicit drugs had full time jobs (Doweiko, 2002). This makes it difficult for researchers or the general public, to comprehend easily the trends in drug use as they evolve. Drug use trends develop over months and years and their immediate consequences are not always obvious.

Many people confuse chemical/substance use with abuse and addiction (Doweiko, 2002). These terms are often mistakenly used as though they were synonymous, even in clinical research studies (Minkoff, 1997). In reality, most drug use and misuse is on a continuum between abstinence and physical addiction (Kaminer, 1999). Little is known about people who use drugs on a social basis as they manage to control their use and avoid coming to the attention of the authorities and treatment agencies.

Addiction remains a widely used and misused concept employed to describe a range of drug and non-drug related behaviors. Professionals speak of people being addicted to food, sex, gambling, women, shopping, credit cards, unhappy relationships, and the internet (Peele et al., 1991). As we will see in the next section there are different models used to interpret addiction and theories used to understand this elusive concept.

Models of addiction

There are different models used to interpret and understand addiction. A model is an overall framework for looking at reality e.g. addiction. Models are like paradigms shaping the way we interpret reality. Models are usually broad and general. We tend to choose models that will support our interpretation of reality. Here are the dominant models that shape our thinking about addiction.

The moral model

Alcohol had personal, social and commercial value in colonial America up until the 17th century. Alcohol was used as a medicine to kill pain, fight fatigue, soothe indigestion, and prevent fever. Drinking was believed to contribute to social well-being and trade and alcohol provided an important source of revenue for the early colonists. In the 17th century the domestic distilling trade took off and became an indispensable element of economic expansion westward (Rasmussen, 2000: 24). This led to an increase in alcohol consumption and the rise of the temperance movement which saw overindulgence in alcohol as sinful and immoral. Morality refers to feelings, which people have about right and wrong, or good and bad. The failure to resist the temptation of alcohol was a sin. The treatment for such moral failings tends to concentrate on punishment, or on 'saving' the person, often by religious conversion.

The temperance movement is associated with the most recent widescale usage of this moral explanation of alcohol and drug problems. Alcohol and drug abusers are at fault in this explanation – they have a bad or sinful character (Hamilton, 1998). In Ireland the Pioneer Total Abstinence Association founded in 1898 was firmly institutionalised within the Roman Catholic Church. Levine (1992) makes the point that Ireland never had a 'temperance culture' based on the idea that alcohol was inherently evil. Levine suggests that temperance cultures of this kind are uniquely associated with Protestantism. The Irish Pioneer movement, while acknowledging the potential and actual harm resulting from alcohol consumption, reflected the mainstream Roman Catholic view of alcohol as inherently good (Butler, 2002: 19).

Many moral objections to drug use reflect a notion developed by Gerald Klerman, the notion of 'pharmacological Calvinism', what he describes as a 'general mistrust of drugs used for non therapeutic purposes and a conviction that if a drug 'makes you feel good, it must be morally bad' (Klerman cited in Murphy, 1996: 43).

The legal model

The legal model is embodied in the war on drugs and the criminalization of drug users. Following the revolutionary war, the United States experienced a sudden growth in population. Alcohol production and consumption increased as well as excessive drinking and public disorder. The growing awareness of the harmful effects of alcohol and drugs such as cocaine and opium prompted the enactment of laws to control the possession and distribution of drugs. The Harrison Narcotics Act (1914) was the first act passed by a nation establishing the word *narcotic* as a legal term. Ireland has a raft of legislation from the Misuse of Drugs Act 1977 to the Drug Trafficking Act 1999 aimed at reducing the supply of illicit drugs getting on to the market. However despite legal attempts to control the supply and demand for drugs it is widely recognized that the war on drugs is a phoney war.

Prohibitionists stress the intrinsic harm that drugs do and they believe that sanctions will make people refrain from using them. Anti-prohibitionists agree that drugs can be intrinsically harmful but believe that the prohibitionist approach will not succeed in keeping people from using drugs (Inciardi & Harrison, 2000: 119).

The legal regime of drug prohibition criminalizes large numbers of young people for whom drug use is problematic neither to themselves nor to society (Paraskeya, cited in Murphy, 1996: 55). Murphy (1996: 1) suggests the tendency of political figures and media is towards simplification of the issues into a single threatening entity, 'drugs', against which we have no choice but to wage war.

The disease or medical model

The idea that drunkenness is a disease was common among doctors in the 18th century. In 1790, Dr. Benjamin Rush described a disease syndrome caused by alcohol and characterized by individual moral and physical decay. However it was not until after the World War II that the disease concept of alcoholism re-emerged as the dominant explanation. The disease concept began to be used with drug abusers with the intention of changing public attitude from one of blame and punishment to one of concern and treatment (Cunningham et al., 1996). The disease concept was championed by Alcoholics Anonymous and the subsequent publication of *The Disease Concept of Alcoholism* 1960. Since then the World Health Organisation has recognized alcoholism and other drug addictions as diseases (Rasmussen, 2000: 28).

The disease model did not originate from scientific research. It came first from religious thinking about social problems among Protestantism and the nineteenth century temperance movement (Schaler, 2000: 2). The disease model constructs the addict as a sick person unable to control his/her habit. The only cure is abstinence and medical treatment. Once exposed to the drug the diseased person is unable to control the addiction at will. Controlled use of the drug is not an option, for once an addict always an addict. The disease concept of addiction lifts the responsibility for the addict's behavior. The possibility of choice is removed. The drug takes over and becomes responsible for the person's behavior. Physiological and biological processes are used to explain addiction and validate the disease conception of addiction.

Theories of addiction

Models give us general frameworks to understand addiction and as we have seen there are three dominant models for interpreting addiction. Theories on the other hand provide us with a set of concepts we can use to define and explain a phenomenon like addiction. Theories address phenomena with much greater specificity than models. Theories deepen our understanding of a phenomenon by connecting concepts in a meaningful way. Theories and models help practitioners to describe, explain, predict and control phenomena (Rasmussen, 2000: 23).

Biological theories of addiction

The biological model is based on the assumption that if you introduce a narcotic to the body it causes a metabolic adjustment that requires continued and increasing amounts of the drug in order to avoid withdrawal. No alteration in cell metabolism has yet been linked with addiction. Endorphin theorists have suggested that regular use of narcotics reduces the body's natural endorphin production, thus creating a reliance on the external drug for ordinary pain relief (Goldstein, 1976b). The dominant biological theories of addiction focus on disease, genetics and pharmacology.

Peele (1985) challenges the biological model and provides an important alternative view on addictive behaviours. Addiction is defined by tolerance, withdrawal and craving. The inadequacy of the conventional concepts lies not in the identification of these signs of addiction as they do occur, but in the process that are imagined to account for them (Peele, 1985: 1).

Exclusively biological concepts of addiction are ad hoc and superfluous and that addictive behavior is no different from all other human feeling and action in being subject to social and cognitive influences. (Peele, 1985: 2)

Disease theory

The disease theory of addiction has been widely misused and misapplied. Doweiko (2002: 40) sees the guardians of social order – the courts and the lawyers assuming the power to define who have the disease of addiction and how it must be treated. There are many health care professionals and scientists who maintain that there are no biological or personality traits that automatically predispose people to become addicted to drugs. Some researchers question the contention that alcohol or drug addiction is a disease. Others concede that there is evidence of biological or psychological predispositions towards drug abuse but maintain that certain environments forces are needed to activate biological and psychological predispositions towards addiction (Doweiko, 2002: 30).

Many people believe that addiction is a disease because doctors say it's a disease (Schaler, 2000: 13). Being attracted to members of ones own sex was considered a disease by the psychiatric profession until the American Psychiatric Association declassified it as an illness in 1973. People who support the disease model of addiction appeal to certain socially unacceptable behaviors resulting from certain addictions. Yet the fact that a behavior creates terrible problems does not show that it's a disease. Schaler points out that many treatment professionals have a significant economic investment based on the concept that addiction is a disease. The more behaviors that are diagnosed as diseases, the more they will be paid by health insurance companies for treating these diseases (Schaler, 2000: 15).

Studies showing that craving and relapse have more to do with subjective feelings and beliefs than with chemical properties, call for a reinterpretation of the essential nature of addiction (Peele, 1985: 18). According to Peele, there are no biological indicators that can tell if a given individual is addicted.

We decide the person is addicted when he acts addicted. We cannot detect addiction in the absence of its defining behaviors. In general we believe a person is addicted when he says that he is. No more reliable indicator exists. (Robins et al., 1975 cited in Peele, 1985: 18)

There are four main problems with the disease notion of drug addiction. Firstly there is no independent means of verifying the existence of the disease. Secondly drug abuse appears to

fall along a continuum of disordered behavior as opposed to a binary (yes/no) perspective often attempted to define a disease. Pathology requires an identifiable alteration of bodily tissue, a change in cells of the body for a disease classification. No such identifiable pathology has been found in the bodies of heavy drinkers and drug users. This alone justifies the view that addiction is not a physical disease (Szasz, 1991; 1994 cited in Schaler, 2000: 16).

A person who becomes drunk and obnoxious once a month may be perceived as an alcoholic in a church going community, but may be considered a fun person in a college dormitory. (Sussman & Ames, 2001: 23)

Thirdly there are many variations in behavioural symptoms that may or may not reflect the same underlying factors (Littrell, 1999). A person who exhibits a periodically problematic drinking pattern and a person who never drank in a controlled fashion, are subject to the same disease histories. Finally to define drug abuse, as a disease requires a leap of faith, as the aetiological factors for drug abuse as a behavioural disorder are not known (Sussman & Ames, 2001: 23).

Peele and Brodsky (1991) state that the disease model of addiction does more harm than good because it undermines one's capacity for self-management. Putting forward the '*life process model*', they advocate that drug abuse is a means of coping with oneself and ones environment. Their perspective is that addiction stems from other life problems the person has and that drug use can be outgrown.

Genetic theory

Genetic theories emphasize the role of heredity in the development of addiction. Brain reward helps explain why a drug or addictive behavior is self-administered. Genetic theories of addiction suggest there are inherited mechanisms that cause or predispose people to be addicted. Addictive inheritance has been most studied in the case of alcoholism. Goodwin et al., (1973) using adoption studies found that children adopted away from parents who were alcoholics were four time more likely to become alcoholics than those whose parents were not alcoholics. Vaillant (1983) also saw some genetic causality in alcoholism but did not support

Goodwin's conclusion. Vaillant found that children with alcoholic relatives and not just parents were more likely to become alcoholics and so it became harder to distinguish between the effects of the alcoholic environment from inherited dispositions (Peele, 1985: 48). However Peele (1985) argues that proposing genetic mechanisms in alcoholism on the basis of concordance rates does not provide a model of addiction.

Not only has no biological mechanism been found to date to underlie alcoholism, but also research on alcoholics behavior indicates that one cannot be found in the case of the loss of control of drinking that defines alcoholism. (Peele, 1985: 49)

Genetic theorists still insist that an inherited genetic vulnerability predisposes people to addiction. The basic problem with genetic models of alcoholism is the absence of a reasonable link to the drinking behaviours in question.

Pharmacological theory

Theories have been used to explain narcotic addiction in terms of an endorphin deficiency that could leave a person more vulnerable to the need for narcotics (Goldstein, 1976 & Snyder 1977). The discovery that the body produces its own opiates called endorphins provided the catalyst for some researchers began to hypothesize about inherited mechanisms to account for differences in addictive susceptibility. Dole and Nyswander (1967) introduced the concept of 'metabolic disease' to describe a tendency to become addicted where by some people might already have such a need when they started taking drugs (Peele, 1985: 51). Such people would then welcome and might even require the elevation of their pain threshold brought on by drugs. However heroin addicts have not yet been demonstrated to show unusual levels of endorphins.

According to the pathologist Rudolf Virchow (1821-1902) there must be an identifiable alteration to bodily tissue and change in cells of a body for a condition to be classisised as a disease. Yet to date no alternation to cell metabolism has been found in bodies of heavy drinkers or drug users. This alone justifies the view that addiction is not a physical disease (Szasz 1991; 1994).

Conditioning theory

Exposure and conditioning theories of addiction hold the view that the substance has gained considerable control over the individual's behaviour (Donegan et al. 1983: 112). The addict who relapses can be conceived to have had his craving for the addiction reinstated by exposure to the setting in which he previously used drugs (Wilker, 1973).

The exposure model of addiction is based on the myth that narcotics are irresistible to any organism, once having tried them, that organism has free access to drugs (Peele, 1985: 63). The substance acts as a powerful reinforcer of positive feeling and biological reward in preventing painful withdrawal symptoms. A body of research with laboratory animals has shown that most animals cannot be made into addicts. The central question this model seeks to answer asks how is it possible for human beings to become addicted and lose the possibility of choice? Once addicted the person loses the possibility of choice. McAuliffe & Gordon (1974) suggests that pleasure is the primary reinforcer particularly with heroin use.

In the popular image of heroin use and its effects, euphoria seems the only possible inducement for using a drug that is the ultimate symbol of self-destructiveness. (Peele, 1985: 64)

Zinberg et al., (1978) interviewed a large number of addicts and other heroin users over several decades and found that after prolonged heroin use the subjects experience a 'desirable' consciousness change induced by the drug. Applying labels such as 'pleasurable' or 'euphoric' to addictive drugs like heroin seems paradoxical since like depressants they lessen intensity of sensation (Peele, 1985: 64).

According to Peele (1985) our inability to conceive of addiction realistically is tied to our reluctance to formulate scientific concepts about behavior that include subject perceptions, cultural and individual values, and notions of self-control and other personal differences (Peele, 1983e).

The addictive personality

Some believe that personality factors play a role in the development of addiction (Jenike, 1991). There are a number of variations on this predisposing personality theme but all are strongly deterministic where by the individual is viewed as being powerless to avoid developing an addictive disorder. Another version of this theory is the addictive personality. Researchers have attempted to identify whether people with substance use disorders in treatment shared common personality traits. Doweiko (2002) suggests that the so-called addictive personality might more accurately be called the 'treatment personality'.

Because there is a real chance that those individuals with alcohol and drug addiction who do not enter treatment have far different personality traits from those who either ask for treatment or are coerced into seeking treatment. (Doweiko, 2002: 40)

Nathan (1988) has questioned the validity of this construct, concluding that there is no one type of personality more likely to misuse or develop dependence on substances. There is at present little conclusive evidence that there are personality characteristics that predispose the individual towards alcoholism or drug addiction (Stetter, 2000).

Nonbiological factors in addiction

Cultural

Anthropological theory emphasizes the values, attitudes, beliefs and norms that a population holds with respect to substance use and other addictive behaviours. Primitive societies know and use many kinds of drugs, yet addiction is rare (Rasmussen, 2000: 35). Different cultures react to substances in different ways. Opium was never prescribed a dangerous substance in India, but it quickly became a major social problem in China after it was introduced there by the British.

The external introduction of a substance into a culture that does not have established social mechanisms for regulating its use is common in the history of drug abuse. (Peele, 1985: 12)

An interesting transition is emerging from the Jewish subculture, especially in the ultraorthodox sects. As the younger generation explore new behaviors many are experimenting with 'unclean' chemicals and becoming addicted. In the Italian-American subculture, drinking is limited mainly to religious or family events where excessive drinking is not tolerated. Socially acceptable drinking, behavior is modelled by the adults and there are strong familial and social sanctions against failing to follow the rules. As a result of this process they experience low rates of alcoholism (Doweiko, 2002). In many cultures in the Middle East, alcohol is prohibited, but the use of hashish is quite acceptable. Ireland is going through its own cultural changes in relation to the excessive use of alcohol among the younger population.

Social

Drug use is embedded within the social group to which a person belongs. Styles of drinking are strongly influenced by that social group. Addiction is not an isolated experience or event in the participants life as they also bring with them into treatment multiple social, medical, legal, financial, occupational and personal problems (Doweiko, 2002). Many of the risk factors identified for substance misuse have also been found to predict other adolescent problems and so drug use should be addressed in association with a range of possible co-existing problem behaviours (Mayock, 2000).

Sociocultural theories look at the role of family, environment, culture and economic factors in the development and expression of addiction. Family theory challenges the premise that addiction is an individual problem or disease. Systems theory views people as primarily social beings rather than as biological or psychological entities. The family system plays a critical role in the onset, development and treatment of addiction. Economic theories of addiction are concerned with the social costs of excessive addiction and the economic dimensions of government policies aimed at changing consumption habits.

Ritualistic

The rituals that accompany drug use and addiction are important elements in continued use, so much so that to eliminate essential rituals can cause an addiction to lose its appeal. In the case of heroin the rite of self-injection and the pursuit of the drug are meaningful rituals. Addiction is a ritual and according to Zoja (2000) the use of drugs in our society is part of a much bigger resurgence of our collective human need for meaningful initiatory rituals.

Drug addiction is not, as generally believed, an escape from society, but a desperate attempt to occupy a place in it... it is almost impossible for many young people to feel in any way useful in today's society. (Zoja, 2000: 15)

The myth of addiction

Addiction is a myth according to Davies (1992) who argues against the prevailing notion that addiction is something that happens to people, imposed from outside by the inescapable pharmacological properties of an alien substance, rather than as a state negotiated through human desire and intention (Davies, 1992: vii). Davies argument is supported by attribution theory, i.e. the ways in which people explain their actions. The myth of addiction is based on the idea that 'addiction' changes the basis for human behavior. The assumption is that 'non-addicted' people have control over their behavior in ways that 'addicted' people do not. The keystone to the addiction debate is that 'non-addicted behavior is 'free' in some way that 'addicted' behavior is not (Davies, 1997: 1). According to Davies explaining one's behavior as either within, or with out one's control, has either positive or negative consequences depending on the situation and the moral or legal climate. It may be too scary to imagine that we have the power to choose paedophilia, murder, rape, and suicide and so we appeal to explanations that are out side of our control.

Davies argues that people take drugs because they want to and because it makes sense for them to do so given the choices available, rather than because they are compelled to by the

pharmacology of the drugs they take (Davies, 1992: x). Still we prefer to conceptualise our drug 'abusers' in terms that imply that their behavior is not their own to control. In accessing health services many drug users self report for functional reasons, that they are addicted and that their lives are out of control because of their drug use. Addiction discourse is dominated by notions of helpless addicts who has no power over their behaviour because they are diseased, dysfunctional, genetically deficient and morally redundant. If we continue to base our policies on stereotypes and inaccurate perceptions of the drug user we will continue to justify extreme measures in eradicating drugs and treating those who use them, whether they need treatment or not.

Davies is not saying that drugs have no pharmacological effect or that some individuals become enmeshed in a cycle of substance use and misuse, sometimes with tragic consequences. His argument calls for a rethinking of contemporary moral attitudes to addiction and he challenges our assumptions about addiction as a disease, in the context where deaths due to illicit drug use per annum in Britain is around 300-400, where smoking accounts for some 100,000 deaths and where alcohol is implicated in three out of four of all deaths due to liver disease (Davies, 1992: xii).

People become classified as addicts or alcoholics because of their behavior. Behavior in humans refers to intentional conduct. Human action is governed by the meaning it has for the acting person. The behavior of heavy drinking is not a form of neurological reflex but it is the expression of values through action. (Schaler, 2000: 19)

Self-Efficacy versus the disease model

According to Schaler (2000) the disease model of addiction discourages the development of self-efficacy in individuals. Self-efficacy is people's confidence in their ability to achieve a specific goal in a specific situation. It refers to the capability of people to believe they possess the capacity to affect a specific behavior or to accomplish a certain task. Self-efficacy is not the skills one has but rather one's judgement of what one can do with those skills (Bandura, 1977 & 1986). Having confidence to achieve some thing for yourself, has a lot to do with

whether you will actually make the effort to do well at something you set your mind to do. When you believe you can do something, you are more likely to be successful at it.

Models and theories of addiction are important because our interpretation of addiction directly affects our response in terms of its treatment. No matter what model or treatment system is applied, without self-efficacy the treatment is likely to fail. So what are the treatment options for heroin addicts and problem drug users?

Treatment

Treatment programmes for problem drug users and addicts reflect the values and beliefs of the society in which they are embedded. Programmes are designed to reflect varying commitments to the moral, legal and medical models of addiction, adopted by the service providers. Programmes funded by Government generally adopt models of international good practice integrating various approaches depending on the circumstances and needs of various communities.

Assessment of young people for drug treatment

Experience of working with young people who use and misuse drugs, indicate that they present to treatment and other services with an array of needs and problems (Rahdert & Czechowiz, 1995). These include homelessness, educational disadvantage, criminal and offending behavior, minimal family involvement or support, identity issues and mental health problems (Kaminer, 1994; Pagliaro & Pagliaro, 1996; Petersen & McBride, 2002). Any treatment programme must take account of this complex psychosocial matrix in which any young person presenting to services is enmeshed (Crome, 1999).

The assessment of adolescent drug use remains a complex clinical and practical process (Meyers et al., 1999). It requires the careful and skilful implementation of procedures across a wide range of service systems and providers. There are problems associated with identification, recruitment and referral of the individual as well as matching treatment with the specific needs of each young person. Assessment seeks to find out the age at which use begins, the type of substances used, the pattern and consequences of use and the nature and scope of problem behaviors in non-drug related areas.

Several factors can affect the integrity of measurement instruments used in assessing young people and their drug histories (Meyers et al. 1999). Because clinical research and epidemiological data on adolescent substance abuse rely heavily on adolescent self-reports,

assessment measures must obtain data that are reliable, valid and sensitive to change. The reliability and validity of self-report data depend upon a variety of contextual and interpersonal factors (Hirschi et al., 1980; Maisto et al., 1990; Rouse et al. 1985).

Psychological interventions

Psychotherapy and counselling is offered by most drug treatment services. There are many different schools of therapy and counselling being employed in drug treatment services with young people. *Cognitive therapy* is probably the most commonly used form of psychological treatment with adolescents. Cognitive therapy is directed at problem solving and decision-making skills, anger management, stress reduction and assertiveness. Adolescents are helped to develop skills required to deal with problematic behavior associated with their drug use. *Social skills' training* is applied to assist adolescents in dealing more effectively with a range of social situations and feelings. *Family therapy* is very effective in helping to reframe the young persons problem behavior associated with the drug use within the larger family dynamic and family system. *12-Step programmes* – Alcoholics and Narcotics Anonymous understand addiction as a disease with no cure, and the fellowships provide a support structure to secure lifelong abstinence. *Therapeutic communities* provide structured environments to equip young people with the ability to deal with responsibilities of the outside world (DeLeon, 1994).

Pharmacological interventions

Pharmacological interventions are aimed at treating the effects of withdrawal symptoms, relapse prevention and psychiatric illness. Young people presenting to services most commonly want to be withdrawn from heroin. *Methadone reduction programmes* are directed towards individuals who are using prescribed methadone as a means of reducing withdrawal symptoms from coming off opiate drugs. The aim is to prescribe a gradually tapering dose over time with the ultimate aim of the individual achieving abstinence. *Methadone maintenance programmes* are designed to stabilise the user by prescribing methadone as a

substitute for heroin and other opiate drugs. In some cases individuals can be prescribed methadone for a number of years (National, Drugs Strategy 2001-2008).

Harm reduction

Harm reduction accepts the reality that people desire to use drugs that may cause them harm. Harm reduction initiatives focus on reducing the adverse consequences of drug use through a variety of programmes and policies including the following:

1. Advocacy for changes in drug policies – legalization and decriminalisation.
2. HIV/AIDS related interventions – needle/syringe exchange programmes.
3. Methadone and heroin substitution programmes.
4. Drug counselling to promote safer and responsible drug use.
5. Social interventions – housing programmes and support or advocacy groups

The essential feature of harm reduction is to reduce the adverse health, social or economic consequences associated with drug use (Inciardi & Harrison, 2000: viii). In Ireland the Department of Health embraced the 'harm-reduction model' of treatment for opiate use because of the relatively high HIV risk in Dublin's injecting drug users (Barry, 2000).

Skills training and motivational interventions

Skills training approaches in the treatment of addiction work through a variety of learning techniques, including behavioral rehearsal, modeling, cognitive restructuring and teaching methods. Addictive behavior is understood here as a maladaptive way of coping with personal, social and other stressful experiences. Skills' training equips the individual with a range of skills to enhance their coping ability in situations that they find difficult. These skills include assertiveness, interpersonal skills, problem solving and managing emergencies.

Treatment here is often organized around a task and can be conducted in both individual and group settings (Baer, et al., 1999).

Motivational interviewing analyses how people change addictive behavior and then develops therapeutic strategies that are supportive of individual change. People are described as moving through stages of motivation for change from precontemplation (not considering change) to contemplation (considering change) to preparation for action, to maintenance (Prochaska & DiClemente, 1982; Prochaska et al., 1992). The focus of motivational interviewing is practical, surrounding a style and content of therapeutic interactions that empathically yet strategically support an individual's decision to make behavioral changes and support self-efficacy (Baer et al., 1999).

Social model of recovery

The social community model of recovery evolved out of Alcoholics Anonymous (AA) and has a distinctive programme philosophy with different assumptions, knowledge and practice than professionally based treatment models. Referred to as Social Model Programmes (SMPs) they began in the 1940's in California, evolving by the 1980's into a continuum of recovery services that are state funded, legally incorporated with charitable status. They provide a range of services including social setting detoxification, residential recovery homes, non-residential community recovery centres and dry hostels. They are generally managed by recovering addicts and their structure is based on the 12 traditions of AA, which emphasize democratic group processes and shared leadership (Borkman et al., 1998). SMPs work on the principle that alcoholics or addicts are themselves helped when they provide a service to others. The principle of 'grounded knowledge' is used to convey the learning and knowledge gleaned from experience rather than from professional or academic training (Borkman, 1983). Education occurs through experiential peer support and not by instruction.

In contrast to biological and psychological models, sociocultural models believe alcohol problems stem from a lifetime socialization process in a particular social and cultural setting

that implicitly or explicitly encourages excessive alcohol consumption. Recovery from this negative socialization involves both the person and his or her social and cultural environment. The social model recognizes the interdependence of the person recovering from substance abuse problems and their social environment (Barrows, 1998).

In assessing the value of social model programmes we are limited by the lack of comparative analysis in the evaluation of these programmes. Reporting systems and precise information on client progress not only burden staff with paper work, they run counter to the social model reliance on self diagnosis and self-directed recovery. There are also some controversies surrounding the social model programme in particular a concern that quality standards of care are maintained. To ensure standards are met, funders often turn to the qualifications of staff, which is a problem in the social model programme where the basis of authority is legitimised by experience rather than by qualifications.

Barrows (1998) examined the community orientation of both social and medical models of recovery. He found that those who used the social model made more links with the community in terms of utilizing community resources for health, education and social service needs.

Community based programmes

Community based outpatient drug treatment programmes began in the 1970s are specifically designed for young drug users. Research on community-based programmes demonstrates that they were a less expensive alternative to prison (Anglin et al., 1996). Treatment in the community is offered to young drug users through various methods that include detoxification, residential, therapeutic community, and outpatient treatment. The primary treatment approach relies on counselling and social skills training to address factors that foster drug use. Methadone maintenance programmes have been shown to reduce criminality but studies suffer from lack of comparable groups. Detoxification has not been shown to be effective in reducing long-term drug use and criminal behavior, but has shown effectiveness in reducing drug use and criminality temporarily (MacKenzie, 1997).

Interagency and multi-agency approaches

Risk factors for problem drug use include lack of attachment to parents, failure in school, poor social and coping skills, negative peer influence and poverty (Sussman & Ames, 2001: 79). Young people require a specialized intervention from a variety of agencies and professionals to respond to their multiple needs (Christian & Gilvarry, 1999). Services, which intervene with these young people, must be capable of comprehending and addressing the complexity of their needs and the multiplicity of vulnerabilities (Health Advisory Service, 1996). Many of the risk factors identified for substance misuse also predict other adolescent behavioral problems (Hawkins et al., 1988).

Interagency cooperation targeting vulnerable young people can be a protective factor in reducing the risk of problem drug use developing (V. Johnson & Pandina, 2001). This requires a close working relationship between a number of agencies and individuals, from parents to the Gardai, social services, community health workers, schools, voluntary and community groups. Co-operation at the individual level needs to be supported by joint agency working and management policies that emphasise child protection. There is a need to develop a range of partnership approaches, which incorporate multi-disciplinary teams, joint working, collaboration and co-ordination between agencies (Christian et al., 1999).

Ireland's current approach to tackling the drug problem focuses on the four areas of supply reduction, prevention, treatment and research. Central to the approach has been the bringing together of key agencies, both statutory and community/voluntary in a planned and coordinated manner to develop an integrated strategy (National Drugs Strategy 2001-2008). The 14 local *Drugs Task Forces* were set up in 1997 as part of the National Drugs Strategy to facilitate a more effective response to drug related problems in areas experiencing the highest levels of heroin use. The Task Forces recognise that utilising the skills and experiences of all key players is essential in the design and delivery of effective services (North Inner City Drugs Task Force, 2001).

The Integrated Services Initiative was established in the northeast inner city of Dublin to develop models of provision in the areas of education, health, justice and other social services

which allow every in the local community to contribute actively a sustainable end to poverty and social exclusion (Integrated Services Initiative, 1997). The Combat Poverty Agency also recognized the need to develop integrated responses to the needs of early school leavers (Cullen, 2000). The Gardai in corporation with youth services and local community groups developed an integrated way to divert young people away from crime through the Gardai Special Projects (Bowden et al., 2000). The Department of Health and Children developed the Springboard Projects as an integrated response to the needs of vulnerable families (McKeown, 2000). Each of these initiatives can impact positively on the life of the young person at various stages of their drug using history. These non-direct interventions can have a long-term sustainable impact on the life of the young person and the choices they make.

Alternative treatments

Alternative treatments have begun to filter into mainstream discourse in the treatment of addiction. In general they do not sit easily along side the interpretations supplied by the moral, legal or disease models of addiction. They are alternative because they have evolved from outside the dominant paradigm of western thought and biomedicine.

Acupuncture

Acupuncture has been shown its usefulness in alleviating opiate withdrawal symptoms (Brewington et al., 1994). Wen and Cheung (1973a) first described the effects of acupuncture in alleviating the severity of opiate withdrawal symptoms. Stimulation of acupuncture points by needle insertion is considered to have positive effects on internal and external organ function. Clarke (1990) compared treatment outcomes for 84 individuals addicted to opiates, who voluntarily chose either acupuncture or methadone detoxification. Forty-two pairs of acupuncture and methadone patients were matched regarding age, race and sex. Subjects were interviewed regarding recent drug use 90 days after completing treatment and also provided urine specimens for drug content analysis. At the follow up interview, 31% of acupuncture subjects showed drug free urines compared to 14% with methadone patients (Brewington et al., 1994).

Homeopathy

Homeopathy has been used for about 200 years to help overcome addiction to alcohol and other drugs. In the treatment of addiction, it has many advantages as it recognizes that the illness is mental, emotional and physical (Meenaghan, 2002).

In the fifth century BC Hippocrates (c.470-400BC), the 'father of medicine', wrote that there were two methods of healing: by 'contraries' and by 'similars'. His observations on cure by 'similars' were not followed by the medical profession and lay dormant until Samuel Hahnemann developed homeopathy (from the Greek words meaning 'similar suffering') in

1796 (Castro, 1990). Homeopathy is an effective and scientific system of healing which assists the natural tendency of the body to heal itself. It recognizes that all symptoms of ill health are expressions of disharmony within the whole person and that it is the patient who needs treatment not the disease.

Nutritional approaches to addiction

Modern lifestyles encourage us to consume excessive amounts of caffeine and sugar and to unwind from stressful lives with tobacco, alcohol or tranquillisers. Untreated, some addictions can cause metabolic damage, leading to heart disease, high blood pressure and immune disorders, as well as causing nutritional deficiencies, fatigue and depression (Mars, 2001).

Holford (2003) suggests we need to radically rethink our approach to the treatment of addiction. Addiction, whether it be to alcohol, tranquillisers, cigarettes or heroin is less likely to occur in those who are well nourished for a number of reasons. First the use of stimulants, like caffeine, nicotine or cocaine, is more attractive if you are constantly tired. Secondly, the use of relaxants such as alcohol or tranquillisers is more attractive if you suffer from anxiety. The more your brain chemistry is out of balance, the more out of balance it will become if you expose yourself to potentially addictive substances (Holford, 2003: 263). According to Holford it is the combination of body chemistry, psychological and environment factors that predispose a person to addiction.

Holford suggests that most alcoholics and drug addicts have dysglycaemia. People control their blood sugar level by eating, drinking and smoking substances that alter their body chemistry. The first step he suggests in treating addiction is to prepare the person for withdraws by correcting nutrient deficiencies. By giving heroin addicts high levels of vitamins, minerals, amino acids and essential fats can dramatically reduce symptoms of withdrawal and increase chances of staying clean (Holford, 2003: 269).

Conclusion

The purpose of this chapter was to set the scene for a more detailed examination of the heroin treatment programme in the Crinan Youth Project. How we understand heroin use and addiction, mirrors much of the social and political history in which it is consumed. Likewise our understanding of addiction has evolved along side the history of scientific discovery. Today the obsession is on finding the gene that causes addiction so that we can treat it genetically. Our approach to treatment also reflects the moral, legal and scientific thinking of the day. Having introduced the drug heroin, the problem of addiction, the common types of treatment for heroin addiction, I will now examine in more detail the three central discourses that shaped the construction of the Crinan Youth Project; education, therapy and medicine.

Chapter 3

Adult and community education - towards a treatment discourse

Introduction

There are many different traditions in adult and community education, as it has become a mechanism to nurture tradition as well as being a catalyst for social change. It has been taken up with equal enthusiasm by industry trying to keep up with the changing needs of the economy and by community groups working to house the homeless, treat drug addicts and rehabilitate prisoners. In more recent times it has been expressed in the now universally accepted concept of *Life Long Learning*.

The concept of *Life Long Learning* has become popular within the European Union and member states. The Irish White Paper on adult education '*Learning for life: A white paper on Adult Education*' (2000) adopts a concept of life long learning that is market led. The thrust of this policy conceives adult education as a mechanism to prepare people for an ever-changing employment market in an expanding economy. The market led approach to adult education builds on the principle that there will be a 'trickle down' effect that will benefit all sections of society and that the rising tide of economic growth and employment will lift all boats equally.

This vision of adult and community education, has been criticized by Fleming (1996: 49) who is concerned with the narrow economic focus adopted in the White Paper. It is a policy document saturated with economic references, 'skills, training, competencies, economic growth and vocational training'. Adult education he suggests is about the economy but it is also about participation, citizenship, social democracy and developing a cohesive civil society (Fleming, 1996).

This chapter will look critically at adult and community education and explore its potential as a treatment discourse and source of useful knowledge in tackling the heroin problem systemically. The chapter will focus on adult education as expressed through critical theory and the challenges presented to it by neo-liberalism. Critical theory is an analysis that enables people to move and act in ways that challenge dominant discourse and construct more liberating ones (Ryan, 2001: 22). Neo-liberalism is the dominant development discourse or hidden framework to market led approaches to human and community

development. I will argue that drug treatment services exist on a continuum between the position adopted by critical theorists and the pull of neo-liberalism and economic logic.

Philosophical foundations of adult and community education

A look at the philosophical foundations of adult and community education will help to set the research in context. There are several different traditions and approaches within adult and community education. Elias and Merriam (1980, 1995) in *Philosophical Foundations of Adult Education* have outlined the five lasting philosophical traditions that have shaped adult education, as we understand it today.

Liberal adult education is the oldest and most enduring of educational philosophies with roots in classical Greek philosophy. Liberal education emphasizes the development of rational thinking with the role of the educator as expert whose job is to transmit intact existing knowledge. *Progressive adult education* on the other hand holds a holistic view of education focusing on the learner's experience and emphasizing life long learning. The progressive educator facilitates the learning process and views adult education as a form of social development. *Behaviorist adult education* is considered a psychological theory, but Elias and Merriam point out the philosophical nature of this view of education, which is to ensure the survival of individuals and of society. Educational behaviorism focuses on observable, measurable behavior and emphasises the control of behavior by controlling the environment. John Watson (1878-1958) and B. F. Skinner (1904-1990) are the key proponents of behaviorism.

Humanist adult education emphasises the freedom, dignity and potential of human to develop their full potential. Rooted in the idea that 'human beings are capable of making significant personal choices within the constraints imposed by heredity, personal history, and environment' (Elias & Merriam, 1980: 118). Learning is personal, self-motivated and the goal is the development of self-directed learners. Humanist education has been strongly influenced by the work of Carl Rogers and Abraham Maslow who both believed that humans have a tendency towards self-actualization (Smith, 1990: 14).

Radical adult education espoused Critical Theory to question many of the assumptions underlying the pedagogical process. Radical adult education or Critical Theory is particularly concerned with confronting the liberal-humanist ideas of the individual with a pedagogical practice aimed at 'producing politicised human subjects, capable of successfully resisting oppressive structures and knowledges' (Ryan, 2001: 3). In a radical interpretation of adult education knowledge and power are intertwined.

The practice of adult and community education is usually shaped by a combination of different philosophical traditions depending on the underlying assumptions of the educator about the person and the nature and context of the project. It is unlikely that we will find ourselves confined to one tradition.

Critical theory provides the most useful theoretical framework to examine the discourses through which the Crinan Youth Project is constructed and constructs. Critical theory allows us to question and challenge the assumptions underpinning addiction and drug treatment. In particular critical theory provides an important analysis of neoliberalism - a development discourse dominated by individualism and economic perspectives.

Critical theory

There is now a new sociology of education that is challenging the dominant educational discourse. Sociologists are leading this debate about equality in education (Lynch, 1999: 3). A radical theory of education has emerged that is broadly defined as a critical theory of education or critical pedagogy that examines the social and political fabric of neo-liberalism, which construes education as an absolute good. Critical theory presents a growing challenge to the psychological reductionism that has dominated educational practices within adult and community education theory. Psychological reductionism in education reduces the educational process to explanations drawn solely from psychology. It rejects the objectivist ideal and recognises that knowledge is not autonomous but embedded and produced in social, political and economic relations and produces subjectivities with patterns of subordination among certain groups e.g. inner city youth (McLaren, 1995: 183).

Critical educational theory can be traced back to the work of the Frankfurt School of critical theory, where Erich Fromm and later Jürgen Habermas based themselves (McLaren, 1998: 163). They believed that social theory must play a role in changing the world that resulted in two world wars. Social theory refers to any theoretical account that seeks to understand and explain social relations between individuals and groups in different societies. Influenced by Marx's philosophy of praxis, early critical theorists rejected the logic of rationalism and its positivistic posture in research. In the positivist posture, the researcher employs the language of objectivity, distance and control. The positivist view of research avoids the realm of subjectivity and invokes impartiality and objectivity to support their views (Denzin & Lincoln, 2000: 93).

There are many articulations of critical pedagogy, with Freirean pedagogy, some feminist pedagogies and resistance post-modernist pedagogies. In general they agree that pedagogy embodies a social and cultural critique; that all knowledge is socially and historically constituted; that we are social beings; that language is shaped by subjectivity; that oppression must be deconstructed and that research methods are implicated in the reproduction systems of class, race and gender oppression (McLaren, 1995: 230).

Critical theory is part of an oppositional social movement and strategy of transgression within the neoliberal frame of reference (McLaren, 1995: 172). Researchers within this tradition raise important questions about the nature of knowledge, power, subjectivity and agency. Postmodernism is sceptical about the big ideological and epistemological theories of the past. In postmodern theory, subjectivity becomes central to any debate about the nature of the person. Foucault, who himself resisted labels, understood philosophy was concerned with the self and that it involved working on the self. Teaching for Foucault should allow the individual to change at will (Foucault, 1984: 329). Identity within postmodernism is fluid, changeable and derived from multiple discourses. Foucault thought that education must be nonmanipulative and must allow us to dissociate ourselves from the regimes of truth that have classified, objectified, normalised, and constituted our identity as beings of a particular kind (Foucault, 1966: 15).

Knowledge is not self-generating, nor does it exist in some pre-ontological world waiting to be discovered. Knowledge is constructed through discourse. Critical theory must begin with a critique of knowledge itself. We need to critique our present theories of knowledge and seek out new ways of knowing that will unveil the oppressive nature of our present circumstances (Mayo & Thompson, 1995: 20).

Neo-liberalism

Neo-liberalism is the nemesis of critical theory. Neo-liberalism is a new line on an old story that dates back to the work of John Locke and Adam Smith on classical liberalism and the idea that market forces bring prosperity, liberty and democracy. Neo-liberalism finds its roots in liberalism, an expansionist ideology dating back to the late eighteenth century and the advent of the industrial revolution.

In 1776, the British economist Adam Smith published his book, *The Wealth of Nations* where he suggested that for maximum efficiency, all forms of government interventions in economic issues should be removed and that there should be no restrictions or tariffs on manufacturing and commerce within a nation for it to develop. Later the economist, John Maynard Keynes, suggested that regulation and government intervention was actually needed in order to provide more equity in development. This led to the Keynesian model of development and after World War II; the Marshall Plan for Europe was the foundation for the rebuilding of the international economic system.

Neo-liberalism is a set of economic policy that favors deregulation, the rule of the market, privatisation, a reduced role for government, and elimination of the ideals of collective responsibility. (Roddick, 2001: 249)

Neo-liberalism also known as the New Right refers to a range of ideologies and groups, which aim to promote free-market, anti-welfarist and libertarian policies (Jary & Jary, 2000: 416). Neo-liberalism has become the dominant doctrine of development in the new world order. In this new world order the economy dictates the rules of society rather than the other way around. Margaret Thatcher came to power and undertook the neo-liberal revolution in Britain. The central value of Thatcher's doctrine and of neo-liberalism itself is the notion of competition - competition between nations, regions, companies and of course between individuals. Competition is central because it separates the sheep from the goats, the men from the boys, the fit from the unfit (George, 1999).

Dominated by individualism and economic growth, neo-liberalism is guided by a vision of a weak state (Apple, 1999: 203). Neo-liberalism promotes the ideas; that the market should be allowed to make major social and political decisions, the idea that the State should

voluntarily reduce its role in the economy, that corporations should be given total freedom, that trade unions should be curbed and that citizens should be given much less rather than more social protection (George, 1999).

Governments in Ireland in recent years have moved from a social democracy to a neo-liberal style of Government under the influence of the Progressive Democrats. The Irish economy is dependent on the neo-liberal framework of competitiveness and growth. Wage restraint has begun to see multinationals shift their manufacturing base to Eastern European countries where labour is cheaper. Economic policy is now influenced more by the policies formed by the EU and other multi lateral institutions than by our own Government. These policies in turn are dictated by globalization and international trade agreements, aimed at protecting European producers and manufactures. In this European and global scenario, Ireland must remain competitive so that the economic gains of the Celtic tiger years will not be lost. In this post Celtic tiger economic down turn, the economy is dominated by high inflation, a rising euro and increasing redundancies and unemployment. To protect the economy the government wants to link wage increases with productivity and performance to avoid the painful process of job losses.

Smart (2003: viii) shows that with the development of neo-liberal global capitalism there has been an acceleration in private wealth and rapid deterioration of public services. The uneven effects of global capitalism have created growing disparities both between and within countries along with new exclusions and social imbalances. Economic practices and institutions are embedded in wider social, cultural and institutional relations and have social implications and consequences.

According to Taylor (The Irish Times, October 3, 2003), what we are experiencing in Ireland is 'a tale of two economies'. One is of the multinational sector, which is continuing to grow, and generated huge profits here, while the domestic economy languishes. Multinational profits rose sharply from about €26.3 billion in 2001 to €32.3 billion in 2002. Much of the rapid multinational output and growth came from the pharmaceutical sector employing around 24,000 people, providing stable and growing job numbers.

State intervention in health and other social services is now dependent on economic performance indicators set by the EU. Neo-liberal politicians promote deregulation and the sale of state assets through privatisation. They seek reductions in the state of welfare guarantees, health care and social insurance.

Politicians and business leaders have merged and now work collaboratively to create the conditions to develop the economy. Tribunals investigating political corruption in Ireland have illustrated the embedded relationship between politicians and business leaders. The ideological and promotional work of the New Right, works on the principle that if they can occupy people's heads, their hearts and hands will follow (Roddick, 2001). The New Right has made neo-liberalism seem as if it were the natural and normal mode of human progress.

Neo-liberal policies promote a kind of globalization that have had many negative consequences in regard to increased ecological degradation, persistent poverty, worsening working conditions, various expressions of cultural violence, widening inequalities and a deepening of democratic deficits (Scholte, 2000: 9). The naïve application of neo-liberal economic policies developed in the USA and the UK has not led to widespread improvements in well being and economic capacity (Christie et al., 2001: 25). The trickle down effect, by which wealth is created by the successful and reaches the poor through the market economy, is badly flawed. The combined wealth of the world's 200 richest people now equals the combined annual income of the world's poorest 2.5 billion people (Jeff Gates in Roddick, 2001: 186). The neo-liberal model of globalisation, economic development, higher growth and consumption rates, are unsustainable. The widening gap between rich and poor has created new sources of global conflict that are threatening peace and security. The economic policies of neo-liberal globalisation are also threatening environmental security and the increased risk of ecological disaster.

To allow the market mechanism to be sole director of the fate of human beings and their natural environment...would result in the demolition of society. (Polanyi, 1944: 74)

Neo-liberalism gives priority to adult education that serves the needs of the economy. Education is seen as a product of the market place, one that is necessary to fuel economic growth, employment and prosperity. Neo-liberals seek to shift adult education as a social

movement for change, to an emphasis on continuing education, skills training and human resource management. This reflects a concern with marketing skills at the expense of social justice. It seeks a flexible, adaptable workforce capable of moving with the movement of capital and industry (Mayo, 1999: 1). For the neoliberal entrepreneur, education is a function of the economy. Unrestricted economic development has become the common sense approach underlying neo-liberalism and is seen as a natural and normal part of a developed society. Neo-liberalism is a form of cultural hegemony of the ruling classes, who seek to exert their influence and authority on society.

Critical theory – a framework for analysis of drug treatment

Critical theory has inspired a radical approach to adult and community education that is challenging the dominant educational and development discourses of neo-liberalism. A radical approach to adult and community education has the capacity to construct treatment knowledge that is liberating (Barr, 1999). Adult and community education is part of a wider social and political movement, working to shift the social imbalances brought about by neo-liberalism. Radical adult education is underpinned by the idea that change is possible. Change occurs through critically reflexive people acting as agents of transformation. A critical theory or radical approach to adult and community education, theorizes the person in treatment through a broad range of concepts that focus on discourse, subjectivity, hegemony, agency, resistance, civil society and the political economy.

Discourse

The relationship between language and meaning is addressed in the concept of discourse. A discourse is a historically and socially structured set of statements, beliefs and practices used to filter and interpret experience (Holland & Eisenhart, 1990). Discourses often remain hidden and veiled behind every day educational, social or moral assumptions. The fact that these discourses are not always in the conscious mind makes them more powerful. We may not be aware that we are thinking, feeling and acting out of a particular set of discourses. Discourses are expressed powerfully through organisations and institutions of religion, medicine, education and law. For Foucault, a discourse is a strongly bounded area of social knowledge, a system of statements within which the world can be known (Ashcroft et al., 1998). This world is not simply out there to be talked about, but it is through discourse itself that the world is brought into being. Medicine is a good example of a discourse that represents a system of statements that can be made about bodies and disease. The rules of this discourse determine how we view the process of healing and the identity of the sick person. Within the medical discourse powerful organisations and institutions control the way medical knowledge is regulated, what is known, how it is known and who has access to its secrets.

Foucault says that if enough people accept as 'common knowledge' the particular belief systems of a group of authority figures, such as scientists, priests, or medical doctors, then this group exercises power in society by defining right from wrong and who, or what is 'normal'. It is a subtle form of power, easier to overlook than power enforced by law or violence, and hard to resist because it has been normalized. He came to this conclusion through studying prison systems, mental asylums, schools, and the ways in which society creates categories of deviance and abnormality.

The discourses of science, psychology and psychiatry are implicated in the production of knowledge used to define normality and abnormality (Ryan, 2001: 32). The treatment of addiction is dominated by a medical discourse, particularly through the profession of psychiatry. Discourses can compete with each other (Davies & Harre, 1990) and often represent political interests, constantly vying for status and power. This research reflects the relationship between different sets of competing discourses; critical theory and neo-liberalism; medicine and education; psychiatry and psychotherapy. The site where these battles are contested is the subjectivity of the individual (Weedon, 1997: 40 cited in Ryan, 2001).

Subjectivity

Subjectivity is an arena of political activity (Ryan, 2001). Ryan challenges the liberal-humanist view of the person, untainted by its surroundings and known only objectively as unitary, rational and asocial at its core. She suggests that by taking a feminist, poststructuralist approach to adult education we can know things about the person and about subjectivity. For too long, she argues, that adult education has taken its definitions of the person from mainstream psychology. Mainstream psychology has not resolved issues concerning identity, personality or the concept of self or self-esteem. Poststructuralist theories have attempted to overcome these dualisms through its understanding of subjectivity (Ryan, 2001: 5).

Subjectivity is concerned with understanding the person through the concepts of self, subject and identity. These concepts are used interchangeably to talk about and construct the person. Subjectivity is constructed through discourse. Subjectivity challenges the western neo-liberal humanist notion of the self as unitary, rational and possessing an essential self or personality. Here the unitary, rational self is reduced to biology and information-processing mechanisms (Henriques et al, 1984; Hollway, 1989).

Jean Barr suggests that adult education is being reduced to psychological theories and practices of facilitating adult learning (Barr, 1999: 105). She challenges the present orthodoxies in adult learning and pedagogy. Critical pedagogy highlights the ways in which mainstream pedagogy produces forms of subjectivity preferred by dominant culture that are passive, domesticated, devoid of agency but rationalized and validated by existing regimes of truth (McLaren, 1995: 231). McLaren suggests that critical pedagogy seeks to contest legitimate and privileged ways of knowing through resistance and insurgent practices that will enable learners to interrogate the formation of their subjectivities.

If radical adult education does not actively theorize subjectivity, then liberal humanist or neo-liberal ideas about the individual will prevail, under the guise of objective knowledge and neutrality. (Ryan, 2001: 3)

An understanding of subjectivity is important in the context of drug treatment because of the powerful discourses that shape people's experience and expectation of treatment. Young people entering treatment are subject to passively accepting powerful constructions or labels such as addict, dysfunctional or diseased. Discourses maintain their dominant position through hegemonic practices. The concept of hegemony is important to understand so that we can position ourselves along side counter discourses e.g. critical theory.

Hegemony

Gramsci's (1891-1937) concept of hegemony refers to domination exerted not by force, or active persuasion, but by a more subtle kind of power exercised through education and the media where the interests of the dominant class are presented as the norm (Ashcroft, et al. 1998: 116). He used the term to criticize the narrowness of approaches, which focused only

on the repressive potential of the capitalist state. Gramsci argued that the domination of ideas in the major institutions of capitalist society, including the Roman Catholic Church, the legal system and the education system promoted the acceptance of ideas and beliefs which benefited the ruling class.

Gramsci's concept of hegemony helps us to see more clearly the way in which neo-liberalism works behind the scenes of capitalism and globalization. The existence of the biomedical hegemony in health and medicine has helped ensure that the pharmaceutical industry would become one of the most powerful industries in the world. Multi nationals invest billions in advertising to win the minds, hearts and hands of consumers who will go out and buy their products across the globe. Pharmaceutical companies spend more on advertising, marketing and promoting their products than they do on research and development (Families USA, 2002). In 1998 the pharmaceutical industry spent \$10.8 billion on advertising their products while 6.1 million people died from malaria, tuberculosis and other infectious diseases. These people did not die because there was no cure for them. They died because it doesn't pay the pharmaceutical industry to keep them alive (Silverstein, 1999).

Critical theory is constructing counter hegemonies capable of resisting the pervasive influence of neo-liberalism. To achieve this adult education needs to recast how we conceive the person in adult education to construct politicised human subjects, capable of successfully resisting oppressive structures and knowledges (Ryan, 2000: 3). The concept of agency must be understood if we are to be capable of resisting the influence of the dominant discourse. The development of agency is central to the rehabilitation process for young people in treatment for addiction.

Agency

Agency refers to the ability to act or perform an action. It hinges on the question of whether individuals can freely and autonomously initiate action or whether these actions are determined by the ways in which their identity has been constructed (Ashcroft, 1998: 8). Most critical social psychologists would suggest that the individual has room to manoeuvre

within given social constraints. They resist the view of the person as a passive recipient of her or his experiences inscribed in much traditional social psychological theorizing (Gough & McFadden, 2001: 114). Rather the individual is represented as actively negotiating his or her social activities. All choice is constrained by various social and cultural processes, including gender, class and ethnicity (Smith, 1988).

Jary and Jary (2000) describes agency as the power of actors to operate independently of the determining constraints of social structure. Boal developed the concept of 'spect-actor'. Spect-actor refers to the activated spectator, the audience member who takes part in the action. In *The Theatre of the Oppressed* there are no passive spectators. Boal emphasizes the potential involvement of even those who do not physically participate, and the fact that they at least have the choice. The spect-actor is the active participant rehearsing strategies for change (Schutzman et al., 1994).

Mayock (2000) in her study '*Choosers or Losers?*' Is concerned with the social context of drug use among young people in the south inner city of Dublin. The study presents young people's perspectives on drug use and articulates their sense of agency with respect to their choices. The idea that young people choose to use drugs, challenges the standard conceptions about young people and drug use and the inconspicuous drug pusher on the corner. In a similar way agency is important when it comes to choosing treatment, when there is recognition that drug use is becoming problematic. In most cases young people do not choose treatment, it is chosen for them by concerned others.

Agency is fundamentally concerned with people's capacity to be creative and reflexive, to be choice-makers and resisters of other people's determinations (Maycock, 2000: x). Viewing the person, as an agent demands that educators explore ways that people can resist dominant representation and understandings imposed on them.

Resistance

Resistance is the antithesis of the victim identity often associated with young people who choose to use drugs. Treatment programmes need to take resistance into account when interpreting young peoples choices and behavior around drug use. The concept of resistance gives us a positive perspective on the young person as rebel and transgressor. hooks (1994) in the tradition of critical anti colonial and feminist pedagogy and influenced by Freire's concept of education as the practice of freedom, articulates a vision of education rooted in transgression. To transgress is to defy, go astray, break the law, to be out of order or to overstep the norm. Learning to transgress is about learning how to resist the oppressive hegemony of neoliberalism and its white western male assumptions about the world. Learning and teaching for hooks should be pleasurable and exciting. hooks suggest teaching is a performative act that forces learners off their seats and on to the stage. This is similar to Boal's concept of theatre, where the dichotomy between audience and stage is broken down. The spectator is encouraged to become spect-actor, or engaged citizen rehearsing for reality (Boal, 1979, 1992). The spect-actor leaves their seat and crosses the boundary between onlooker and actor. Now on stage the spect-actor engages proactively with the official script. There they become dynamized and motivated with a desire to become the author of their own script. Learning, as passive consumption of knowledge, becomes redundant, as learners are dynamized into the practice of insurgence, resistance and transgression.

A radical approach to adult and community education places it in solidarity with a range of new social and political movements resisting the hegemony of neo-liberalism. The anti-capitalist movement has grown in recent years in response to the failure of globalization to usher in an equitable and sustainable world. This resistance movement critiques the neo-liberal consensus that puts profit before people. The movement unites people across the globe on the problems of street children in Bogotá, drought stricken Zambian farmers, homeless Dubliners, AIDS sufferers in Zimbabwe and abused women in Saudi Arabia (Jackson, 2001). While the label 'anti-globalisation' portrays the movement as one of opposition, it proposes many economic, political and social alternatives.

Treatment programmes for problem drug users need to take these issues into consideration. Programmes need to take into account the broader sociological and anthropological realities of human life. All citizens have a right to participate fully in the development of a civil society that is capable of resisting the negative influences of globalization and neo-liberalism.

Civil society and the political economy

Cunningham (1992: 112) suggests 'civil society is the development of the infrastructure within a nation which mediates between the state and its citizens'. A strong civil society promotes the full participation of its citizens and strives towards the goal of participatory democracy. It counters the development of a civil society dominated by the powerful interests of the state and those citizens representing a dominant cultural majority (Cunningham, 1992). Drug treatment programmes evolve and exist within this relationship between state and civil society. Civil society plays an important role in ensuring that the vested interests of psychiatry for example do not dominate the dialog when it comes to responding to the problem of heroin use. Psychiatry and law have become two of the most powerful gatekeepers of the state and civil society ensures that these institutions are monitored and held accountable to its citizens. Even within gatekeeper institutions like psychiatry there can be a tug of war between the needs of the state and the needs of civil society. These tensions and the relationship between the state and civil society is central to the development of a healthy and vibrant nation. Another important set of relationships are those between the state and the economy and between the economy and civil society. The concept of the political economy is important in this regard.

The term 'political economy' used in the 19th Century reflected the fact that economics was directly concerned with the interrelationship between economic theory and political action. After this period economics emerged as a pure science in its own right and was discussed and understood apart from politics (Jary & Jary, 2000). For a while it was thought that politics and economics functioned independently of each other. Recently however sociologists and economists who recognize that economics and politics are inseparable have revived the term political economy. In general the term denotes a concern with explaining the relationship

between political processes and economic processes in the state. The practice of economics cannot be conducted in isolation from the political setting of the state.

'Political economists have always been clear about the purpose of their analysis: to understand the world in order to change it' (Munck & O Hearn, 1999: 92). They seek to understand the co-relationships that exist between poverty, educational attainment, unemployment and drug use.

Drug treatment – a critical perspective

Applying the above theoretical framework to drug treatment begins by examining the development discourses that shape how we think about drugs and drug treatment. Drug discourses are the stories and narratives we tell ourselves about drugs. Most of the narratives we tell about drugs is that drugs are dangerous and to be avoided. In his book *Reconsidering Drugs* (2000) Lawrence Driscoll invites us to turn our focus away from the drug and place ourselves in the spot light instead.

What role do we play? At what moments in the narrative do we cheer?
When do we boo, and why? How does our role in this scenario affect
what drugs can and cannot mean? (Driscoll, 2000: 2)

Driscoll encourages us to radically reflect and question our own discourses. He suggests drug programmes are maintained to ensure the survival of a particular treatment discourse. The present treatment discourse dominated by the scripting of methadone, is not achieving any objective other than that of surveillance and social control of young people, who are extending the boundaries of normal and acceptable activity. The present treatment maze is not working. The way we think and talk about issues is not advancing either the treatment or rehabilitation debate. Any claims to truth about drug treatment are in Nietzsche's words 'illusions of which one has forgotten that they are illusions' (Driscoll, 2000: 2).

Community development and drug treatment

Finger and Asùn (2001) suggest that the vocation that has guided and invigorated adult education for decades is now bankrupt given the failure of development to usher in a better life for everyone. Development does not lead to a better life for all but instead exhausts the environment and degrades human beings, communities and social systems. They call for an examination of the relationship between learning and the organization to gain a new understanding of the dynamics of institutions and power (Finger & Asùn, 2001: 177). We need to question the links between development and the institutions of psychiatry, medicine and the pharmaceutical industry. Particularly we need to be critically aware how these institutions impact on the development aspects of drug treatment. Development practices at

local level have failed to adopt this kind of critical perspective. This deficit of analysis has left a vacuum in which psychiatry and medicine have filled with increasing doses of methadone. Development has failed to shift the debate about heroin from the personal to the social. An examination of development theory can inform us to construct a development approach capable of resisting the hegemony of biomedicine.

Development theory

The modernisation perspective, generated in the United States, became the dominant development discourse and expressed in terms of neoliberalism and globalisation.

Development here is contingent on constant incremental economic growth and increased cultural uniformity. In Ireland the modernisation approach was reflected in the economic policies of Lemas in the 1960 under the programme for national recovery. The main assumption of this approach is that every one benefits from the 'trickle down' affect of increased economic activity and employment opportunities. Modernisation approaches are also reflected in sociological and psychological theories of human development and some pedagogical practices in drug treatment.

The dependency theory of development saw underdevelopment as a result of a process of colonialism and western imperialism. Embedded in Marxism, liberation theology and a post-colonial analysis, it focuses on disengaging from structures of domination and oppression and challenged the assumptions of modernisation theory. Paulo Freire (1972) is a key reference point within this tradition as he sought to challenge the underdevelopment that was produced by dependency. The dependency theory with its anti-colonialist approach and critique of western materialism did not materialize as a radical panacea. As an approach to development the dependency perspective tended to be paternalistic, blaming its old colonial oppressor for their problems instead of taking responsibility.

The participatory model of development came from a critical theory of development and encompasses a broad range of social movements, including feminism, environmentalism and other global resistance movements for change. Inclusion of previously marginalized or

silenced voices, ways of knowing and being, become part of an emancipatory struggle for change. Participatory democracy, active involvement of target groups, importance of culture, diversity of perspective, embracing difference as richness and empowerment, are key components of this development paradigm (Munck & O Hearn, 1999).

Critical development theory is concerned in a very particular way with gender, the environment, culture and the impact of globalisation (Munck & O Hearn, 1999). Development theory seeks to understand the lack of development in many cases, where investment and aid packages have had the desired impact. The concept of development finds its roots in the social theory of Marx, Durkheim and Weber and their analysis of the transition from industrial to modern and capital society (Youngman, 2000: 49). Vincent Tucker in *Critical Development Theory* (1999) argues that after decades of development and aid programmes millions continue to suffer and die from starvation and malnutrition.

It would seem that the model of development now widely pursued is part of the problem rather than the solution. (Munck & O Hearn, 1999: 1)

Critical development theory seeks to demythologise this ideology and release us from a dehumanising paradigm of an essentially western ways of conceiving and perceiving the world. The old solutions, models and practices are no longer sustainable (Williamson, 1998: 193). This myth of development plays 'an important role in mobilizing energies for social reproduction and in legitimising the actions of believers' (Munck & O Hearn, 1999: 2).

In this development context methadone treatment is also a myth that must be challenged and seen for what it is. It does nothing to nurture agency. It induces the person into a passive state. Methadone fails to ignite any form of resistance. In fact evidence suggests that clients who challenge their doctor or complain about aspects of their treatment receive sanctions. These sanctions include dose reductions and loss of support from the service (UISCE, 2003: 22). Methadone treatment typifies the discourse of neo-liberalism that pervades in the ideology of drug treatment in some development contexts.

Neo-liberalism

Community development is dominated by the policies of neoliberal-globalisation and its narrow focus on economic growth. The first director general of the World Trade Organisation described globalisation as 'the reality, which overwhelms all others' (W.T.O, 1996b).

Neoliberal policies towards globalisation have had negative consequences with regard to ecological neglect, persistent poverty, worsening working conditions, increased inequality and growing deficit in democracy (Scholte, 2000: 9). Aldous Huxley once said 'Technological progress has merely provided us with more efficient means for going backwards' (Roddick, 2001: 41).

The rapidly expanding Irish economy of the 90s was dubbed the 'Celtic Tiger' after the tiger economies of East Asia. In his assessment of the Irish economy, O' Hearn questions who benefits and who loses from such foreign capital led growth. The country's most significant economic achievements have shown to be dominated by growth in corporate profits and professional incomes, with little evidence so far of any trickle down to other sectors (O Hearn, 1998). The final indictment of the 'Celtic Tiger' is that economic growth generated during this period has failed to address the poverty in terms of access to health, affordable housing, adequate primary school buildings and care for the intellectually and physically disabled. The list could go on but the simple point is that we have learned that economic growth that is divorced from the needs of ordinary people is unequally divided and unsustainable in the long term.

Community development in Ireland is historically rooted in the co-operative movement.

Muintir Na Tire founded in the 1930's also stresses the importance of self-reliance and local initiative. The 1970's saw the funding of EU anti-poverty programmes sowed the seeds for a broad infrastructure of community and local developments in Ireland. The community development programme, anti-poverty networks and other national level community and voluntary organisations play a central role in shaping national social partnership agreements (White Paper Supporting Voluntary Activity, 2000). Community development is concerned with developing collective local responses to a range of complex social and economic problems. It works to enable genuine equality and social participation, adequate state

support to realize the vision of social citizenship and democracy (Combat Poverty Agency, 1999).

Sustainable development

Sustainable development was defined in the Brundtland Commission report, *Our Common Future* (1987) as, 'development, which meets the needs of the present without compromising the ability of future generations to meet their own needs'. The concept of sustainable development was endorsed by 149 countries, at the UN Earth Summit on environment and development at Rio in 1992. Sustainable development is a political process that affects every aspect of our daily lives from food safety and other health scares, traffic congestion and urban decline, loss of species and habitats to the threat of climate change (Christie & Warburton, 2001: 30).

The paradigm of sustainable development allows us to examine the sustainability of drug treatment initiatives, youth projects and community development initiatives. This paradigm enables us to question the sustainability of the knowledge used to define, construct, talk about and understand many of the problems confronting us today.

Development and the international drugs trade

While there are development-related implications of heroin use, it should not be overlooked that millions of people live under the influence of synthetic drugs like amphetamines and other substances ranging from alcohol and tobacco to industrial products such as inhalants and solvents. Psychotropic substances illicitly consumed in developing countries often originate in industrialized countries. This illustrates the need to rethink outdated strategies, which have long assumed a one-way passage of drugs from developing to developed countries (UNDP, 1994).

The drugs trade has an enormously impact on development. The influence of illicit drugs reaches far beyond the heroin addict and the crime syndicate. It is a problem deeply rooted in broader socio-economic concerns. And that is the point at which the interests of people in the fields of drug control and development intersect. The illicit drugs trade creates significant economic activity in many parts of the world. Despite its illegality, the drug trade in some cases does provide the basic necessities for economic survival.

The war on drugs is a war on drug users

There are many myths about heroin and those who use it. No drug has been more argued over and legislated against than heroin. No drug has been more subject to misinformation and moral panic than heroin. Heroin is depicted in popular media and culture as one of the most addictive and destructive recreational drugs. Addiction to heroin is seen as inevitable. Users are too weak to quit. The debate around heroin and its use is fuelled with misinformation and moral panic. Anxieties about heroin are exaggerated.

The U.S. federal government spends over 19.2 billion dollars at a rate of about \$609 per second on the War on Drugs every year. Miller (1996) in *Drug Warriors & Their Prey* shows how the war on drugs is really a war on an ordinary group of people and their civil liberties. In the United States in the 1990's he argues that drug users were targeted for destruction. Arrests for drug law violations in 2003 are expected to exceed the 1,579,566 arrests of 2000. Someone is arrested every 20 seconds (Uniform Crime Reports, 2003). The war on drugs is an attack on democracy. Certain drug users have been criminalized, medicalized and diagnosed with mental illness, while producers of alcohol, tobacco and pharmacy drugs continued to receive huge government endorsement. He argues that the legal status of a drug is determined by its standing in a culture and by what people believe about its users.

Claims by President George Bush in 1989 that illicit drug use was costing the economy \$60 to \$100 billion a year, were fabricated. This figure was based on a survey in 1982 of daily marijuana users who were earning 28% lower than non-daily users. The income difference had more to do with socio-economic factors than the fact that workers used marijuana. The

president could have argued that a low minimum wage costs the economy \$60 to \$100 billion a year. In fact studies have shown that marijuana users can perform accustomed tasks without measurable disability (Miller, 1996: 3).

Young people and drug treatment

Young people are directly affected by the ebb and flow of neo-liberalism and globalization on a daily basis through fashion, music, sport and recreation. Youth culture transcends the boundaries of geography, culture, religion, ethnic background and language connecting people across the globe. The period of adolescence is like that of the outsider (Wilson, 1956) fraught with anxiety, turmoil, self-doubt and profound alienation. Adolescence is defined as the period of transition from childhood to adulthood that is marked by a rapid process of change in social and psychological functioning, as well as physical growth. During this transition young people experience changes in emotions, values and behaviour, self-image, social role redefinitions, intellectual development, school transitions, social and psychological autonomy and the emergence of sexuality (McNamara, 2000: 30).

In Ireland the conventional defined stages and sequences of transition to fully independent adult status, to a job, independent residence, marriage and family formation is still the dominant pattern. Transitional failures have serious consequences. Failure in education almost guarantees failure in employment. The typical pattern of transition of young people from a lower working class background is one of leaving school early, entry into low status and unstable sectors of the labour market, with persistent experiences of unemployment and consequently being marooned in the parental home (Hannan et al., 1993). Young people who find themselves in this position often have little control over their lives and experience higher levels of apathy, fatalism and powerlessness.

Responses to social exclusion among young people

Young people who leave school early and use drugs are more at risk in terms of their health behavior than their school going contemporaries. Alaszewski et al., (1998) define at risk as 'the possibility that a given course of action will not achieve its desired and intended outcome but instead some undesired and undesirable situation will develop'. These life situations are characterised as being involved in criminal behavior, living in poverty, having learning or physical disabilities, working in prostitution, experiencing educational disadvantage, being out of home, having mental health problems, having a crisis pregnancy, living in geographical isolated areas or living with substance misuse (Burke, 1999). Research shows that 58% of those who present for drug treatment had left school before the age of fifteen (Moran et al., 1996: 13). Those responsible for service provision for young people at risk include teachers, youth and community workers, Juvenile Liaison Officers, Youthreach, FAS and Community Training Workshop trainers, health board promotion staff, social workers, child and family support workers, addiction counsellors, probation and home school liaison officers. The methodologies employed by these professions, are often strongly influenced by the principles from youth work and adult and community development. Examples of such programmes include Spring board projects working to support vulnerable families; Garda special projects working to divert young people at risk from crime; Breaking the Cycle initiative targeting extra resources to pupils in the most disadvantaged schools; Stay in school programmes to prevent early school leaving.

Hurley and Treacy (1992) provide a comprehensive sociological analysis of youth work in Ireland. In that analysis they highlight four models and paradigms of youth work. The first is the *functionalist paradigm* where equilibrium and stability are prioritised. Character building is the basic model of youth work within this paradigm. Here the person is viewed as a bundle of desires, which need to be regulated and tamed and given direction for the sake of social order and individual happiness.

The second is the *interpretive paradigm*, which seeks to understand the world as it is, from a subjective point of view. Personal development is the basic model of youth work according to

this paradigm. The young person here is an individual actor constructed through social relations with others as they negotiate their lives in the context of the status quo.

The third is *the radical humanist paradigm*, which places an emphasis on radical change, emancipation, deprivation and potentiality (Burrell & Morgan, 1979: 32). Critical social education provides the basis of youth work in this paradigm, with a concern for the freedom of the human spirit and the prevention of alienation of the individual. Human will and agency are important here, as people creatively adapt to and influence the environment in which they find themselves.

The final paradigm presented is *the radical structuralist paradigm*, which is committed to radical change, analysis of structural conflict, modes of domination and deprivation. The model of youth work it advocates is one of radical social change. In this model traditional education is seen as reproducing the conditions necessary for the capitalist system. Equality is seen to promote a myth of equal opportunity, which conceals deep-seated inequalities and alienation from education (Ryan, 1991: 19). The young people here are viewed as social transformers and political activists.

Youth work according to Costello (1984) was defined as the social education of young people in an informal context:

Youth work must empower young people and enable them to emerge from the enveloping state of dependence... young people must know, feel and believe that they have some control over their situations in the sense of having the ability to influence intentionally what happens to them and their community. The ability of young people to assess alternatives and choose the most appropriate one in any given situation is central to our views of social education. (Costello, 1984: 115)

Social and informal learning is also a key concern within the field of adult and community education. In recent years, a number of commentators in the area of life long learning have shown an interest in informal learning. Bentley (1998) has examined 'learning beyond the classroom; Coffield (2000) 'the necessity of informal learning' and McGivney (1999) 'informal learning in the community.'

Griffin (1993: 2) argues that much of the mainstream research on socially excluded young people characterizes them as both the sources and the victims of a series of social problems. Here a victim blaming, thesis is adopted search of causes for specific phenomena. Critical theory adopts a structuralist and post-structuralist analyses and deconstructs the association between young people and social problems by asking different questions and by viewing research as a political project. Griffin points out that after a decade of Thatcher in Britain and Reagan in the United States, there was a resurgence of biological determinism, which had profound implications for the treatment of youth and adolescence. Biological determinism prescribes young people as deviant, deficient or resistant and that these states are natural, inevitable and irrevocable. Discourses concerning the 'wasted abilities' and 'problem attitudes' of working class school leavers, dominated educative initiatives that sought to address their biological problems with cognitive restructuring, self-esteem and motivational interviewing techniques.

O'Brien (2000) in his analysis of the causes of 'early school leaving' in St. Teresa's Gardens in Dublin's south inner city found that these young people were constructed through six separate discourses. In his deconstruction of early school leaving, O'Brien shifted responsibility for early school leaving from the young person to the discourses that shape the construction of the problem. The genetic discourse located the problem of school failure in the young person's intellectual genetic deficit. If you were from the 'Gardens' it was accepted that you lacked the intelligence to succeed in school. The class discourse constructed the problem as part of the structural reproduction of class inequalities, where it becomes inevitable to leave school early if you're from the 'Gardens'. The discourse of cultural deprivation located the problem in the cultural conditions of poverty where schooling itself plays a part in denigrating the culture of St. Teresa's Gardens, marketing mainstream culture as the only acceptable one.

The political discourse constructed the issue of early school leaving as a political act of resistance on behalf of the young person who rejects the official curriculum (Willis, 1977). The gender discourse constructed working class girls as not expecting too much from education or the work place. The hidden curriculum (Lynch, 1989) was seen to reinforce gender inequalities and to domesticate young women to the values of caretaker and homemaker. Finally the development discourse constructed 'developers' specializing in youth

and community work, as the ones with the radical approach to tackling the root causes of early school leaving. The problem with our modern concept of development according to Vincent Tucker is that first of all development is a myth and secondly it is a failed concept (Tucker in Munck & O Hearn, 1999: 202).

Griffin (1993) further describes several important discourses that have dominated thinking in relation to socially excluded young people, since the 1980's. The troubled or delinquent youth is constructed through a clinical discourse, which likened these behaviours to a disease, which can manifest itself in various disorders of consumption in the form of drug abuse, eating disorders and suicide. The deficient youth is helped by the constructions of medical (cured) and developmental (rehabilitated) models of adolescence, through employing a discourse of education and training. The rebellious youth (discourse of disaffection), straddles the categories of normality and deviance. It is assumed that the rebellious youth can be trained to channel their potentially disruptive energies into the relatively acceptable forum of competitive sport (Griffin, 1993: 118). This is reflected in the discourse of muscular competition, which unites the concepts of youth, sport, leisure, delinquency and masculinity in cathartic configuration.

As St. Teresa's Gardens and the Northeast inner city of Dublin share similar social, cultural and economic experiences, these discourses articulated by O'Brien (2000) provide an accurate educational profile of the young people attending Crinan for drug treatment. They enter the stage of treatment with dual constructions through discourse not only as failed school leavers but also shamed as diseased school leavers.

Young people who enter treatment for drug use are often referred by the criminal justice system or as the result of the intervention of family or friends. Their motivation for treatment is minimal. A very important prerequisite for effective treatment is that individuals want to solve their drug problem and are willing to engage in a programme that will address their needs. Treatment services for young drug users are best located in their community with collaborative links between the youth service, schools, social services and specialized drug treatment services e.g. Crinan Youth Project.

Creative arts and rehabilitation

The Soilse drug rehabilitation programme designed, implemented a creative arts project to evaluate the project's relevance to the health and social gain of the participants in the context of their addiction. In doing so, the project enabled the participants to engage critically about the issues of drug treatment, using creative means to include, articulate, empower and create. In another example the North City Centre Community Action Project (NCCCAP) worked with a group of trainees to develop a compact disc (CD) of their own songs and music, expressing their experiences of drug use and life in the northeast inner city of Dublin. Their music is reflective, critical and expressive of the pain and vulnerability faced by many young people in this community. Both of these project's expressions through art and music, are critically reflexive, provocative and expressive, while at the same time inviting their viewers and listeners to share their experiences and feel their pain. This kind of experience was also reflected in the 2003 Special Olympics, where a nation was transformed having shared the feeling of a group, normally hidden away from society. The important thing about these two examples is how the participants were involved at every level of the process and shared in the outcomes.

Conclusion

Adult and community education is a broad discipline and body of knowledge constantly being renewed and developed. In this chapter I have focused on the more critical aspects of adult and community education that can be applied to an analysis of drug treatment in a community development setting. I have highlighted the main issues and looked in some detail at the discourses of neo-liberalism and critical theory as they apply to adult and community education. I have identified some of the strengths and weaknesses of adult and community education and highlighted some of the issues that require further analysis. In particular I have critiqued the dominance of methadone in the treatment of heroin addiction. The next chapter looks at this issue in more detail through the discourse of biomedicine.

Chapter 4

Biomedicine – a treatment discourse

Introduction

This chapter looks critically at the discourse of biomedicine and examines how it came to be the dominant force in the treatment of heroin addiction. In doing so the chapter will examine the social construction of medical knowledge and the problems associated with the medical model of disease. The chapter will also examine neo-liberalism and health, the medicalization of life and the medicalization of drug treatment by the use of methadone. The pharmaceutical industry and its relationship with medicine is also examined as it has enormous influence on how medicine is practiced and in some cases financed.

Biomedicine

Our relationship to medicine and medical knowledge is not only intellectual, but also emotional and moral. Modern culture is full of stories about great doctors who invented cures, saved lives and supported communities single-handed. Most people have stories about being saved or cured by modern medicine (Tucker in Cleary, 1997).

The biomedical model of illness is based on a mechanical conception of the body as a physical system, which can break down and need treatment to restore it to good working order. The biomedical model is underpinned by a dualistic understanding of the person made up of a mind and a body. The Cartesian divide of mind and body is at the centre of how diseases are understood and treated. Here the mind and the body are sharply distinguished, with the body being the subject of the natural sciences and the mind the subject of the human sciences (White, 2002: 124). Here both mind and body are thought to operate independently of each other. The Cartesian view of the body has left us with a reductionist image of the priority of the physical over the mental, in both the psychological and medical sciences. This divide is reflected within the Irish addiction services where consultant posts are all filled by psychiatrists. Psychotherapists and counsellors fill positions further down the hierarchical ladder.

Jary and Jary (1991: 43) outline the biomedical model of illness in the following way:

- a) Normally people are free of the symptoms of ill health or are unaware that they are ill;
- b) That illness consists of deviation from a set of biological norms;
- c) That emotional or physical change which are biological in origin make people aware that some thing is wrong;
- d) That the initial response to something being wrong is rest;
- e) That if the symptoms get worse people will visit a doctor;
- f) If the person is diagnosed as sick the doctor will prescribe a treatment;
- g) The core concept of medical treatment is cure.

Jewson (1976) outlines Foucault's history of medicine, which moves from bedside medicine, to hospital medicine to laboratory medicine. The period from the Middle Ages to the eighteenth century was one of *bedside medicine*. Here doctors were dependent on the patronage and the command of the patient. Disease was something that happened to the person and understood as a lack of balance involving both physical and spiritual factors. The Industrial Revolution of the nineteenth century resulted in the growth of huge hospitals to house the sick marked a period of *hospital medicine*. The patient became dependent on the doctor and disease was a problem for specific organs and not the whole person. The doctor is only interested in physical information. The patient yields to treatment. From the mid-twentieth century on is the period of *laboratory medicine* in which both patient and doctor are displaced by the scientist and laboratory technician by what Foucault calls the scientization of life. Healing no longer depends on any charismatic ability of the practioners (White, 2002: 121).

Biomedicine is mechanical in its treatment of the person who is compared to a machine with complex parts that can go wrong. The purpose of medicine is to treat and repair each part in isolation. Biomedicine takes a reductionist approach to explaining diseases purely in biological terms. Medical knowledge is applied to repair damage or sick biological systems. Biomedicine adopts an empirical approach where knowledge is generated by observation and confirmed through a process of experimentation (Hardey, 1998). The bio-medical paradigm is

based on a reductionist scientific methodology that reduces complex wholes to their constituent parts and explains the whole by reference to its smallest parts. In medicine, reductionist methodology draws attention away from social, economic, environmental and psychological factors in the pursuit of the disease.

Critique of bio-medicine

Modern medicine is based on the belief that science provides us with objective knowledge about the natural world.

Medical facts do not simply emerge when a new technical instrument such as the microscope allows us to uncover previously unknown layers of reality. (Tucker in Cleary, 1997)

The construction of scientific facts does not happen in hermetically sealed laboratories cut off from the social and political world. Health and medicine are deeply embedded in the social world. Social scientists have shown how medical knowledge is itself social and reflects the culture and politics of its time. The pharmaceutical industry for example prioritises the profits of its shareholders ahead of treating the sick (Robinson, 2001). For science to be successful it must find political and commercial support to help promote and finance their research.

Engel (1980) suggests the biomedical model has been transformed into a folk model that is based on a number of myths. Firstly, the myth that equates health with medicine and the associated belief that the health of a population is dependent on doctors and drugs. This myth promotes the view that doctors are responsible for maintaining the health of a population. The second myth of the biomedical model is that modern medicine has succeeded in curing the dominant diseases of Europe and thus increased the longevity of people in western societies. These myths are central to the medical discourse, which is promoted by powerful interest groups such as the medical profession and the pharmaceutical industry (Tucker, 1996).

McKeown (1979) demonstrated that the decline in deaths caused by infectious disease at the end of the last century had little to do with medical discoveries such as drugs and vaccines, but resulted from social, political and environmental changes. In 1984 the Minister for Health, Barry Desmond TD questioned the effectiveness of biomedicine in improving the health of the Irish population. Twenty years later with the Irish health care system in deep crisis Desmond's words seem prophetic. Hospitals, particularly those close to Dublin seem in a permanent state of turmoil. The winter vomiting bug, nurse's strikes, industrial action by junior doctors and public health doctors, funding shortfalls, bed closures, and the crisis

precipitated by Severe Acute Respiratory Syndrome (SARS) are all symptomatic of the failure of the biomedical paradigm at the heart of our health care system. Other factors that are putting extra pressure on the health care system include coronary heart disease, cancer, alcohol abuse and road accidents, all factors closely associated with environment and lifestyle choices. Inglis (1983) calls these 'diseases of civilisation', which are due to social, and environment conditions rather than simple biological agents and are not as readily amenable to biomedical treatments such as infectious diseases.

D'Arcy (1986) has shown that in the US in the 1980's \$5 billion a year was spent on treating adverse drug reactions. Less than half this amount was spent on prescription drugs during the same period. About 1.17 million Britons end up in hospital each year because of doctor error or a bad reaction to a drug. If you live in the US, where about 40,000 people are shot every year, you are nevertheless three times more likely to be killed by a doctor than by a gun (McTaggart, 1996: 6). According to Illich (1976) the medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic. Iatrogenesis, the name given to this new epidemic comes from *iatros*, the Greek word for 'physician' and 'genesis' meaning origin. Iatrogenic disease is particularly evident in the case of prescription drugs. The pharmaceutical industry has brought mixed blessings producing and promoting such drugs as heroin and cocaine, which have led to massive problems of dependency and addiction (Medawar, 1992; Braithwaite, 1994).

One of the most worrying aspects of modern medicine is that the overuse and abuse of antibiotics will expose us to new viral infections for which we have no cure. New viruses such as SARS have developed stronger resistance to antibiotics. Vithaulkas (1991) argues that the increasing incidence of AIDS, cancer, asthma, epilepsy, Alzheimer's disease, rheumatoid arthritis and other difficult to treat diseases is related to the weakening of the human immune system due to the over prescribing of drugs. Despite this Tucker in (Cleary, 1997) argues that health authorities and doctors look towards the pharmaceutical industry to produce new drugs to keep us a head in the race against mutating bacteria instead of taking the measures necessary to curb the abuse of antibiotics and other drugs. However the number of deaths attributed to such 'new' diseases is insignificant when compared to deaths by heart disease,

cancer and long-established and preventable diseases such as measles, whooping cough and diarrhoea that remain significant causes of death in the developing world (Hardey, 1998: 20).

Mendelsohn (1979) suggested that 'modern medicine is neither an art nor a science, it's a religion'. Medicine as it is practised today is largely a conspiracy of faith. Mendelsohn was the first to liken modern medicine to a church with doctors its high priests following the teachings with blind faith. Engel's (1980) argues that biomedicine has come to constitute a dogma and like all dogma is maintained through authority and tradition.

Social construction of health and illness

Parsons (1951) gave medicine a central role in maintaining the stability of society. Health was adopted as a major theme for the first time within the functionalist theoretical framework. A healthy population ensures the smooth running of society. Illness was understood as deviant in that the sick person could not undertake their social role. An inappropriate amount of illness could threaten social stability. The sick person could be exempt from employment and domestic work but they had to seek and comply with the treatment given and must recover as soon as possible according to Parsons.

Following Parsons' functionalist theory, various forms of Marxist or conflict theories and interactionist theories entered into academic debate about the virtues or deficiencies of the different approaches (Hardey, 1998: 23). Conflict theories conceived medicine as generated and supported by the economic and social system of market-based economies. It may also reinforce health inequalities in society by focusing on health as an individual matter and drawing attention away from factors such as poverty and housing.

The social construction of medical knowledge

Constructionists argue that medical knowledge is produced by and reflects the society in which it is embedded. Medical knowledge reflects the assumptions of the neo-liberal society that produces it. These arguments are based on the classical sociology of knowledge of Emile Durkheim. He argued that the concepts, which we use to think, are not reflections of nature, but of the social organisation of society (Durkheim, 1933).

For a long time medical sociology did not concern itself with an analysis of medical epistemology. Wright and Treacher (1982) suggest several reasons for this omission. First, medical knowledge was taken for granted by sociologists. Instead, research focused on the great achievements in medicine. Second, medicine was seen to be part of the natural sciences and granted an epistemological privileged position. Medical knowledge claims were not open to inquiry. Finally, it was believed that for medicine to advance it had to distance itself from the social. The more abstract and 'scientific' it became the better it would perform (White, 2002).

These claims have been contested by sociologists who argue that the boundaries of medicine are defined by powerful para-medical groups (Willis, 1989) and other professional groups such as the legal profession. These boundary definitions concern areas of competence, particularly the right to define insanity (Smith, 1981).

For Fleck (1935 [1979]) medical knowledge was a social product. He understood scientific knowledge as collective knowledge, historically located and a product of interactions between competing groups with alternative definitions of reality (White, 2002: 25). Douglas (1973) argued that medicine is a set of categories that filters and constructs experience. Foucault (1973) described medicine as a discourse, which produces its own objects and opened a wider debate on medicine as a social institution. Foucault is concerned with the process whereby the human is turned into the subject of scientific investigation and control (Foucault, 1982).

Foucault argues against Marx that there is more to modern societies than economics. In particular he points to the development of bureaucratic surveillance of the population as a

dominant feature of society, where information needs to be generated, monitored and evaluated. For Foucault the new academic disciplines of psychology, psychiatry and medicine were also disciplines in the sense of prescribing how people should act and behave, the lifestyles they should adopt and in establishing norms of behaviour which they could enforce (White, 2002: 120). This is brought about by the development of professional groups whose claim is both to understand human beings (knowledge) and to prescribe to them how to act (power). This is central to Foucault's analysis of society. Foucault's analysis of modern society moves around the three interrelated aspects of body, power and knowledge. 'The body is both the target of and is constituted by the power relations focused on it, which render it obedient and docile' (White, 2002: 118). In the same way the body is a carrier of commodities and lifestyles, whether in the gym, by the labels one wears or the drug choices one makes. The body in this way becomes a symbolic maker of social status (White, 2002: 122).

According to Foucault modern medicine produces a techno-political register of the body for submission and use. Rather than breaking the body, the aim of rehabilitation of the body/mind through the prison, the hospital, the asylum or drug treatment centre.

Some subjugated groups become the target of the medical profession or of the state for rehabilitation in the guise of empowerment are drawn into a power/knowledge field. The subjugated groups are labelled 'insane' or 'homosexual' or a 'drug addict' and so must be allowed to dispute their labels.

The way that we understand ourselves, Foucault argues is a product of professional discourses, which provide us with a vocabulary to understand ourselves. We internalise these images and then take them for granted. (White, 2002: 129)

The domain of medical knowledge remains a negotiated one. The social constructionist theory of medical knowledge examines medicine as a social practice constituted as an abstract entity whereby medical concepts are transferred into social life (Wright & Treacher, 1982). The most important application of this argument is to be found in the sociology of disease.

The problem with the medical model of disease

Within the biomedical model, disease is presented as a fact within the context of a natural science methodology. Here disease is understood as the absence of health placing the organism at a biological disadvantage. Within contemporary medical philosophy, it has become almost impossible to distinguish disease from non-disease (White, 2002: 18). Attempts to distinguish between disease and subjective psychological or social factors have been made by Taylor and Scadding (1980);

They suggest that disease in general that which separates patients from non-patients is distinguished by (1) a desire for therapy by the patient; (2) a recognition by other in the individuals environment that aid should be administered; and (3) a concern expressed by a medical practioners. However, as they point out, these characteristics embody those very social and cultural influences that they think should be excluded from any definition of disease. (Taylor & Scadding cited in, White, 2002: 18)

It remains difficult to distinguish diseases from social circumstances especially where the named disease is contested e.g. addiction. This inability to theorize diseases only arises because they are given a privileged epistemological position within biomedicine. Rosenberg (1986) suggested 'disease does not exist as a social phenomenon until it is somehow perceived as existing'. Heroin addiction only became a social problem when it was linked to the spread of HIV among the heterosexual community. Addiction had already been constructed as a disease under the biomedical paradigm. Delaporte (1986: 131) went even further by suggesting that 'disease does not exist; what exists is social practices'.

Historical evidence supports the constructionist approach of understanding disease as being embedded in social relations. Masturbatory insanity was a major disease of men in the eighteenth and nineteenth centuries. The disease of masturbatory insanity had physical symptoms including baldness, stammering, blindness and skin diseases. The disease of hysteria operated in a similar way in the nineteenth century to constrain women. These two examples illustrates the way in which medical thought is structured and sustained by the social, political and economic concerns of the social groups producing it (White, 2002: 20).

On the other hand, many taken for granted medical practices of today have in the past been met with resistance at the time of their discovery. Stern (1927) documents opposition to

dissection, to the theory of blood circulation and to vaccination. His argument that if technology did not fit in with the prevailing cultures then it did not count as a technical advance (White, 2002: 22).

Social relations also shape the application of medical technology particularly in cultures in which there is inequality based on ethnicity. The treatment of coronary artery disease is a well-established surgical procedure, which can be determined on objective clinical grounds. Yet in New Zealand in 1983, when 822 coronary bypass operations were performed, only 10 were carried out on members of the minority indigenous population, the Maori who suffer heart attacks at significantly higher rates (Pomare, 1988). The diagnosis of diseases among subjugated groups is a product of the social structures of those societies (White, 2002: 22).

The medical profession has risen to its position of dominance in the health sphere not because of its scientificness, nor because of its technical advances, but because it has organized itself as an occupational group to exclude or control other workers in the field. (White, 2002: 23)

McKeown (1979) shows how the medical profession organized itself and achieved high social, political and economic status in the late nineteenth and early twentieth centuries before it had developed a coherent knowledge base.

Neo-liberalism and health

Philosophical liberalism has its origins in the eighteenth century and became politically influential in the nineteenth century. Liberalism became the political force behind the capitalist class that created the industrial revolution. Under liberalism individual effort was encouraged and rewarded, whereas collective action was discouraged and suppressed. The main problem with liberalism was that we do not all start equally and so some get off to a better start than others and end up with more capital and power. The outcome of liberalism was the formation of a capitalist class that exploited workers in the pursuit of profit (White, 2002: 57).

The industrial revolution brought with it rampant poverty, huge social inequalities and a decline in the health of the population, particularly among the working class and the poor. Disease was not evenly spread across society but concentrated among slum dwellings and industrial occupations. In England, social reformers began linking the conditions of poverty and inequality with higher incidences of disease and death (Engels, 1974). Engels argued that the pursuit of profit produces sickness and disease and that in such a social system individuals were powerless to protect themselves (White, 2002: 58). As early as 1880 the Royal Sanitary Commission documented that severe overcrowding, lack of sanitation, poor diet, damp and cold conditions and foul air, all conspired against the health of tenement dwellers. This was dramatically confirmed by the end of the century when Dublin recorded the highest death rate of any city in the United Kingdom. Twice as many people died of tuberculosis in Dublin as in London (Kearns, 1994).

The tenement population was threatened by a host of illnesses – tuberculosis, diphtheria, pneumonia, smallpox, typhoid, whooping cough, rheumatoid arthritis, respiratory problems, diarrhoeal disease and various infections. The susceptibility of the poor to sickness and disease was clearly due in greater part to their malnourished and physically unhealthy condition at birth. (Kearns, 1994: 35)

It was only through government reform and collective action that the social causes of disease would be effected (Szreter, 1988). Political and economic changes after the Second World War led to the emergence of the Welfare State. Governments moved towards policies that regulated the market, protected workers and improved living conditions.

Today globalisation has resuscitated liberalism under the guise of neo or new-liberalism also referred to as the New Right. The shift of industrial production to low-cost sites in developing countries where worker protection is lower and an estimated 1.1 million people are killed worldwide each year according to the World Health Organisation (*The Ecologist*, Sept 2000). Health is being threatened by neo-liberal policies. This shift towards neo-liberalism was enshrined in the words of Margaret Thatcher 'Society does not exist, only the individual' (White, 2002: 59). The impact of neo-liberalism on public health has been colossal. In 1993 there were 244 doctors per 100,000 people in the First World and 13 doctors per 100,000 people in the Third World (*The Ecologist*, Sept 2000).

It is increasingly clear that the burden of disease is on the poor, with an ever-increasing gap in health status between those at the bottom and those at the top of the social system (White, 2000b). The World Health Organisation has reported that the health of populations depends upon collective action to control unemployment, the psychological environment of work, the provision of public transport to the elderly and poor and the provision of community structures that support social cohesion (Marmot & Wilkinson, 1999). Individual actions are always 'at the end of the chain of social causation and not at the beginning' (Montgomery et al., 1998). The further out from the individual that an intervention occurs the more impact it has on the behavior of an individual and their community. An individual's health related behaviour is shaped by their social position and is not freely chosen. Good health depends on prosperity, redistribution of wealth and welfare sectors of governments (White, 2002: 60).

Epidemiology now reflects the core assumptions of neo-liberalism: it is individualistic, and makes little or no reference to 'social factors', focusing rather on individual risk behaviours (White, 2002: 61). Individual risk factors do not take into account the complexities of social life. According to Terris (1996) the risk factors for heart disease have more to do with social and cultural factors than individual ones.

Even if it were lifestyle risk behaviours that were the cause of disease, extensive studies have shown that it is almost impossible for people to change on their own and in isolation from their social circumstances. (White, 2002: 62)

Link and Phelan (1995) argue that individuals lack the resources required to respond to the individual risk factors and that if we want to change the pattern of disease then we must change the distant, not the proximate causes. In other words the further out in society we intervene in the social system the more likely we will affect the patterns of disease.

According to Syme (1996) one way of doing this is to develop a sociological model of the causes of disease, in contrast to the medical and epidemiological explanations of disease as inherently individual occurrences. Diseases should be classified by their social causes. Davis (1994) has developed a sociological model of disease and shifts the debate on health from the individual to the economic, political and cultural institutions that produce disease (in White, 2002: 63). In doing so Davis breaks with the sense of biological inevitability that the medical model of disease leads to. People's lifestyles and actions are seen in the context of the social groups they live in and the political and economic context that shapes the treatment offered to them. This argument is backed up by extensive evidence that inequalities in health status are replicated within class positions (Marmot, 1998). Marmot found that education levels were the strongest predictor of health. The lower the education, the lower the health. Wilkinson (1995) also argues consistently that patterns of sickness and disease, and most importantly early death, are a product of the systematic inequalities in society.

Medicalization of life

The expanding range of medial interventions aimed at prolonging our lives characterizes the medicalization of life. There is an unprecedented level of medical surveillance in relation to sexual, mental and physical health. The definition of disease has expanded to include a wide range of social and biological phenomena including crime, alcohol and illicit drugs. People are suffering from an expanding range of disease states, evaluated in psychological and moral terms (Fitzpatrick, 2001: 6). It has been recognized that our modern diet and lifestyle is unhealthy. Life expectancy has increased by thirty years in the last century and we are increasingly preoccupied with our own health. There is also a huge disparity between the rich and the poor in health terms. Reducing the socio-economic inequalities in health is a major concern for individual countries within the European Union (MacKenbach & Bakker, 2002).

Dubos (1960) argued that modern medicine was reaching its limit in tackling the great medical problems like cancer, heart disease and mental illness. Health has come to be associated with self-discipline and regulation. The causes of most disease states are the indirect out come of a constellation of circumstances. Starr (1982) reflected on the new social movements and their articulation and demand that health care is a matter of right not privilege.

Critiques of medicine have also come from feminist thinkers with their analysis of the medical profession as dominated by middle class men. The anti-psychiatry movement has also yielded varying critiques on the medicalization of life from Foucault's *Madness and Civilisation*, (1965), Thomas Szasz' *The Manufacture of Madness* (1971) and R.D. Laing's work *Sanity, Madness and the Family* (1964). Foucault's work has opened up new lines of inquiry and permitted sociologists to think about medicalization of society within a new framework (Petersen & Bunton, 1997: xiii). Of particular concern to this study is his concept of the McDonaldisation of society and understanding the clinic as a site of bio-power. The mass dispensing of methadone to increasing numbers with greater efficiency and standardisation is an example of this concept. Methadone has come to represent a form of medical surveillance, which is normalised through medical discourse. Lacking in medical knowledge patients are

placed in a position of vulnerability, where they are maintained by the social power of the doctor.

Methadone - medicalization of drug treatment

Illicit opiate use became a public health problem in Dublin in the early 1980s and throughout the decade the dominant form of healthcare response was one of abstinence. In 1991, the Department of Health embraced the 'harm reduction model' of treatment for opiate use because of the relatively high HIV prevalence in Dublin among injecting heroin users. Harm reduction sees addictive behaviour along a continuum. Harm reduction has as its first priority a decrease in the negative consequence of drug use. The roots of harm reduction are found in the United Kingdom, the Netherlands and North America (Riley, 1993; 1994).

Methadone is part of the 'harm reduction model' and is most common treatment for opiate users and addicts. Methadone is a legal synthetic opioid used to treat the withdrawal symptoms in addicts who have ceased using heroin on commencing a treatment programme. Methadone works by occupying the opiate receptors in the brain and suppressing opiate withdrawal for up to 36 hours. It can be taken orally thus reducing the risk of contracting HIV associated with injecting heroin. Methadone treatment is considered to be largely part of a medical or biomedical approach to drug use and addiction.

HIV and AIDS have been the main catalyst for the rise in popularity of harm reduction. Before the AIDS pandemic, drug use was associated with a relatively low mortality rate because of periods of abstinence and natural recovery (Brettell, 1991; Wille, 1983). During the 1980s there was a rapid increase in both AIDS and non-AIDS related deaths in drug users (Stroneburner et al., 1989). The UK reports from Edinburgh revealed a prevalence of HIV among injecting drug misusers which was considerably higher than in the rest of the United Kingdom and parts of Europe and the United States (Peutherer et al., 1985). The issue of potential heterosexual spread of the virus was not new. The blood transfusion question and the spread of the virus among haemophiliacs had, in 1983-4, raised the question of the spread of the virus into the general population (Berridge, 1996a). Harm-minimisation became the primary objective of British drugs policy in reducing the spread of HIV infection and allaying public concern. The threat of the spread of HIV into the general population seemed to justify a response based on the minimisation of harm from drug use and on attracting drug users into contact with services.

The gravity of the problem was such that on balance the containment of the spread of the virus is a higher priority than the prevention of drug misuse. (Scottish Health and Home Department, 1986: 5)

In Ireland the traditional objective of drug policy has been to maintain people in or restore people to a drug free lifestyle. Since the 1980s when the link between needle sharing and the transmission of HIV was first recognized, a more pragmatic approach has been taken (O'Brien & Moran, 1997). Although general practitioners in Ireland were advised not to treat addiction problems, any registered medical practitioner could legally initiate methadone treatment for unlimited numbers of clients in their practices until October 1998. At that time the Minister for Health and Children introduced regulations by means of a statutory regulation under the 1977 Misuse of Drugs Act to limit the prescription of methadone by general practitioners.

In October 1998 the Misuse of Drugs Regulations came into operation in Ireland, creating a licensing system for the prescription of methadone by general medical practitioners. The new system referred to as the methadone protocol restricted the prescribing of methadone to Level 2 GPs who have specialized training. The scheme also established a register or central list of patients for whom methadone was prescribed so as to avoid multiple prescribing for individual drug users and the diversion of methadone onto the black market (Butler, 2002b: 311). The value of prescribing methadone was welcomed with caution by one member of the expert committee on the establishment of a protocol for the prescribing of methadone.

Methadone should always be regarded only as an adjunct to treatment and not treatment per se. (Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone, 1993 cited in Butler, 2002: 318)

Today all European States run drug-substitution programmes and it is estimated that over 300,000 drug users in the EU are receiving substitution care from general practitioners, treatment centres, methadone clinics, mobile 'methadone buses' and pharmacies (Farrell et al., 2000). In Ireland the number of heroin users on methadone maintenance programmes at December 2000 was 5,032 compared to 4,332 at the end of 1999 (National Drugs Strategy, 2001).

The effectiveness of methadone maintenance treatment in reducing opiate use, crime and HIV risk behaviors is well documented (Ball & Ross, 1991; McLellan et al., 1993). However many patients drop out of treatment or continue using opiates and other illicit drugs (Morral et al., 1997; Nunes et al., 1997; Belding et al., 1998). A large number of patients relapse within one year of terminating treatment (Simpson & Marsh, 1986).

The role played by methadone in drug overdose is a serious concern (Kaa, 1992; Oppenheimer et al., and Scott et al., 1998). Large doses of methadone in combination with other substances and its accidental ingestion by intolerant persons can all result in toxic reactions and overdose fatalities (Neale, 2000). Some commentators have suggested that prescribed methadone is more dangerous than the heroin it replaces (Harding-Pink, 1993, Marks, 1994 and Newcombe, 1996).

There are persistent issues including the problem of methadone diversion, isolation from other health care institutions, opposition from abstinence based programmes and treatment complications associated with co-morbidity (Milby et al., 1996). One of the persistent issues about methadone treatment is the question of optimal dosing (Blaney, et al., 1999). While low dose methadone may be ineffective for some patients to eliminate illicit heroin abuse (Payte & Khuri, 1993) and may result in higher rates of patient dropout (Capelhorn & Bell, 1991) high dose methadone is associated with improved client-retention rates (McGlothlin & Anglin, 1981).

Methadone has been linked to a number of drug related deaths in Ireland in recent years. Of the 108 deaths related to drugs or alcohol investigated by the coroner, Dr. Brian Farrell, in 1998, methadone was implicated in 37 deaths (*The Irish Times*, 16-9-1999). In practice, the extent to which methadone is implicated in drug deaths is likely to be influenced by a number of factors. O Connor (2001) consultant psychiatrist with the Drug Treatment Board found many substance abusers are 'doctor shopping' in order to satisfy their addiction and that nearly all post mortem deaths indicate they were using benzodiazepines with other drugs.

The literature on gender differences in substance abuse treatment has been limited (Wells & Jackson, 1992). Rowan-Szal et al., (2000) examined a sample group of 635 clients (199

females and 436 males) and found that women entered treatment with more psychological symptoms and AIDS/HIV risky behaviors; presented with less criminal activity, less alcohol use and higher motivation. Similar studies have shown that females in methadone treatment have higher rates of psychological and family problems (Craddock et al., 1981; Marsh & Miller, 1985). Symptoms often include low self-esteem, more depression, higher anxiety and more suicidal thoughts and attempts. They enter drug treatment with child welfare issues, domestic violence experiences as well as employment and training problems (Wechsberg et al., 1998). Women also report more illegal tranquilliser use and more HIV/AIDS risky sexual behavior. Women on methadone were more likely to stay in treatment longer and have higher rates of treatment completion (Savage & Simpson, 1980).

Rowan-Szal et al., (2000) found that greater improvement in post-treatment outcomes have been demonstrated in programmes that provide larger amounts and types of services that matched individual client needs, especially in the area of mental health and employment. Meulenbeek (2000) in a study of heroin users on a methadone programme in the Netherlands found that clients needed help in the areas of employment, drug use, legal status, social and psychological functioning.

Knowing how patient characteristics, service usage and treatment outcomes interact, has important implications for the design of treatments (Widman et al., 1997). Several studies have suggested that methadone treatment varies widely in terms of services available to patients and the impact of these varied services (D'Aunno and Vaughn, 1992). While the quantity of treatment experience has been shown to affect patient outcomes, the quality of such experience needs to be considered as well (Ball et al., 1988).

Lilly et al., (2000) suggest the primary emphasis has been on 'how much' and 'how often' rather than studying the social processes and the context of methadone treatment delivery. The management of staff-client relationships, and the provision of counselling and support in methadone treatment, has been linked to treatment effectiveness (Ball & Ross, 1991; McLelland et al., 1988). In the context of this research Lilly et al., argue that we have little understanding of the factors that are important in building and maintaining effective relationships between staff and clients.

It has been noted, for example, that clients may experience 'alienation and powerlessness' because of the high regulatory nature of methadone treatment and how this limits the extent to which staff can engage in a counselling process. (Lilly et al., 1999 cited in Lilly, et al, 2000: 164)

Lilly et al., (2000) found that the relationship with the keyworker was central because it was seen as providing the 'gate way' to treatment and methadone. The stability of this relationship is made problematic by the chronic relapsing nature of opiate addiction. The ongoing management of such tensions within this relationship is a particularly important feature of methadone treatment delivery. Lilly et al., (2000) argue that methadone treatment consists of more than the dispensing and consumption of a 'medicine'.

Little is known about the long-term impact of methadone on the length of a drug-using career. McIntosh and McKeganey (2002) ask 'do individuals remain longer as a result of being prescribed methadone over many years that they would have done had they not been prescribed the drug?'

Little is known about drug users own views of methadone. One of the few studies that has reported on this, was carried out by Neale who interviewed 80 addicts receiving methadone in Scotland (Neale 1998, 1999a, 1999b). According to Neale the addicts interviewed in her study regarded methadone as a complex drug with positive and negative consequences. Positive benefits included improved emotional and physical health, a reduction in illicit drug use and participation in crime. Nearly two-thirds of the addicts interviewed in Neale's study commented that they had experienced negative health effects resulting from their use of the drug, including constipation, sweating, sleeping problems, stiffness and hallucinations. For some methadone has simply become another drug to which they were addicted.

They also resented the fact that, on at least some occasions, writing out a prescription for methadone had been the easy option for doctors who, they said, were unwilling to address the real causes of their drug addiction. (McIntosh and McKeganey, 2002: 145)

Although there has been an increased emphasis on stabilisation, detoxification, rehabilitation and reintegration, abstinence is still the official governmental goal of all treatment programmes. In a recent study methadone maintenance was well received by many when the ultimate goal was abstinence. But support for such programmes may wane if they are not

seen to be able to restore the drug-addicted individual to a drug free lifestyle (Bryan, et al., 2000).

The pharmaceutical industry and drug treatment

The pharmaceutical industry has come in for a lot of criticism in recent years for its own self interest in prioritising profits ahead of the millions of people through out the world who are dying because they cant afford to buy expensive medications (Channel four, 2003).

Faced with a cure looking for a disease the drug industry has been ingenious in defining new illnesses and hence new applications for its products. (Johnstone, 1989: 168)

Profiting from Pain

Pharmaceutical companies are among the most powerful and profitable in the World. They have been ranked as first or second most profitable industries in the world in most years since 1955 and are outstripped only by the international arms trade (Johnstone, 1989: 166). Drug companies argue that the high cost of drugs is justified in order to pay for ongoing research and development of new drugs. Data gathered by Families USA demonstrate that the major pharmaceutical companies spend significantly more on marketing, advertising, and administration than they spend on research and development.

In 2001 Families USA in a report '*Profiting from Pain*' examined the accounts for nine of the most profitable pharmaceutical industries (Merck & Company; Pfizer, Inc.; Bristol-Myers Squibb Company; Abbott Laboratories; Wyeth; Pharmacia Corporation; Eli Lilly & Co.; Schering-Plough Corporation; and Allergan, Inc). They found that the combined income of these nine companies was \$166,678 million, of which 27% or \$45,413 million was spent on marketing and advertising, 11% or \$19,076 million was spend on research and development and their combined profit was 18% or \$30,599 million (Families USA, 2001).

The drug industry pumps huge sums of money into marketing because it works. Advertising and marketing help drive sales, and top-selling drugs can generate large revenues. For example, Pfizer had eight drugs with sales of over \$1 billion in 2001 (Findlay, 2000). The industry is also very generous to its top executives, offering them millions of dollars in annual pay, supplemented by even larger company stock options. The 10 highest paid executives

across the nine companies received a total of \$236 million in compensation in 2001 (Families USA, 2001). Rising drug prices hurt everyone who pays for health care especially the estimated 65 million Americans who lack insurance coverage for prescription drugs and must shoulder these price increases on their own (Findlay, 2000).

Advertising

Drug companies spend vast sums of money on advertising, aimed at influencing the prescribing patterns of general practitioners. In Britain and Ireland it is illegal to advertise prescription drugs directly to the patient.

In the US, multinational pharmaceutical companies have found they can hugely expand their markets by advertising prescription drugs to the public and through 'disease awareness' campaigns, where direct to consumer advertising is allowed. Spending on 'direct to the consumer' advertising in the US, was virtually non-existent in the early 1990s; now it has grown to over \$2bn. From the companies' point of view, this investment has been extremely rewarding, in terms of increased sales, premium prices, 'patient pull', brand awareness and high return on investment (Medawar, 2000).

In the US, pharmaceutical companies finance much activity by patient organisations. The National Alliance for the Mentally Ill (NAMI) received \$11.72m from 18 drug firms between 1996 and mid-1999. Although NAMI describes itself as 'a grassroots organisation of individuals with brain disorders and their family members', its leading donor (providing \$2.87m) during this period was Eli Lilly and Company, the manufacturers of Prozac (Medawar, 2000).

Infiltration is widely practiced by the pharmaceutical industry, a process that ensures their products form the background to just about every medical activity. They begin at the front line, courting practising physicians, most notoriously by proffering gifts including complimentary meals, travel and entertainment, all of which have a documented impact on prescribing, and on increasing the use of the sponsor's products regardless of appropriateness. If gifts and other inducements did not effect prescribing behaviour, economic theory predicts that they would not be offered (Wazana, 2000). Gifts stamped with

the company and product name – pens, blotters, clocks, paperweights, calendars, notepads, textbooks, pencil cases, paper clip holders and leaflet displays are given out to medical students and fill the GP's office and waiting room. Consultants and junior doctors are taken out for dinner by drug companies seeking to promote their products. Ironically these events are referred to as 'drug dinners'. Senior consultants and their spouses are flown to conferences in exotic locations, with trips, amenities and entertainment laid on (Johnstone, 1989).

The inspector of mental health in Ireland, Dr. Dermot Walsh his annual report for 2002 said he was concerned at the inroads made on consultant time:

By the sharp increase in the promotional activities of pharmaceutical companies, some in out-of-state jurisdictions and of several days' duration. (Donnellan, 2003)

He said that while some meetings were educational and instructive and qualified for continuing professional development purposes:

Others appear to present unscientific material aimed at influencing prescribing practice... a lot of these entertainments are lavish and one could say that there is almost an element of seduction about it all which is worrying... In the era of compensation culture, there is no way doctors could allow themselves be inappropriately influenced as regards prescribing for patients. (Donnellan, 2003)

Six good reasons to be concerned about drug promotion:

- Drug companies spend on average around 35% of sales on promotion (Devlin et al., 1997).
- Companies would not spend such massive amounts on promotion if it were not effective at influencing prescribing.
- Promotion influences prescribing much more than most health professionals realise (Caudill et al., 1996; Orlowski et al., 1992; Waud, 1992; Chren, 1994).
- Many advertisements and statements from pharmaceutical representatives are misleading (Wilkes et al., 1992; Roughhead, 1995).
- Promotion, which exaggerates benefits and glosses over risks, threatens optimal treatment.

- Reliance on promotional information may endanger lives and expose prescribers to the risk of litigation (Aders, 1991).

Pharmaceutical companies are a major source of revenue upon which hospitals and universities increasingly depend. In addition to fees paid on contract for specific studies, drug companies give large corporate grants to public institutions.

Medical journals rely on funds from drug advertisements and may not be able to afford to offend the pharmaceutical industry. Drug companies fund research in universities, hospitals and medical schools, so that investigations into non-drug and non-medical approaches are much harder to get off the ground. Medical associations have long been a third-party source of drug-related information for prescribers (Morgan et al., 2000). Prescribing information, cautions, and guidelines disseminated under the auspices of medical associations, carry the implicit scientific credibility that such endorsement brings. As a result so drug companies have invested tremendous resources in marketing activities channelled through medical associations. In the process, drug-makers have allied the medical profession as a whole, just as they have allied individual physicians. Through grants, advertising and other sources of financial support, medical associations are heavily reliant on the pharmaceutical industry as a source of funding, placing the associations in an obvious conflict of interest (Guyatt, 1994; Glassman, 1999).

The whole arena of research is shaped towards biomedical models and treatments. (Johnstone, 1989: 171)

Healy (1997) shows how drug companies are actually involved in the construction of new illnesses and the selling of diseases in order to create markets for their products. New illnesses are flagged and highlighted at conferences and in medical journals e.g. panic disorder, obsessive-compulsive disorder and social phobia opened up new markets for existing products.

Difficult children in pre-school are now being diagnosed as having oppositional Defiant Disorder (ODD) characterized by recurrent negativism, defiance, disobedience and hostility to authority (Lavigne et al., 2001). This is being linked to the onset of conduct disorder and the development of attention deficit hyperactivity disorder (ADHD). 'School Refusal' is now being classified as a new condition that causes stress for the child, the parents and the school

personnel (Heyne et al., 2002). Such conditions are finding their way on to the DSM-IV where they are categorized as psychiatric disorders, opening the way for psychiatric and medical treatments.

As many as six million children, now take Ritalin and other stimulants, Adderall, Dexedrine, Concerta and Focalin for ADHD and similar problems. These products have properties similar to cocaine and are highly addictive and subject to abuse. They cause many physical problems, including brain damage and dysfunction. They can cause serious psychiatric side effects such as agitation, aggression, psychosis, mania, depression and obsessive-compulsive disorder (Breggin, 2002).

Corruption

Corporate crime is a bigger problem in the pharmaceutical industry than any other (Robinson, 2001). There is evidence of bribes being paid to every type of government official that could conceivably affect the interests of pharmaceutical companies. Rats, which die during trials on new drugs and are replaced with live (animals) rats, which develop tumours, are replaced with healthy rats. There is also evidence that doctors are being paid 1,000 dollars a patient to test new products (Johnstone, 1989: 172).

Poor standards have consistently been found in clinical trials for new drugs. Drug companies are also very careful about what aspects of their studies reach the public domain. Dr. Stephen Penford Lock former editor of the *British Medical Journal* suggested that between 10 and 30 per cent of medical research is known to be fraudulent, involving plagiarism and the invention of data (Lynch, 2001). Lynch quotes from the *British Medical Journal* of 5 October 1999 from a presentation given by Dr. David Eddy, then professor of Health Policy and Management at Duke University, North Carolina, who suggests that only about 15 per cent of medical interventions are supported by solid scientific evidence. Lynch also quotes Irish psychiatrist Dr. Peadar O Grady from *Medical Weekly* on 24th September 1997 expressing his concerns about medical research.

Most medical research is unhelpfully biased, or incompetently or fraudulently constructed. Research is largely funded by pharmaceutical

companies, which obviously favour research that will either develop a new drug, or show an old drug to be better than other therapies. (Lynch, 2001: 23)

Usually when drug companies 'donate' money for medical research, only biomedical research will be funded by this investment. Biomedical research concentrates on the body as a physical entity and on finding drug treatments as cures for illnesses (Lynch, 2001: 25).

At least part of the selling process in the pharmaceutical industry involves creating and disseminating scientific evidence about the merits of a product. Doctors have been offered money for every patient they treat with a certain drug in a 'research trial', which has the underlying aim of getting patients to switch to the new product. In an ideal world, corporate investment in clinical research would facilitate prescribing decisions based on objective evaluations of scientific evidence concerning safety, efficacy and cost-effectiveness. Not only do firms influence the process by which evidence is disseminated, putting their 'spin' on whatever the findings may be, but they also influence how the evidence is created in the first place. Science and objectivity are of interest to a private, for-profit corporation only insofar as they further the drive for profits (Morgan et al., 2000).

Pharmaceutical industry and development

Infectious diseases kill over 14 million people a year worldwide. Most of these deaths affect poor people in developing countries, particularly children under the age of five. HIV and AIDS account for 8,000 deaths a day worldwide. Diseases such as HIV and AIDS are undermining economic progress. Adults of income-earning age are worst hit, leaving communities populated with grandparents and orphans. The cost of medicines has a significant impact on healthcare in developing countries. Overwhelmingly, poor people in these countries pay for medicines out of their own pockets. They make enormous sacrifices to get treatment, sometimes at great financial risk to their families (Bluestone, 2002).

Drugs that have been banned in the West can be 'dumped' in the developing world. Channel Four ran a hard-hitting investigation into the global power of the world's most profitable business - the pharmaceutical industry. The programme revealed how far drug companies are

prepared to go to get their drugs approved and what they will do to make sure they get the prices they want.

In Africa the programme showed how one of the world's biggest drug companies experimented on children without their parents' knowledge or consent. In Canada they revealed how a drug company attempted to silence a leading academic who had doubts about their drug. In South Korea the cameras followed the attempts of desperately ill patients to make a leading drug company sell them the drugs they needed to save their lives at an affordable price. And in Honduras the team uncovered the brutal consequences of drug companies' pricing policies. The film showed the alarming implications for everyone whose health depends on prescription medicines. If the power of these multi-nationals remains unchecked, many more people will soon be dying for drugs (Channel Four, 2003).

Alternative healing paradigms

Alternative or complementary medicine is becoming increasingly popular and is challenging the scientific basis of biomedicine and how it is practiced (Hardey, 1998). Critical theorists across disciplines have identified the emergence of a holistic paradigm that is helping us to see medicine in a different light. Ludwig Von Bertalanffy a biologist in Vienna during the 1920's set out to replace the mechanistic foundations of science with a holistic view (Capra, 1997: 47). In 'Man Adapting' (1965) Rene Dubos traced the relationship between environmental and biological systems and shed new light on the links between nutrition, infection and air pollution and related health factors. Engel (1977) developed a biopsychosocial model using systems theory to explore relations from cell to society. Capra developed and popularised 'holism', recognizing the impact of social and economic issues on health. Holism refers to an understanding of reality in terms of integrated wholes, whose properties cannot be reduced to those smaller units. In the Marxist tradition examining the political economy, Doyal (1979) analyse health, as a problem, which is embedded in the nature of capitalism, as an economic and social system (Doyal et al, 1979: 11).

Paradigms are only as useful as we allow them to be. hooks (1994) suggests we can benefit more from moving between paradigms rather than blindly accepting singular viewpoints. The holistic paradigm is useful in helping us to understand the limitations of the medical discourse that constructs addiction as a disease. The holistic paradigm also promotes self-reliance and self-knowledge about health matters. The holistic paradigm offers a breathing space to rethink the assumptions of the biomedical paradigm, that is absorbing incremental resources to meet the growing medical demands of the Irish population.

Conclusion

This chapter examined the biomedical discourse and highlighted how it came to dominance in the treatment of addiction. Biomedicine adopts a reductionist model of health drawing attention away from the social, economic and psychological factors that influence the development of disease. Health and medicine are deeply embedded in the social world and so addiction must be understood in this context. Modern medicine is no longer the panacea it once was. In fact it could be argued that addiction has become what Illich (1976) calls a Iatrogenic disease i.e. a disease of modern medicine. The ideology of neo-liberalism supports the development of biomedicine that is tied into the mechanisms of the market and development of capital. The chapter highlighted the role of the pharmaceutical in this context and questions the influence it exerts on the prescribing habits of doctors. The central argument of the chapter is that biomedicine has led to the medicalization of drug treatment through the drug methadone. In the context of this research this is achieved and maintained with the support of psychotherapy. The following chapter will examine the discourse of psychotherapy in the treatment of heroin addiction.

Chapter 5

Psychotherapy – a treatment discourse

Introduction

Psychotherapy, in its multitude of forms, is generally understood to be effective (Dawes, 1994). No one doubts that psychotherapy has an important role to play in the treatment of addiction. Talking to someone who will listen with empathy and understanding is an enriching experience. In the past there was a stigma attached to going to see a psychiatrist or therapist. It was thought that there must be something wrong with you if you needed to talk to a therapist. Today there is a greater acceptance of the role of psychotherapy and counselling in helping people deal with emotional and psychological stress.

It is widely accepted that psychotherapy works, but precisely how it works and what is it about psychotherapy that makes it effective is yet unclear. Research studies into psychotherapy demonstrate positive outcomes, but have yet to articulate precisely what led to these outcomes (Goldberg, 2002). Part of the problem lies in the limitations imposed on psychotherapy by the scientific paradigm of positivism. Qualitative studies in psychotherapy are not taken seriously by the courts, the legal profession or by medicine. Biomedicine privileges the psychiatrist over the psychotherapist as the gatekeeper of treatment knowledge in the area of mental health and addiction. This chapter examines the relationship between psychotherapy and biomedicine in the treatment of heroin addiction.

To understand how psychotherapy works in the treatment of addiction and its relationship with psychiatry we need to engage in some deconstruction analysis. Deconstruction is an intensely critical mode of reading systems of meaning and unravelling the way these systems work as narratives, privileging certain ways of knowing over others (Parker, 1999:1).

Deconstructive unravelling looks at how a problem like heroin addiction is produced through a discourse like psychotherapy (Derrida, 1978). The conceptual apparatus of deconstruction in the theory and practice of psychotherapy is being widely applied to problems understood to have narrative constructions rather than as properties of pathological personalities (White, 1995a). Deconstruction in therapy does not presuppose a self under the surface, but alerts us to the way concepts of an essential self can be smuggled in as part of the help offered in therapy (Parker, 1999:3).

Defining psychotherapy

Psychotherapy is a vast field of practice with over 400 distinct types. The term has come to denote virtually any kind of psychological treatment. Practitioners now include psychiatrists, social workers, clinical psychologists, priests, psychiatric nurses and counsellors working in private practice, hospitals, prisons, schools, youth centres and drug treatment programmes (Erwin, 1997). People are turning to psychotherapy to find answers to human experiences for which there are no definitive answers e.g. loneliness, emptiness, fear, death and loss. What people are looking for is a supportive mechanism to help them negotiate the changes that occur naturally in life. It is our inability to deal with these human experiences that is contributing to an increase in psychological and emotional stress. The overriding purpose of psychological counselling and psychotherapy is the promotion of the client's autonomy, which goes beyond the relief of symptoms (Kovel, 1978; Thompson, 1990:13).

At its core the therapeutic discourse promises to heal those suffering from emotional and psychological pain. The word therapy comes from the Greek word *therapeutikos* meaning one who takes care of another. The word *psycho* comes from the Greek *psyche* meaning soul or being. Psychotherapy is therefore about taking care of the soul or being, it is about attending to the core of the person. The Greeks believed that the body could be cured directly, but they regarded this form of therapy as superficial, leaving the underlying disharmonies uncorrected and potentially capable of causing new diseases elsewhere in the body.

A radical healing is thus obtained only when the mind itself is cured; when there is a change of mind (*metanoia*). (Szasz, 1978: 27)

The distinction in Western thought between body and mind or physical and mental diseases goes back to Plato. The fundamental differences that exist today between medical and mental healing emerged in early Greek thought with Hippocrates (460-377 B.C.) exemplifying the medical healer and Socrates (470-399 B.C.) the psychic healer (Szasz, 1978).

Today psychotherapy is concerned with producing a scientific discipline where diagnostic categories and clinical theories can be evaluated to assess what produces a therapeutic benefit. Such a science would appear to require that human thinking and action be caused in

the same sense that events studied by chemists and physicists are caused (Erwin, 1997:2). Erwin suggests that science requires determinism where events are caused, while autonomy requires free will and in turn requires the absence of determinism. Not all psychotherapists, in particular humanistic therapists, agree that psychotherapy can be evaluated solely by the methods of scientific empirical inquiry, as human beings are autonomous, creative and open to change (Parker, 1999).

Not all psychotherapists emphasize the promotion of autonomy as the central aim in psychotherapy. Cognitive-behaviour therapists argue that the primary aim should be the elimination of symptoms like addiction and the modification of behaviour (Erwin, 1997:20). Disagreements about the proper aims of psychotherapy are likely to lead to disagreements about the evaluation of outcomes. Psychotherapies are constructed through different paradigms and so outcomes will differ according that position, whether reducing symptoms or promoting autonomy.

According to Erwin (1997), therapeutic outcomes are very much dependent on the satisfaction of the desires of the client and its effect on their presenting problem. But what are the real desires of a young person entering a drug treatment programme? Jensen and Bergin (1988) point out that people entering therapy can take on the desires of the therapist or at the macro level the desires of the treatment programme. In many cases young people are coerced into treatment by family or friends and have no idea of what psychotherapy is about. Very often the young people agree to psychotherapy as part of the package of treatment measures that includes being prescribed methadone.

Michael Foucault described psychotherapies as 'technologies of the self'. Whether the ultimate goal is autonomy, overcoming addiction or behavioural change, the means of getting there involves the self. The concept of the self has come to play a key role in many psychotherapeutic theories (Erwin, 1997:35). Bandura (1977) theorized the concept of a 'self-efficacy belief' or a person's belief in their capacity for organizing and executing certain plans and actions. The development of self-efficacy is essential to the person who chooses to stop using heroin or methadone. But promotion and development of self-efficacy is not

confined to psychotherapy. Education, complementary medicine, recreation and sport can all play a part in the promotion of self-efficacy and the development of autonomy.

Feminists have problematized the constructs of self, choice, personal control and freedom. They resist the notion of a unitary self that is pre-existent and self-contained in favour of a subject with multiple selves (Seu & Heenan, 1998:13-14). In the arena of addiction, psychotherapy is in conflict with this idea of the person having an essential self. A lot of psychotherapies are based on helping the person to get in touch with their true self. The true self lies beneath the surface. The essential self is waiting to be discovered and realised (Erwin, 1997:49). Here it seems self-determination and personal control, appear not as universal human attributes, but as privileges granted only by some. Psychotherapy as we understand it today is strongly tied to the theoretical framework of psychoanalysis.

Psychoanalysis

Psychoanalysis is the form of psychotherapy developed by Sigmund Freud (1856-1939).

One of Sigmund Freud's basic psychoanalytic claims was that dreams and other symptoms were wish fulfillments of repressed childhood sexual fantasies. Freud's repressive hypothesis located the essence of the individual in his or her sexuality. Psychoanalysis developed a theoretical framework to explain the feelings and thoughts expressed in dreams and fantasies. The psychoanalyst believes that the unconscious motives along with unresolved conflicts lead to maladaptive behavior. The psychoanalyst tries to create a professional atmosphere in which old feelings and fantasies can be brought to the surface so that they may be studied, understood and resolved.

Foucault understood psychoanalysis as a term used to talk about taken for granted understandings of the human subject and its management. Psychoanalysis is a grand narrative that constitutes the human subject as natural, essential, ahistorical and universal. Foucault pointed to the dangers of making assumptions about what constitutes essentially normal or abnormal behavior in a disciplinary society. The disciplinary society of which psychoanalysis is part of is characterised by obedience and surveillance. The disciplinary society according to Foucault encounters resistance. Resistance can be expressed in maladaptive behaviour. Psychoanalysis can be used as a mechanism of subtle control and coercion by instilling controlling habits to manage people (Prado, 1995: 52).

Foucault suggested that psychoanalysis refers to a mode of thinking that creates a binary opposition between normality and pathology. In doing so it creates a society of insiders who are normal and acceptable and outsiders who are pathological and dangerous to society. Individuals then who become specified by the expert and professional as pathological, come to understand themselves as sick, perverted and deviant (Milchman & Rosenberg, 1993). Stigmatised by being classified as sick, these individuals are silenced from their own truth. David Halperin has asserted these individuals are unable to speak the truth about their own lives because they have 'been denied a rational basis on which to speak at all' (Halperin, 1995: 123) their power having been arrogated by the expert, the psychoanalyst.

Psychoanalysis has been accused of denying reality and escaping into a labyrinth of self-deception (Miller, 1987). In her book *The Drama of Being a Child*, Alice Miller describes the power of repression and the inadequacy of psychoanalysis to reveal the truth about her own childhood experiences and how psychoanalysis reinforces repression by its own deceptive theories. According to Miller psychoanalysis was unable to take seriously the issue of child abuse as a reality because it is theoretically flawed and cut off almost hermetically from advance knowledge. Psychoanalysis, with its mystifying conceptualisations, rejects reality as it is felt here and now. Like Foucault she glimpses how psychoanalysis functions in the development of a disciplined society that is 'for your own good'.

Young people, whose behavior has been designated as abnormal or pathological, can now be managed through therapeutic correction. Such young people face exclusion and segregation from their peers, are classified as deviants and become the objects of invasive therapeutic and medical technologies. Young people subjected to this psychiatric assessment and treatment are constantly ignored, silenced and rendered mute in the process. Foucault's work disturbs people's mental habits and challenges us to re-examine the rules and institution of psychoanalysis (Rabinow, 1991).

Psychoanalysis as a theoretical influence reached its peak in the 1950s. Psychoanalytic therapy had become the most powerful and most popular form of treatment of mental illness. As new generations of drugs were developed, the pharmacological treatment of mental illness appeared to be more cost effective and became more popular than psychoanalysis. This trend has continued to the present day, when, under managed care, drug treatment of mental illness is the preferred modality and psychiatrists are primarily trained as psychopharmacologists rather than as psychotherapists.

Freud and psychoanalysis occupies a major part of the training of clinical psychologists and psychiatrists in particular child psychiatrists (Mason, 1997: 9). The medical model of mental illness and psychiatry share a lot of the same background, history and tradition. While there are many new therapeutic approaches it is difficult to stray completely away from the tenants of Freud and his analysis of the person.

The rise of psychiatry

The institution of psychiatry grew up in the 19th century, during the emergence and consolidation of industrial capitalism. Psychiatry as we understand it today, began with the practice of confining mad persons to asylums. Its function was to deal with behaviour that did not comply to the demands of the new social and economic order. Psychiatry interprets these intolerable behaviours like addiction through the medical paradigm and locates the cause of these behaviours in ones individual biology, chemistry and genes.

Whitaker (2002) in his book *Mad in America* describes early methods of controlling the insane by removing their teeth, ovaries and intestines; ducking them in freezing water; spinning them on mechanical devices until they grew weak and nearly passed out; electroshock therapy; forced lobotomies; and the use of thorazine with dangerous side effects and poor results. Through out history, society has attempted to deal with what was commonly called madness or mental illness today. Porter (2002) suggest little advances have been made since 5000BC in the treatment of mental illness, with more people than ever being diagnosed as suffering from psychiatric disorders. He suggests the tension between the biological and social causes of mental illness is not a new phenomenon but a constant tension throughout history.

In the last fifty years there has been a growing disaffection with the medical profession's approach to mental health. The 1960s gave birth to the civil rights movement and the rise of feminism. It was a time of concern for the colonization of women's minds by men, black minds by white, the young by the old, the rich by the poor. Psychiatric patients were viewed as yet another oppressed minority, their psyches manipulated by therapists (Healy, 2002: 148). A broad range of social movements at this time gave rise to the antipsychiatry movement. R D Lang (1960) in his book *The Divided Self* situated adolescent angst along side schizophrenic breakdown suggesting there was little different in these experiences. According to Lang, orthodox psychiatry alienated rather than healed. During the 20th century the anti psychiatry movement has condemned this misleading medical characterisation of psychological and emotional problems and the repressive measure that masquerade as psychiatric treatment. In 1961 Thomas Szasz published *The Myth of Mental Illness*, his

critique of the psychotherapy industry in America. David Cooper (1967) consolidated these views in his book *Psychiatry and Antipsychiatry*. Postmodernism has helped to question the role of experts by challenging the authority of their previously uncontested knowledge.

Lynch (2001) is also critical of those who subscribe to the medical or disease model of mental illness. Tony Humphrey's in the foreword of *Beyond Prozac* questions the assumption:

That people so disturbed have some as yet undetected biological disorder, akin to cancer, tuberculosis or heart disease and that the treatment should be medical... indeed there is no evidence that depression or personality disorder have any genetic, biochemical, biological or hereditary bases. (Lynch, 2001: 11)

Lynch takes issue with the conventional medical treatment of psychiatric or emotional illness. Emotional distress he suggests is one of the greatest epidemics of our time. Modern society has little tolerance for emotional expression. The greater the distress the more uncomfortable we feel so we find ways of repackaging emotional distress to make it more acceptable. The main repackaging process we use is to classify emotional distress as mental illness (Lynch, 2001: 16). The pharmacological revolution has produced a wide range of drugs for use in disorders such as addiction, schizophrenia, depression and anxiety, which has strengthened the role of psychiatry to administer specific cures for specific conditions.

According to most medical experts mental illness i.e. depression or addiction are caused either by a biochemical brain imbalance or a genetic defect. Lynch does not share this view and believes that so called mental illnesses are understandable expressions of emotional pain. He questions the medical research quoting Dr. Penford Lock former editor of the British Medical Journal who stated that between 10 and 30 per cent of medical research is known to be fraudulent. Most research is carried out or funded by pharmaceutical companies, who are biased in favour of the new drug gaining approval in medical circles. The medical research posture adopted in the majority of cases is based on the assumption that mental illness is either genetic or biological.

When psychiatry moved from the discredited asylums to the general hospital, it strengthened its position within the medical community. New technologies have also been employed to study the brain and the development of molecular genetics and the human genome project

with a view to supporting the biological bases for mental illness and its treatment (Moncrieff, 1997). Psychiatry presents itself as a discipline whose advances in classification and treatment represent scientific discoveries similar to those in the natural sciences. The assumption that science and technology can answer society's most complex problems has been thrown open to doubt. Science is no longer regarded as the saviour of mankind. Medicine has become more influenced by science and technology and is losing contact with the person as the subject under treatment.

The school of critical psychiatry challenges the dominance of clinical neuroscience, introduces a strong ethical perspective on psychiatric knowledge and practice and it politicises mental health issues. Critical psychiatry is deeply sceptical about the reductionist claims of neuroscience to explain psychosis and other forms of emotional distress. It is also critical about the claims of the pharmaceutical industry regarding the role of psychotropic drugs e.g. methadone, in the 'treatment' of psychiatric conditions like heroin addiction.

Does mental illness exist?

Approximately 25 per cent of the Irish population suffer from so called psychiatric illness. Up to 10 per cent suffer from depression and one per cent from schizophrenia. The remainder suffer from conditions such as manic depression, anxiety, eating disorders, and addiction to drugs and alcohol. (Lynch, 2001: 39)

Present biological theories of mental illness are highly problematic. In the first place, they are incomplete, because they are biological, reductionist and ignore the psychological dimensions of human experience and thus ignore what is most characteristic of and fundamental to the human experience. According to Szasz mental illness/disease does not exist and so logically psychotherapy does not exist either. The critical point is that mental illness is not a disease, which exists in people, as pneumonia exists in lung tissue. In the same way addiction is not a real disease. Addiction is a social phenomena involving biological, psychological and social realities but not limited or explained to either of these categories.

Mental illness is, rather, a name, a label, a socially useful fiction ascribed to certain people, who suffer or whose behavior is disturbing to themselves or others (Szasz, 1978). In his book *The Manufacture of Madness*, Szasz suggests that 'moral beliefs and social practices based on a concept of mental illness, constitute an ideology of intolerance' (Szasz, 1978: 1).

Mental diseases like addiction have now become *bona fide* medical diseases and psychiatric treatments are bona fide medical treatments. Psychiatric thought more closely resembles political ideology than it does science, in that it is presented and certified by a power elite, the psychiatric establishment, who promote their views as official dogma and who dismiss, exclude and persecute dissenters.

Cruel compassion

There is an element of coercion in the treatment of heroin addiction under the influence of psychiatry. It is a form of pharmacological coercion where drugs are used to treat what Szasz (2001) calls mythological diseases. Coercion is the threat or use of force to compel others into submission. Hegemony, as we know, is the process through which domination occurs through structural rather than coercive means. Young people are coerced into methadone treatment not by force, but by a legal hegemony that criminalizes heroin users. Once on the programme, they are coerced into psychotherapy.

The threat of prison and loss of liberty does not deter many young people from taking drugs, because they do not feel any sense of liberty or personal autonomy. The heroin user is constructed as having an addictive personality and irreversible chronic disease cured only by abstinence or treatment. Psychotherapy is the space where these issues are negotiated. Often psychotherapy is a compulsory part of the treatment programme. Coercing people into participating in psychotherapy or drug treatment through legal pressure will do little to help the person in the long term (Rothbard et al., 1999).

Szasz (1994) examined how people are deprived of their liberty under the guise of treatment. Poorhouses and workhouses were established to store the unproductive and economic

outcasts of the eighteenth century. Psychiatric hospitals housed the insane. Industrial schools in Ireland were established to reform children who had committed minor crimes. Magdalene laundries institutionalised young women for having children outside of marriage. Prisons store away criminals, of which drug users in Mountjoy prison in Dublin account for a large number in the prison population.

The economics of psychiatry

The economist according to Szasz (1994:124) views man as a rational actor. The psychiatrist views man as an irrational patient, who is not an actor at all but a puppet controlled by hidden impulses within the brain. Both economics and psychiatry are ways of constructing reality and controlling social behavior.

In economics we distinguish between those who support the interventionist state (social democracy) and those who support the minimalist state (liberal democracy). In psychiatry we make similar distinctions among various schools. Mainstream psychiatry is based on the proposition that mental illnesses like addiction are brain diseases and that mental patients are dangerous to themselves justifying coercive treatments. Psychoanalysis understands mental symptoms as having meaning that can be resolved with cooperation of the client and therapist in a dialectical relationship. However according to Szasz (1994:126) members of both groups have embraced the dogma of the literal existence of psychopathology (abnormal behavior as illness) and psychoanalysts support the psychiatrist's authority to coerce their patients.

Szasz (1994) notes that the typical psychiatric patient was poor and cast into the patient role against his will and was housed in a public mental hospital. The typical psychoanalytic patient was rich, chose to be a patient and live at home.

Psychiatry acquired the worst features of psychoanalysis – a preoccupation with sex and the past, an elastic vocabulary of stigmatisations, and a readiness for fabricating pseudo explanations. Psychoanalysis acquired the worst features of psychiatry – coercion, mental hospitalisation and disloyalty to the patient. (Szasz, 1994:158)

Szasz (1994) suggests that there is no free market for mental health services because of the relationship between psychiatry and the economy. Psychiatric practice rests on the premise that it is the therapist's duty to protect the patient from killing himself/herself or others, by force if necessary. The psychiatrist is protected by the state from being sued for malpractice.

The political-economic backbone of psychiatry has always been the state mental hospital system, which supplied both its legitimacy for the use of force and the funds necessary for its operation. (Szasz, 1994:127)

In the struggle to protect this situation and protect the cooperative relationship between psychiatry and psychoanalysis, both disciplines have become their own adversaries. According to Szasz the two schools of psychiatry and psychotherapy are incompatible. 'The psychiatrist controls and coerces, the psychotherapist contracts and cooperates' (Szasz, 1994:157). Psychotherapy is contingent on the therapists respect for the patient's autonomy and abstains from coercing into pharmacological treatments. Psychotherapy undermines rather than supports 'psychiatry as a medical specialty and extralegal system of social control' (Szasz, 1994:157).

Rescuing psychotherapy from psychiatry

Psychiatry is concerned with power, the power of the individual psychiatrist and the power of the state. Psychiatrists no longer talk about curing patients but managing them. This attitude is prominent in the addiction services and demonstrated in the mass prescribing methadone and minimalist approach to developing rehabilitative initiatives like psychotherapy or education.

People who threatened the *status quo* or refused to accept the roles society ascribed to them (for example, docile wife and mother, obedient child) became subject to the gaze of the psychiatrist (Masson, 1989). Masson is sceptical of anybody who profits from another person's suffering. He does not deny the magnitude of the problem of suffering and emotional pain, but questions the certainty of psychotherapy as the solution (Masson, 1989:40).

Therapists are expected to possess certain qualities: compassion, understanding, kindness, warmth, a sense of justice and integrity. Masson wonders can these qualities be learned in a training programme or even taught and passed on to prospective therapists.

Psychotherapists are no less immune to political and ideological pressures than any other profession. Psychotherapy must be rescued from the control of psychiatry if it is to remain a credible institution in the promotion of autonomy (Smail, 1987).

Psychotherapy and psychiatry

Psychotherapy is now seen as an essential part of any drug treatment programme in particular in the form of addiction counselling and family therapy. While psychotherapy has gained a prominent position in drug treatment circles, it remains subjugated and subject to validation by psychiatry. Forms of psychotherapy, which take their cue from psychiatric or psychological systems, also take for granted descriptions of pathology, which can oppress people under a guise of professionalism (Parker, 1999:2). To maintain this prominent position in drug treatment, psychotherapy is compromised. Psychiatry is the dominant therapeutic position in diagnosing and treating addiction in Ireland. It also dominates the agenda in national drug treatment policy and practice in particular in relation to the prescribing of methadone for the treatment of heroin addiction.

Though psychotherapy and psychiatry share some historical and theoretical relationship to psychoanalysis, there is huge divergence between these disciplines. Mental health in Ireland has been dominated by the medical discourse. Psychiatry is part of this medical discourse and is responsible for mental health matters including addiction. As a result the addiction services have been strongly influenced by psychiatry. Psychiatry sees the role of psychotherapy as a secondary response in the treatment of addiction. Its first response is to prescribe methadone or alternative drugs depending on what they define as mental illness.

To understand this present relationship between psychotherapy and psychiatry it is necessary to understand some of the wider power discourses at play within society. Within the health services there are visible and invisible hierarchies. Psychotherapy, in desiring validation within this sector, has traded its independence to psychiatry. Psychotherapy has gained a foothold within these services as a sub system validated by psychiatry. Psychiatry maintains this power discourse through its informal contacts with the legal system. Both psychiatry and the legal system validate each other in their ways of knowing and understanding the world in black and white terms.

According to Szasz (1978), psychotherapy exemplified by psychoanalysis, is a myth that has become official dogma like medicine, law and science. Szasz's critique of psychiatry has two

elements: first, the critique of the political function of psychiatry as an agency of social control; second, the critique of the ideology which justifies and facilitates this political function, namely, the medical model of psychiatry. Psychotherapy as a form of treatment has become a mythological practice that promises to cure people of their metaphorical illness.

Is it possible to decide which form of psychotherapy is most suitable for treating substance addiction among young people, in a community setting while involving their families? Can this decision be made on empirical evidence? Erwin (1997:60) suggests that evidence is silent because there is no agreement among psychotherapists about proper, objective epistemological standards. This has led to a growth in scepticism about discovering epistemological standards and a turn towards 'post-modernist epistemology' (Held, 1995). Many psychotherapists have become disenchanted in the way they perceive their work within the traditional positivist paradigm (Sass, 1992:166). Postmodernist epistemologies refer to 'constructivist' ways of understanding and interpreting reality as co-created by us (Mahoney, 1989). Constructivists reject assumptions about beliefs that fail to correspond to objective reality which are, by definition, dysfunctional (Neimeyer, 1993:222).

Psychotherapy is in crisis and it is no longer regarded as the panacea, as it was thought of for years, and now stands far behind short-term intervention and psychopharmacology, as the treatment choice for psychological concerns (Goldberg, 2000a). The crisis in psychotherapy today, centres on the problem of self-understanding. What is the meaningful basis, empirical or any other kind, to support the notion that the inner quest is the best means to living our lives fully and well? Psychoanalysis and psychotherapy have adopted Socrates' claim that 'only the examined life is worth living' as the cornerstone of their theory and practice.

It has been recognized for centuries that we have a propensity for self-deception and a tendency to ignore any self-knowledge that contradicts our preferred view of ourselves, negative or positive. To avoid painful truths about ourselves we erect barriers to our own awareness. Finding a path to our undiscovered self enables us to live in the knowledge that we have choices and the power to act autonomously. Psychotherapy was seen as valuable in enabling people find this pathway to self-knowledge and power. This however is now being

challenged to demonstrate actual evidence to support the assumption that only the examined life is worth living (Goldberg, 2002:130).

Psychotherapy has developed at an astonishing rate over the past decade. Today there is an unquestioning acceptance of psychotherapy as being a good and worthwhile enterprise. Spinelli (2001) wonders if psychotherapy such a good thing? In its earliest years, psychotherapy was a powerful critic of dominant cultural views and assumptions. Over time it has secured a more central place in our lives and within civil society. Spinelli fears that psychotherapy is in danger of basing itself on dubious facts and questionable conclusions masquerading as reason and rationality. He quotes Fredrick Nietzsche who said 'as long as you are seen to believe in a supposed truth with sufficient conviction and passion, others will come to believe in it as well (Spinelli, 2002: 4). Psychotherapists, according to Spinelli, have incorrectly placed their faith in sets of principles and assumptions that are questionable, unnecessary and thus from basis for a serious critique about the profession.

Psychotherapy is regarded by many in the profession as a desirable and effective panacea for a multitude of psychosocial disorders and disturbances. Yet at present, it is unable to demonstrate reliable and valid evidence for any specific determining factor that might explain its overall efficacy. There is no clearly defined basis to assert the benefit of one model of psychotherapy over another. It is widely accepted that some psychotherapy is better than no psychotherapy, but the 'how and what' of it continue to challenge practioners and researchers.

The postmodern person is critical of the suggestion that by going inside, we are maintaining the Cartesian view that 'there is dead matter and the world inside is living... working with yourself, could be part of the disease, not part of the cure' (Hillman et al., 1993 cited in Goldberg, 2002). These are not problems that cannot be 'solved' in any fixed or definitive sense, nor can there exist any 'experts' who can set about resolving them on our behalf. They are problems that are not even our own in a personal sense, but exist at the nexus between each person and the world we share (Spinelli, 2002:9).

Conclusion

This chapter has examined psychotherapy as a treatment discourse in the area of addiction. Psychotherapy is generally understood to be effective within a multi disciplinary approach to the treatment of addiction. But how it works and what makes it effective remains unclear. The nature of psychotherapy rules out quantitative methods of research in assessing outcomes. Psychotherapy is unable to make grand claims about a person's addiction. It is difficult to identify precisely what factors influence a person's choice to stop using drugs. Psychiatry on the other hand does make such claims in treating addiction. Psychiatry measures progress in millilitres of methadone or milligrams of psychotic drugs.

The chapter examined these issues and looked at the rise of psychiatry in the treatment of addiction. History has privileged psychiatry over psychotherapy in gaining prominence and control of the addiction services. Today the psychotherapist requires validation from psychiatry to operate within these services. Psychotherapy secures a role within the addiction services but is compromised as a result. Philosophically psychotherapy and psychiatry are in conflict and yet find agreement on the issue of addiction and methadone prescribing. While psychotherapy remains compromised on these issues, psychiatry and biomedicine have consolidated their position as the gatekeepers of addiction treatment.

These opening chapters have raised important questions about the nature and meaning of heroin treatment. I hope these issues will inform the reader as we embark on the research journey through the methodology and data chapters.

Chapter 6

Methodology

Introduction

In my critique of biomedicine I explain how medicine emerged as the dominant hegemony in the treatment of opiate dependency. In this chapter I will show how biomedicine consolidates its dominance in the treatment of opiate dependency through research methods constructed through the scientific paradigm of positivism. I will then make the case for doing research a different way using qualitative research methods drawing on the work of Augusto Boal '*The Theatre of the Oppressed*' (1979).

Research – propping up biomedicine

The dominant beliefs about how health research should be conducted come from biomedicine. In recent times this dominance has been compounded by the power of the pharmaceutical industry and other vested interests influencing and limiting the research agenda. Clinical research sponsored by the pharmaceutical industry affects how doctors practice medicine. A recent systematic review of the impact of financial conflicts on biomedical research found that studies financed by industry, although as rigorous as other studies, always found outcomes favourable to the sponsoring company (Lexchin, et al. 2003).

As a result biomedicine exerts enormous influence over the institutions and resources that make research possible ensuring that orthodox views about health and correct ways to conduct health research are maintained (Gillet, 1994). In the biomedical research model, it is believed that the highest form of knowledge is provided by evidence-based research.

Evidence-based research

In Europe and America there is an increasing emphasis on health care research and a massive shift in the policy arena towards evidence-based research (Brown et al., 2003). Evidence-based research has become the gold standard and current best practice in research examining the treatment of opiate dependency. Evidence-based research seeks to provide objective

accounts of treatment with measurable outcomes that demonstrate evidence that treatment works. In typical clinical trials, a group of patients exposed to an experimental intervention is compared with patients in a control group receiving a placebo or comparison intervention. Performance on specific outcome measures (e.g. retention in treatment, illicit-drug abstinence) is used as evidence of effectiveness.

Problems with evidence-based research

Enshrined within evidence-based research is the quest for objective observation. Although most researchers today would acknowledge that it is not possible to capture objectivity without the influence of human bias. Popper (1968) suggested that there was no such thing as objective observation rather all observation takes place within the context of a set of theoretical assumptions. Observations are better thought of as interpretations constantly under review as events unfold (Brown et al., 2003). It is widely recognized in research that the values and agendas of the researcher are embedded in the survey instruments or experimental designs. Put simply the person making the observations will influence what is recorded.

The question of who does the research is intricately bound up with the values and evaluations that attach to the findings. According to Lynch (2000) research is inevitably political. No matter how deep the epistemological commitment to value neutrality, decisions regarding choice of subject, paradigmatic frameworks, and even methodological tools, inevitably involve political choices. There are numerous accounts from non-medical professions of how their research proposals are overlooked in funding applications, in favor of those submitted by doctors, particularly if a non-experimental paradigm is proposed (e.g. Meerabeau, 1997) which adds weight to the assumption that only medical and scientific research is worthy of consideration. The influence of the professional status of the researcher on how research is assessed has been demonstrated (Hicks, 1992).

The randomized controlled clinical trial has gained special status in the evidence-based research movement. Evidence gathered in these experiments becomes applicable to clinical practice. But there are many problems associated with such trials in particular those conducted in the area of addiction medicine, where it is unethical to give patients a placebo if an evidence-based treatment is available. Other concerns include denial of treatment or inadequate treatment resulting in adverse outcomes. Randomized controlled trials can be the most costly in terms of time and money as a result most trials are funded by the pharmaceutical industry where unfavourable results are often distorted or suppressed (Smith, 2003). Jureidini et al., 2002 examined the efficacy and safety of antidepressants in children and adolescents and found the pharmaceutical companies exaggerated their benefits and played down their adverse effects.

We are concerned that biased reporting and overconfident recommendations in treatment guidelines may mislead doctors, patients and families. Many will undervalue non-drug treatments that are probably both safer and more effective. (Jureidini et al., 2003: 882)

Within evidence-based research outcome studies are commonly used to demonstrate the effectiveness of specific approaches or services treating opiate dependency e.g. Crome et al., 1998, 1999. Randomised controlled studies using multiple sources of baseline information (assessment of physical and psychological adjustment, substance use and dependence and periods of abstinence) and at follow up points one year later are standard. Substance treatment outcomes studies are generally conducted by medical professionals working within the addiction services whose medical bias dictates which outcomes they decide to measure. Too often outcome variables are selected based on predictable favourable results e.g. treatment retention or improved psychological functioning. Unfavourable outcomes in drug treatment programmes are ignored or suppressed by evidence-based researchers.

Outcomes studies tend not to examine variables that may yield unfavourable results. Significantly researchers from within this tradition have failed to highlight the obvious outcomes of methadone treatment for example the numbers of people failing to detox after stabilization. Detox after stabilization on methadone is more myth than reality. Clinicians and researchers have shifted the focus from complete detoxification as the main outcome of treatment to measuring other outcomes that can demonstrate improvements e.g.

psychological functioning. Researchers have also failed to examine other aspects of treatment including the hidden deaths within the drug treatment context, e.g. people who die accidentally during treatment periods or those who die indirectly because of the wrong diagnosis or because it was inconceivable to think that the prescribed treatment wasn't working. Nor have researchers examined in any great depth, why clients get worse despite prolonged periods of treatment. Instead outcome studies interpret unfavourable outcomes in the context of individual pathology/ diseased identity/ non compliant or resistant to treatment. Evidence-based studies have also failed to critique the dominant epistemological discourse of biomedicine through which most opiate treatment programmes are constructed.

This focus on outcomes in evidence-based research is designed to inform choices within a market led health service (Miller & Crabtree, 2000). There is a pressing need to demonstrate medicine's effectiveness and that it gives value for money. The majority of outcome studies examining the treatment of opiate dependency support the efficacy of methadone treatment.

Positivism and the maintenance of the biomedical hegemony

Evidence-based research helps maintain the biomedical hegemony in the treatment of opiate dependency because it is embedded within the scientific paradigm of positivism. Lynch (2000) suggests that research in Ireland is heavily biased in favour of empirical research in the positivist tradition. Much of the debate about drug treatment has been framed within the language of positivism. In order to shift the focus in drug treatment research from evidence-based outcome studies, to more qualitative methods incorporating phenomenology and interpretive positions we need to understand the failure of positivism as a methodology to advance meaningful drug treatment knowledge.

Positivism is a belief in an independent, external reality that can be apprehended either directly or indirectly through the application of a systemic way of knowing, primarily the scientific method. The rise of positivism has been intimately connected with the development of experimental sciences, such as chemistry, medicine, economics and psychology the crowning achievements of Western civilization.

The enduring impact of positivism in evidence-based research relating to opiate dependency and its treatment is found in the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV) (American Psychiatric Association, 2000). Here substance use dependency is classified as a disease. The DSM-IV sets the stage for the treatment of opiate dependency within the context of biomedicine. The DSM-IV comes out of the positivist, medical tradition with its underlying belief in the possibility of objective descriptions of an independent reality that will hold up over time and across context (Duffy et al., 2002). Within the positivist paradigm the mental disorders specified in the DSM-IV are regarded as existing in the general population and as being identified or discovered through the application of scientific procedure.

Social constructivists on the other hand believe that totally objective reality can never be fully known. They regard the DSM-IV as a socially privileged method of classifying and labeling people whose behaviors deviates from the medical and/or social norm.

Foucault pointed out how labels and classifications are shorthand for interpretations of experience assigned by these privileged groups in a society that effectively drowns out alternative ways of assigning meaning to experience (Duffy et al., 2002).

Irish drug treatment research is largely controlled by the Consultant Psychiatrists firmly located within the positivist research tradition. The methodologies and interpretations employed are based on models and paradigms chosen within this tradition and without the consent of those who are subject of the research (Lynch, 2000). As the gatekeepers of drug treatment research these elite medical professionals are guaranteed their dominant position. It is in their interest to maintain the biomedical hegemony through the promotion of evidence-based research.

Researchers from the positivistic tradition study those at the bottom while holding up its hand for money to those at the top (Reason & Rowan, 1981). Psychological inducements are employed to increase the participation of vulnerable young people in such narrowly focused questionnaires and surveys with little relevance to their real experience of drug treatment. Without intent, this type of research can and does operate as a form of colonisation. It

creates public images about adolescent drug users over which the participants in the research have no control.

An uncritical eye would think that this process of knowledge generation was 'happening all by itself without the intervention of humans to manipulate the theory and construct the data' (Brown et al., 2003: 110). In fact it is widely recognized that the values and agendas of the researcher, are embedded in the instruments they use and the experimental designs they impose on their informants.

Increasing numbers of researchers see the kinds of science that comply with positivist thinking as being overly restricted and are instead searching for a new epistemological model which reveals the limits of reductionistic cause-effect thinking (Baumann 1998: 89-90). Researchers with postmodern sensibilities see the positivist position as only one way of telling stories about society or the social world (Denzin & Lincoln, 2000:10). Post-modernist and feminist scholars have been, however, among the most ardent critics of positivist epistemologies and methodologies (Bernstein, 1976; Lentin, 1993)

Positivism is a product of patriarchy, which feminist researchers are challenging. They are critical of objective, value free, neutral, scientific, male models of inquiry. Feminist scholarship has contributed to the massive proliferation of diverse and contested feminist epistemologies. They see the return of funded research, as support for the positivist turn in the social sciences, which supports the 'institution of ruling' (Byrne & Lentin, 2000:2). Positivist funded research argues that it can generate knowledge that is reliable, valid, worthwhile and of economic benefit. Byrne and Lentin (2000) argue that Irish social science has been dominated by positivistic and post-positivistic paradigms. Despite the strong tradition of ethnographic qualitative research in Ireland, positivism continues to hold sway in the allocation of funding resources for research, in informing policy and in the public perception of what is authentic social research (Byrne & Lentin, 2000:5).

In contrast to evidence-based research this study reconstructs accounts of opiate users in treatment that are critical of biomedicine and the scientific framework of positivism. Such a

critique will highlight the importance of qualitative methods in research the lives of young people in drug treatment settings.

Making the case for qualitative research in drug treatment

Qualitative research may seem unscientific and anecdotal, but as critics of evidence based medicine point out clinical experience is based on personal observation, reflection and human judgement in order to translate scientific results into the treatment of individual patients (Green & Britten, 1998). Personal experience is often characterised as being anecdotal and a poor basis for making scientific decisions. Qualitative research can investigate practioners and patient's attitudes, beliefs and preferences quickly turning evidence into better clinical practice.

Qualitative methods of inquiry have been theoretically eclectic, drawing on methods and theories from phenomenology, grounded theory, feminist research and many more. Interpretive or hermeneutical approaches to health and illness are enabling researchers to penetrate below the surface and consider the meanings people attach to their experience of medical treatment. Medicine is understood here as being embedded in culture and language. Opiate dependency might appear to be rooted in biology, but is embedded within systems of meaning, social structure and economics. The researchers task is to examine the role of language or discourse play in interpreting and making sense of the world (Brown et al., 2003).

The interpretivist view of the world is one where the social world is constructed through the human process of making sense of our social environments and settings. It is sceptical of the possibility of attaining objective certainties and interrogates simplified or reductive views of reality. Interpretivism came from the hermeneutical tradition of interpreting written texts like the bible. Later the notion of text widened to include spoken language and the diverse ways that peoples or societies represent themselves. Interpretive practices allow us to read the human text and interpret the meaning of what people say about their condition or the treatments that health professionals administer for these conditions. Researchers from this

tradition have to interact with the participants of the study to implement their research in a way that implies the social world can be transformed by this interaction.

While the dominant methodological approach in contemporary drugs research remains quantitative there has been increasing receptivity to the use of qualitative methods as a means of understanding and responding to drug use (Rhodes, 1999). Historically, qualitative research was defined within the positivist paradigm, but over time postpositivist and postmodern paradigms shifted the balance towards phenomenology, as an emerging and legitimate paradigm in its own right.

The emerging paradigm – phenomenology

Phenomenology as a research position is a confluence of multiple theoretical paradigms, which comes together under the heading of qualitative research. These paradigms include constructivism, cultural studies, feminism, Marxism and ethnic models of inquiry (Denzin & Lincoln, 2000:6). As a collective paradigm, phenomenology involves a complex set of interconnected terms, concepts and assumptions about being and knowledge. The phenomenological approach focuses on understanding the meaning people attach to experiences and events being studied. The phenomenological approach sees the world as complex and interconnected and seeks to understand and explain this complexity. It stresses the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (Denzin & Lincoln, 2000: 8). Maykut and Morehouse (1994) refer to the phenomenological approach as the emerging paradigm. Yvonna Lincoln and Egon Guba's *Naturalistic Inquiry* (1985) present qualitative research as an emerging paradigm and legitimate method of inquiry.

The emerging paradigm has created a new generation of paradigm inquirers (Denzin & Lincoln, 2000: 176), comfortable with allowing ontological and epistemological positions to influence and complement each other, under constructivism and critical theory, creating new sources of knowledge which are capable of transforming society. As a qualitative approach to

inquiry, it draws on ethnography, grounded theory, naturalistic and hermeneutic inquiry.

Researchers are learning to borrow from many different disciplines.

The combination of multiple methodological practices, empirical materials, perspective, and observers in a single study is best understood, then, as a strategy that adds rigor, breath, complexity, richness and depth to any inquiry. (Flick, 1998:231)

Qualitative research situates the observer in the world and seeks to make that world visible through a series of representations. These representations attempt to make sense of the phenomena being studied and the meaning people attach to them. We can only know a thing through its representation. Objective reality can never be captured.

Positivists are critical of qualitative research suggesting it is unscientific and that researchers have no way of verifying their truth statements. These critics presume a stable, unchanging reality that can be studied using the empirical methods of objective social science (Huber, 1995). Flick (1998) suggests that the emerging paradigms in qualitative research are a response to failure of traditional deductive methodologies in advancing our understanding and knowledge of many problems that confront us today.

These two paradigms are based on two different and competing ways of understanding the world. Lincoln and Guba (2000) acknowledge the contention between postmodern and positivist research paradigms seeking legitimacy. These conflicts, they acknowledge, are based on emerging anthologies and epistemologies that differ sharply from conventional social science. There can be no question that the legitimacy of postmodern paradigms is well established and at least equal to the legitimacy of received and conventional paradigms (Denzin & Lincoln, 1994). Lincoln and Guba (2000) acknowledge that as the methodologies of Marxism and feminism become interwoven, it is more useful to probe where and how paradigms exhibit confluence and where and how they exhibit differences, controversies and contradictions.

Silverman argues that the qualitative-quantitative dichotomy is unhelpful as it encourages researchers to retreat into paradigms (Silverman, 2000: 11). He points out, the implied dangers in these terms, with their fixed preference or pre-defined evaluation of what is 'good'

(i.e. qualitative) and 'bad' (i.e. quantitative) research. Others understand the word *qualitative* to imply 'an emphasis on the qualities of entities and on processes and the meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency' (Denzin & Lincoln, 2000: 8). The choice between different research methods should depend on what the researcher is trying to find out.

Meaningful research methods with adolescent drug users in treatment

A research methodology describes the research process and justifies the approach taken in carrying out the research. Knowing what you want to find out, leads inexorably to the question of how you go about finding that information (Miles & Huberman, 1984:42). The methodology reflects the researchers assumptions about the world, value system and subjectivity.

Constructing a research methodology in the context of young people in drug treatment is a difficult task. Existing methodologies can be intrusive and threatening in circumstances where young people were extremely vulnerable (Allen, 2002). This presented the researcher with the task of constructing and applying a methodology that would maximize the participation of the young people in the research process by encouraging them to become co-constructors and authors of empowering treatment knowledge. This led the researcher to choose a methodology that could engage in the research problem in a new way. Constructing the methodology became part of the theorizing process.

The specific challenges of working with adolescent drug users through research have been well documented (March et al., 1989; Davies and Coggans, 1991). There are unique methodological considerations when undertaking a study that requires the participation of young people, particularly when they are vulnerable because of neglect or social exclusion (Hill, et al., 1996; Hill, 1998).

Research proposal

The research examines drug treatment and is set in a context where medical and therapeutic knowledge dominates the conversation in the construction of treatment programmes for adolescent drug users. According to Ivan Illich;

Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people. (Illich, 1977: 13,14)

In this context the research explores how adolescents who are dependent on heroin from the North East Inner City of Dublin reconstruct their identity while participating in the Crinan Youth Project. By examining the epistemological framework of the Crinan Youth Project it is hoped that the research will highlight the effects of opiate treatment on the adolescents identity, self-knowledge and sense of agency during their rehabilitation.

The identity of the young heroin user/addict is constructed through a series of multiple oppressive discourses which dominate, control, disempower, oppress and sedate the cognitive, emotional and biological systems of the person (McIntosh & McKeganey, 2002). Discourse here refers to how knowledge is constructed through cultural, social and historical filters. Discourse analysis is used in this research to filter and interpret the epistemological experience of treatment in the Crinan Youth Project (Holland & Eisenhart, 1990: 95). Discourse as developed by Foucault, addresses the relationship between language and meaning. The Crinan Youth Project is constructed through the discourse of medicine, therapy and education. The research will seek to decode these discourses, decipher their epistemological assumptions and explore how they function in the construction of the heroin dependent identity. The research asks, why methadone has come to dominate the treatment of adolescent drug users in the Crinan Youth Project? Why education is not impacting more within the existing treatment matrix? Why have we become so dependent on medical solutions for social problems?

In seeking to answer these questions the methodology employed the techniques developed by Augusto Boal (1979) in *The Theatre of the Oppressed*. Boal's theatrical methods have been used to empower people kept down by external forces (or external oppression) e.g. land

reform, housing or educational issues and by internal forces (or internal oppression) e.g. depression, low self esteem, fear or anxiety (Boal, 1995). Using Boal's methods I wanted to explore with the young people their experience of drug treatment and its capacity to bring about change that could empower a sense of agency and self authority in breaking down the oppressions at the root of their opiate dependency. Boal's ideas can serve as a 'door' and enabling 'pathway' through which new ideas and perspectives can come to awareness.

Paradigms in action – conducting the inquiry

Beginning the research process I was aware of my prior knowledge and experience of the Crinan project, having been involved in setting up the project, employing the staff and managing the project as part of a management committee for its first two years. I also worked in the inner city for seven years during this time and would have already known some of the young people involved in the project and was familiar with the cultural nuances of the northeast inner city.

As soon as access to the research site and a research schedule were agreed I began to carry out a series of research workshops using the methods contained in *The Theatre of the Oppressed* (1994). These dramatic methods developed by Augusto Boal are suited to working with groups of people where maximum participation is required in difficult situations. The general nature of young people in treatment for drug use/addiction is marked by a strong sense of apathy towards life, a negative self-concept/image and a resistance to feeling or expressing emotion. In Boal's language these young people have internalised oppressions or 'cops in the head' that act to control and restrict their behavior within a safety zone that maintains their oppression. Using these methods over a number of months had a minimal impact on the young people, in creating a context of movement or change. However the real value of this methodology was to be found in highlighting the potential oppressive nature of drug treatment itself.

Early in the research schedule it emerged that the young people were resisting engaging in many of the educational/development programmes on a regular basis. No matter how much

the young people were involved in designing this part of the programme or how skilled and creative the facilitators were, the results were the same, enthusiasm at the start followed by a sharp decline in interest, participation and attendance. The young people had quickly learned in the project that non-participation in this part of the programme did not threaten their methadone script. The only thing that threatened their methadone script was illicit drug use and this was monitored on a regular basis using urine screening.

The focus of the inquiry then turned to the relationships within the treatment programme between the educational/development, medical and therapeutic components of the programme. This new focus guided the researcher to examine what emerged as competing sources of knowledge in the treatment and rehabilitation of the young heroin user/addict. Each treatment component seeks to construct the person differently during and after treatment and has a significant impact on the outcomes of these programmes. While the research is critical of the role of the medical discourse in drug treatment it recognizes the role methadone can play in the treatment of heroin addiction.

In carrying out qualitative research it is important to be aware of the personal biography of the researcher, who speaks from a particular class, gender, racial, cultural, and ethnic community perspective (Denzin & Lincoln, 2000: 18). All research is guided by a set of beliefs and feelings about the world and how it should be understood and studied. The researcher is bound within a net of epistemological and ontological premises, which, regardless of ultimate truth or falsity, become partially self-validating (Bateson, 1972:314). This net or set of constraints is referred to as a paradigm or an interpretive framework to guide the inquiry. In my case I believe that knowledge is socially construed and not passed on from one generation to the next in hermeneutically sealed containers. The problems that face our world today cannot be solved by the same kind of thinking that created the problems in the first place.

Data collection

According to Bateson (1991) research is an active process. We not only collect data, we interact with it. Negotiating access to the project was the first step in this process.

Negotiating access

The first task involved in conducting the research involved negotiating access to the research site i.e. the Crinan Youth Project. This involved several meetings with the project leader. A contract was drawn up submitted with the research proposal to the management committee for access approval. The proposal was agreed and the contract with the chairperson signed. As with a lot of social research, access is not a once off event, but a social process that has to be negotiated and renegotiated throughout the entire course of fieldwork (Burgess, 1991). In drawing up a contract with Crinan I was conscious that I wanted the project to feel comfortable with the proposed research and I welcomed the projects input into the design of the research.

Summary of data collection methods

<i>In-depth interviews</i>	<i>Augusto Boal workshops</i>	<i>Project meetings</i>	<i>Participative observation</i>	<i>Feed back on research report</i>	<i>Other events</i>
<i>7 with participants</i>	<i>8 workshops with participants</i>	<i>6 facilitated meetings between staff and participants</i>	<i>Ongoing involvement on dates between 11th December 2000 and May 21st 2002</i>	<i>Meeting with management committee 20th February 2002</i>	<i>Conference on Drug policy 11th Dec 2001</i>
<i>9 with staff</i>				<i>Meeting with staff 20th February 2002</i>	<i>Presentation of draft research report to key stake holders</i>
<i>8 with management</i>				<i>Meeting with project manager 6th March 2002</i>	

Participative observation

The data of qualitative inquiry is most often people's words and actions and requires methods that allow the researcher to capture language and behavior (Maykut & Morehouse, 1994: 46) Attending the research site on a regular basis over an extended period of time between 11th December 2000 and the 21st of May 2002 allowed me to access in meaningful way the day-to-day experiences of the staff and young people on the treatment programme. The kitchen and poolroom were key spaces where data could be accessed through an ongoing reflective presence.

Participative observation is a widely used general ethnographic approach employed in the study of drug treatment programmes. Within a treatment setting, this method involves observing and interacting with participants and represents a combination of observing and informal interviewing. The participant observer attempts to enter the lives of others, suspending as much as possible his way of viewing the world.

In the broadest sense, the participant observer asks the question: What is happening here? What is important in the lives of the people here? The task is one of listening hard and keenly observing what is going on among people in a given situation or organisation or culture in an effort to more deeply understand it and them. (Maykut & Morehouse, 1994: 69)

The project meeting was an ideal participative observation mechanism where I could work with both young people and staff and listen to them and to evaluate and develop the programme according to their needs. It was agreed that I would facilitate these meetings for the duration of the research. These meetings provided an important source of data on some of the central issues that concerned both staff and young people on a day-to-day basis.

At other times I was involved in non-participative observation without direct involvement as I passed through the project to carry out a scheduled interview or meeting with the project leader. On these occasions unexpected and useful observations can be made giving the research a new questions and other perspectives. The goal of non-participative observation is to understand how the programme functions and impacts on the participants. Sometimes the presence of observers can lead to both staff and clients changing their behavior to meet the expectations of the observer (Stahler & Cohen, 2000:2).

As a participative observer within the Crinan project during the research period, I adopted an ethnographic style and hung around the project kitchen, a place embedded in my own history and experience of that street and that community. The methodology was designed to include the research participants in a combination of ways, at different stages in the research, from project access, to the feedback process and in the way the data is presented.

Ethnography provides a useful methodological tool to study drug users in treatment, enhancing traditional qualitative outcome studies of treatment effectiveness (Stahler & Cohen, 2000:1). Ethnographies are based on observational work in different settings and attempt to place specific encounters, events and understandings into a fuller and more meaningful context, where data is transformed into written or visual forms (Denzin & Lincoln, 2000:455). Ethnographic studies of medical or treatment settings have normally focused on medical decision-making, clinical training, patient behavior and inter-professional relationships (Bloor, 2001 cited in Atkinson et al, 2001:177). There are also studies carried out within non-medical institutions, for example, observational studies of illness behaviour in school (Prout, 1986) street ethnographies of drug use (Preble & Casey, 1969) and marihuana use (Becker, 1953). Treatment ethnographies exploring drug user's experiences of methadone and other forms of drug treatment, include; Preble and Miller, 1977; Korf & Hoogenhout, 1990; Keene & Raynor, 1993; Schroers, 1995. The common thread underlying these methodologies is the attempt to understand the world from the point of view of the research participants (Brooks, 1994).

Field notes

I recorded detailed field notes in my research diary and these provided me with my first sense of the data I was observing. I also made regular systematic notes during and after each of the research workshops. Notes and records about the management of the research, meetings with my supervisor and the project manager of Crinan were collected in detail chronicling the process, from formulating the research proposal, to carrying out and completing the research.

Boal research workshops

Young people who 'end up' in treatment for heroin use/addiction have varied experiences of exclusion within their family, school and community and may have suffered physical and emotional neglect or abuse. Entering a treatment programme like Crinan, they are generally suspicious, mistrustful of adults, angry at what happened to them and apathetic towards any

one who shows interest or care in their welfare. Given this situation it was important that the research methodology would reflect practices that nurtured the inclusion of whatever these young people wanted to express, create or articulate in different languages or in ways they chose to communicate. The methods of Augusto Boal (1979) in *The Theatre of the Oppressed* provided a research mechanism that would increase the participation of young people in the research process.

The Theatre of the Oppressed is a form of participatory theatre developed in the 1970s by Brazilian director and political activist Augusto Boal, and rooted in the Latin American popular education movements of the last several decades. It's problem-posing techniques have been used by labor and community organizers and educators in six continents, as tools for democratizing their own organizations, analysing problems, and transforming reality through direct action. In *The Theatre of the Oppressed*, participants dramatize their own stories of oppression and propose various solutions to given situations.

Boal's techniques are designed to recognize and confront external and internal forms of oppression. For example in *Image Theatre* the body is used to create images that help participants explore power relations and collective solutions to concrete problems. The principle goal of popular education is to change the power relations in our society and to create mechanisms of collective power over all the structures of society. In a similar way, Boal's methods help groups explore and transform power relations of domination and subjugation that give rise to oppression (Boal, 2001).

Over a period of eight drama/research workshops I drew on the methods of Boal with varying degrees of usefulness, in gathering data about the young people's experience of drug use and treatment. These workshops generated a limited but important source of data and reflection on what continues to be an extremely difficult task in Crinan, namely engaging these young people in new experiences. It was also difficult to engage with young people when they just failed to turn up or attend a workshop. Non-engagement of young people in the educational part of the programme is an ongoing difficulty within Crinan.

In-depth interviews

The one to one interview provides a structured conversation, in which the researcher can generate empirical data about the social world by asking people to talk about their lives (Silverman, 1997:113). Such interviews provided the main source of data collected on the Crinan project. The research proposal formed the basis for the focus of inquiry and guided the researcher a long a path constructed as he walked, talked and listened. The qualitative interview is typically open ended, unstructured or loosely structured to elicit information at about the treatment setting or specific elements of the programme on the participants in treatment.

According to Kvale, the interview is a stage upon which knowledge is constructed through the interaction of interviewer and interviewee roles (Kvale, 1996:127). In a similar way he describes the interview as a conversation that has a structure and a purpose where observations, ideas, opinions are exchanged and where new knowledge can be constructed. Finally he compares the interviewer to the traveller journeying in an unknown territory, listening to the stories he hears along the way and remoulding them into a new narrative, that not only leads to new knowledge, but also has the power to change the traveller or researcher along the way (Kvale, 1996: 4).

The interviews were conducted after the research workshops were completed. The research workshops had helped to shift the focus of inquiry from solely looking at the educational aspect of treatment to the broader implications of how methadone was impinging on participation in the whole programme. This shift of focus informed the interview process and was reflected in the interview questions.

An interview guide was used to indicate the focus and sequence of the interviews (Kvale, 1996: 129). The research workshops contributed to an increased level of trust between researcher and interviewees and enriched the quality of the data collection process during the interviews. If trust and rapport with interviewees is established, ethnographers are able to elicit rich information that is usually out of reach with other methods of inquiry (Walters, 1980).

According to Kvale, the topic of the qualitative interview is the every day life world of the interviewee and his or her relation to it. The interview seeks to interpret the meaning of central themes in the life world of the subject. The interview attempts to obtain open descriptions of specific situations but is open to new and unexpected phenomena that may arise. The process of being interviewed can produce new insights and awareness and the subject may in the course of the interview come to change his or her descriptions and meanings about a theme (Kvale, 1996).

The research interview is an interpersonal situation, a conversation between two partners about a theme of mutual interest. It is a specific form of human interaction in which knowledge evolves through dialogue... a research interview follows an unwritten script, with different roles specified for the two actors. (Kvale, 1996:125)

All interviews were recorded on mini disc and later transcribed for analysis. Consent forms were used to ensure the confidentiality of the interviews and later access to the transcripts and any interpretations of the same transcripts.

In-depth interviews with project participants

<i>In Crinan and on full programme including methadone script</i>	<i>In Prison and receiving methadone</i>	<i>In Training attending G.P for methadone script</i>	<i>In workplace and methadone free</i>
Tara 28 th March 2001	Alan 25 th Sept 2001	Sean 8 th July 2002	Cian 9 th July 2002
John 8 th July 2002		Jack 8 th July 2002	
Sinead 28 th March 2001			

In-depth interviews with Crinan staff and management committee representatives

<i>Project workers</i>	<i>Therapists</i>	<i>Doctor</i>	<i>Management</i>
Mary 11 th December 2000	Luke 28 February 2001	Mark 31 st October 2001	Sarah – Manager 12 th December 2001
Thomas 12 th December 2000	Alison 24 th Sept 2001		Conor – Chairperson and community representative 26 Sept 2001
Darina 12 December 2000	Paudi 29 th March 2001		Chris – Salesian representative 26 th Sept 2001
Charlie 12 th December 2000			Suz – Salesian representative 24 th Sept 2001
Louise 24 th Sept 2001			Brid – Health Board representative 31 st October 2001
			Frank – Health Board representative 22 nd March 2002
			Margaret – Local Drugs Task Force representative 25 th Sept 2001
			Laura – Community representative 24 th Sept 2001

Feed back data

During the research process I produced a written report for the Crinan Youth Project based on an initial analysis of what I had found. When writing this interim report I was conscious that its findings like most research reports would only be read and interpreted by a few people in the project, most likely management or the professional staff. With this in mind I included

feed back process to allow as many people in the project to read and comment on the draft report. These comments and observations were included in the final report and allowed for the possibility of greater ownership of the final report and its recommendations.

The feed back procedure sought to democratise the research process and maximize participation by those researched, in the production of research out comes. While this process facilitated the collection of useful data from the management and staff teams, it was more significant in yielding knowledge about the project that could not have been observed by other means. Of key importance here, was the exclusion of the young people from being facilitated in giving feed back on the research.

Ethnography makes special provision for early feedback of results to research participants, some times with disastrous results – cf. Emerson and Pollner's (1988) account of the feedback process in their ethnography of the work of psychiatric emergency teams (Bloor, cited in Atkinson et al, 2001:182).

The main criticism of the report was made by one management source who thought the use of 'jargon' in the report made it difficult to read and understand. His observation raised the important question about the use of language, interpretation and theory in communicating and accessing out comes in research.

Separate feed back from the staff highlighted the same issue but focused on the power of allowing the voices of the young people to come through in the report.

I have to say a lot of it was over my head you know with the big words and what ever it is em I agree with Charlie the quotes from the young people brought it accurate... I love the words 'do you know what I mean' and I was impressed that you didn't hide any thing you said what you heard... you didn't kind of disguise it. (F.B-Staff-1)

Despite literacy deficit among some of the local staff they did put in the effort by reading and reflecting on the findings of the report and attending the staff feed back session. On the other hand where there was no question of literacy challenges in reading the report among the management team, only three out of seven turned up to the meeting to give feed back on the report.

Other data sources

Other data sources included attending a conference on family support structures for parents and friends of drug users and presenting the interim report to a wide range of stake holders involved with the Crinan Youth Project. Both of these events provided new information and positive feedback on my own research from others working in the area.

Data analysis

The main task of analysing qualitative data is to identify the primary patterns (Patton, 1990). Data from interviews, workshops and observation notes usually ends up as a pile or a blob that needs to be sorted into categories or themes for further analysis and interpretation. Strauss and Corbin (1990) have identified the purpose of data analysis as reconstructing data into a 'recognizable reality' for the people who have participated in the study. Analysis is not simply one of the later stages of research, it begins at the early stages of data collection with your first sense of what you are seeing, hearing and feeling. Recording what we feel as well as what we see and hear in our field notes expands the data beyond our immediate observations. Our sense of data is also a source of data. In order to make 'deeper and more general sense of what is happening', Spradley (1979) suggests that observers keep four sets of notes; short notes made at the time, expanded notes made soon as possible after each field session, a record of problems and ideas that arise during each stage of the fieldwork and finally, a provisional running record of analysis and interpretation.

Beginning data analysis

My own field notes and diaries helped chronicle my research journey. This journey through the research terrain forged its way changing direction at times as new data and insight invited the researcher to explore new and deeper questions, about the epistemology of treatment. Half way through the research I wrote an interim research report for the Crinan Youth Project entitled '*Rescripting dependency narratives in the lives of young people from the North East Inner City of Dublin*'. Writing this report began the first systematic analysis of the data and contributed to identifying the major categories and themes that would later emerge when a more comprehensive analysis took place. This report examined in detail the three main elements of the Crinan programme namely the medical, therapeutic and developmental aspect of treatment and rehabilitation. This first stage of analysis began to identify how the medical discourse was dominating the programme and suffocating the transformative possibilities of the development discourse.

Developing data analysis

The methodology must demonstrate that the procedures and methods used were based on critical investigation of all data and not just a few well-chosen examples. A critical investigation requires adopting a systematic approach to carrying out the research and analysing the data. While it is not possible to get a true fix on reality, what you find and describe must be set in the context of - how you found it and why you think the way you do about it. We must avoid the temptation to jump to easy conclusions, just because there is some evidence that seems to lead in an interesting direction. Instead we must subject the evidence to rigorous scrutiny. Here I used the constant comparative of data analysis developed by Glaser and Strauss (1967) (Maykut & Morehouse, 1994: 126-149).

While the interim report served as a starting point in my data analysis and helped to identify emerging themes I found on reflection that I had a tendency to evaluate without convincing argument. Extracting hot data or quotable quote from the data pile, to argue a research position, is referred to as anecdotalism. Here researchers appeal to a few 'telling examples' of some apparent phenomenon, without any attempt to analyse less clear or even contradictory data. Brief conversations, snippets from unstructured interviews are sometimes used to provide evidence of a particular research position (Silverman, 2000:11).

According to Strauss and Corbin (1990) the process of qualitative data analysis involves weaving descriptions, speakers' words, fieldnote quotations and the researcher's own interpretations, into a rich and believable descriptive narrative (in Maykut & Morehouse, 1994:122). This study draws on the work of Maykut and Morehouse (1994), to carry out a systematic analysis of the data, in such a way as to describe the epistemology of drug treatment in Crinan with a minimum of interpretation (Maykut & Morehouse, 1994:126). Building on the work of Glaser and Strauss's (1967) constant comparative method, and Lincoln and Guba (1985) *Naturalistic Inquiry*, Maykut and Morehouse (1994) have developed a method of data analysis that remains close to the research participant's feelings, thoughts and actions in a thoughtful and challenging style of analysis.

An inductive approach to data analysis

Unlike the deductive approach to data analysis, where hypothesis are generated prior to beginning the study and data is collected to test the hypothesis, the inductive approach generates hypothesis from the data collected through a process of inductive reasoning. This method is known as the constant comparative method (Maykut & Morehouse, 1994:127). The constant comparative method of data analysis involved inspecting and comparing all data fragments that arise in a single case (Glaser & Strauss, 1967) and ensures that all of the data is fully utilized.

First the data must be prepared for analysis. Fieldnotes are typed and audio taped interviews transcribed. Notes from diaries and hand written documents are typed. The data is then photocopied and the originals filed for backup and reference. Each page of data is coded with reference to the type of data and its source (e.g. T-J.S-2 = interview transcript with John Smith page two). The next step is to identify units of meaning from the data, which are then cut from the source and taped on to separate 5"X8" index cards. The appropriate code is written at the top of each index card, to make it easier to refer back to the main data source for further clarification. A word or a phrase is written on the card to indicate the essence of the unit's meaning. Additional information can be put on the blank side of the card to indicate age, gender or other important details that emerged during the interaction. This process of culling for meaning from the words and actions of the participants in the study, is framed and guided by the researcher's focus of inquiry. The goal is to identify as many potentially important experiences, ideas, concepts, themes in the data, in the search for meaning (Maykut & Morehouse, 1994:132).

As units of meaning form larger clusters, using the look/feel a like criteria, new categories can be formed e.g. medical, with possible sub categories included under the headings methadone or doctor-client relationship. The look/feel alike criteria was advanced by Lincoln and Guba (1985) as a way of describing the emergent process of categorizing qualitative data. Initial categories can be changed later, merged or omitted with new categories generated and new relationships discovered. Categories should provide a reasonable reconstruction of the data. Lincoln and Guba (1985) also suggest the writing of a rule, for inclusion as a propositional

statement. This is a statement of fact grounded in the data and conveys the meaning contained within the data. An audit trail is developed which summarizes and traces the initial ideas to the research outcomes. This document allows people to walk through your work from start to finish, in a way that they will understand the path you took and so measure the reliability and trustworthiness of your outcomes (Maykut & Morehouse, 1994:146).

The impact of postmodernism and poststructuralism on data analysis

The data emerging from this inquiry indicates that the medical discourse maintains a privileged epistemological position within the Crinan treatment programme. The data presented in the next chapter will show how this is the case with subsequent chapters analysing and discussing the implications of this thesis. In order to show how I have arrived at this position and went about theorizing my data, I will discuss the philosophical issues that underpin my argument and support my findings that were central to my analysis.

Postmodernism like poststructuralism escapes easy definitions. Postmodernism marks more a historical watershed and philosophical style or movement. Instead of rushing to definitions it is more useful to accept some degree of indefiniteness and accept the uncertainty of these terms. Both are concerned with questioning the failure of the grand narratives of the past to deliver the promises espoused by modernity and focus on philosophical issues about language and power, meaning and representation. Postmodernism and poststructuralism both have a tendency to stir things up and problematize dominating forms of expression e.g. the biomedical approach in the treatment of addiction. As Lincoln and Denzin remark; 'if there is a center to poststructuralist thought it lies in the recurring attempt to strip a text, any text, of its external claim to authority' (1994: 579).

Postmodernism and poststructuralism have been heavily criticized for their 'anything goes' approach, where they seem to condemn everything and propose nothing (Bauman, quoted by Billig and Simons, 1994: 6). Wilkinson (1997 cited in Ryan, 2001: 10), indicates another difficulty, that postmodernism and poststructuralism are perceived as currently fashionable in

academia, but of little practical use 'the real world'. Ryan (2001) aspires to show their practical value and points out how authors such as Lather (1991) Lewis (1993) and Middleton (1993) have used them in practical ways to construct feminist change.

Discourse analysis

In analysing the data I have drawn on the concept of discourse to examine the meanings within the narratives of this study and how these are in turn shaped and constructed through discourse. Discourse refers to how knowledge is constructed through cultural, social and historical filters and is contained or expressed in organisations and institutions, as well as in words. The rules of discourse are rarely explicit, nevertheless, everybody 'just knows' the dominant discourse of a particular culture. Discourse can become institutionalised and dominant. Discourses can also compete with each other, creating different perspectives on a particular reality (Ryan, 2001). The subjectivity of the teenager using drugs is a political space where different and sometimes, competing discourses are in conflict for power, control and influence. Discourse, as defined by Foucault refers to:

Ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations, which inhere in such knowledge and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of subjects they seek to govern. (Weedon, 1987:108)

For Foucault a discourse is a strongly bonded area of knowledge and system of statements within which the world can be known (Ashcroft, Griffiths & Tiffin, 1998:70). Discourse joins power and knowledge together. Those who have power, control what is known and the way it is known.

Implications of postmodernism and poststructuralism for qualitative research

In terms of qualitative research, postmodern theoretical truth is not a fixed entity waiting to be discovered, but rather something that is constructed within a self-reflective community in which theorist, social scientist and research participant are interchangeable positions (Brown, 1990). Researchers here are concerned with the way theories are constructed, the assumptions they make and their claims to authority. There is a preference for diversity rather than unity, difference rather than synthesis, complexity rather than simplicity and multiple interpretations (Rosenau, 1992: 8). The postmodern researcher deconstructs and re-constructs rather than merely presenting what is being researched. Ehn and Lofgren (1982) advocate dramatization by combining objects and incidents that seem to be incompatible as a method of deconstructing.

Turn social hierarchies upside down; let individuals switch roles, interests and language. Play and experiment with the empirical material as if it were a stage prop or a paper doll. Confront taboos, category divisions and sacred cows within everyday practice. (Ehn & Lofgren, 1982: 113)

The postmodernist researcher places great importance on his/her role as author and co-producer of a text, far beyond the writing up of results (Fine, 1994; Richardson, 1995; Van Maanen, 1988). The text remains open to different interpretations, multiple reality and ambiguity. In the text, closure is avoided and instead inconsistencies and fragmentation are either avoided or silenced (Alvesson & Skoldberg, 2000: 173).

Presenting the data – the script

Alvesson and Skoldberg (2000: 190), argue that in a research project and subsequent text, the voices encountered in the site of research must come through in a sensitive and multifaceted way. Many researchers agree with this, but as a rule the data is processed and interpreted giving priority to patterns and connections and trimmed to the researcher's terms. In presenting the data I wanted to allow the many discourses, narratives and spoken words to engage each other on the stage in a dramatic dialogue, where the reader can imagine him/herself as a spect-actor. To achieve this I have presented the data as a script for a play,

drawing on the techniques used by Augusto Boal. Different voices are allowed to speak. The selection of data for the script followed the use of the constant comparative method of data analysis, which had distilled and reduced the data to a number of central concerns, which the research was seeking to address. The role of the researcher is not be limited to presenting data he finds. Rather, the researcher assumes the role of script editor, gleaning from the sources of data, found between the lines, weaving script, weaving power, evoking play. The way the researcher interprets, selects and narrates is of crucial importance to the very production of a plausible text (Alvesson & Skoldberg, 2000: 193).

Prioritising data for inclusion in the script focused on the main categories identified earlier in the analysis process. Quotations were included to best represent these different categories, using field notes and other sources of data to support the main script and set of outcome propositions (Maykut & Morehouse, 1994:159). The script not only focuses the discussion in question but also serves to bring the reader closer to the direct experience of the participants' perspective. Reading direct quotations in the participants' vernacular, also has the direct benefit of reminding the research audience of the 'research participants humanity', often overlooked in the course of research (Stahler & Cohen, 2000: 4).

Conclusion

There is no correct telling of any event and so the findings of this research are limited. There are only multiple viewings and perspectives to any human experience. It is hoped that this viewing and telling of the Crinan Youth Project story will offer new insight and knowledge about the meaning of drug treatment. Qualitative research is a site of multiple interpretive practices. We can attempt to secure in-depth understandings of the phenomenon in question. This inquiry involved gaining access to the lives young people in a drug treatment setting. The purpose of the research was to understand the meaning of drug treatment in that setting. The findings of this research will inevitably reflect the assumptions and values of the researcher.

Data chapters in research reports can often be tedious and labour some to read. The voices of the research participants are often silenced by the constraints of writing and editing research. With this in mind I chose to present the data in the form of a script for a play. Through out the play you will find the discourses of medicine, psychotherapy and education competing and searching for solutions. These discourses are embodied in the different characters at the heart of this treatment drama. I hope that this drama reflects to some degree the reality of drug treatment and the conflicts that exist between different sources of knowledge competing for the young persons attention.

Chapter 7

Data presentation

'A treatment drama'

Introduction

This is a story about a group of young people and their experience of the Crinan Youth Project. The central theme running through their story is how methadone fails to break the conditions that have silenced and excluded them from mainstream social, economic and cultural life. Methadone fails to treat the causes of their condition and acts to further silence them by labelling and medicalizing them. Therapy has been silenced by its own need to be validated by the medical establishment, the gatekeeper of treatment knowledge for heroin users and addicts. The educational discourse is split between a radical agenda of social and personal transformation and a conservative or neo-liberal approach that goes along with young people being medicalized, criminalized and demonised because of their drug use. Their story reflects the story of the community they come from, in the northeast inner city of Dublin.

Northeast Inner City of Dublin – a profile

Modern Irish society has undergone a rapid period of economic and social modernisation since the 1970's, changing from a largely agricultural and rural driven society to an urban society driven by economics and information technology. As these changes took place, they had a knock on effect on labor markets and unemployment increased during the early part of this period during the 70's and 80's. Of particular importance to the North Inner City was the containerisation of Dublin docks and the loss of employment for the indigenous work force. Most employment in the North East Inner City was traditionally in low-paid, unskilled manual activities, with under-employment and unemployment as accompanying features (Kearns, 1994). In the 1970's alone over 10,000 jobs were lost from the entire inner city as new technologies replace unskilled and semi-skilled labour. Unemployment rates for the inner city rose from 9.3 per cent in 1971 to 31.8 per cent in 1991 and by 1994 the figure reached 14,530 unemployed people and in some parts of the North East Inner City unemployment rates reached 85 per cent in the mid to late 1980's (Integrated Services Initiative, 1997). Much of the new employment, which was generated in Dublin's inner city, has been white

collar or highly skilled work, for which the area's largely unskilled labour force has been unable to compete (Breen et al., 1990). These levels of economic disadvantage are accompanied by many social problems, including high rates of drug misuse and crime, poor educational outcomes, and relatively high levels of family break down (Integrated Services Initiative, 1997).

The decline in traditional industries introduced the concept of long-term unemployment and by the 1990's the young people exposed to the heroin epidemic had already experienced multi generational unemployment. This was compounded by a tradition of early school leaving that evolved at a time when it was easy to secure employment without formal education (Murphy-Lawless, 2002).

The data arising from their story and from this research is presented here as a script. This script represents a snap shot of their treatment experience in the Crinan Youth Project. The aim of presenting the data as a script in the form of a play is two fold. Firstly to bring you the reader close to the young people and to the dynamics of treatment as it unfolds in the project. Secondly to reflect dramatically the experience of drug treatment which is like a series of scripts inhabited by different actors and vested interests. Influenced by the work of Augusto Boal (1979, 1998) the research enacts metaphorically some of his techniques, inviting the reader to shout stop and to intervene in shaping the direction of the play and in reality the direction of drug treatment for young people.

The general picture

The United Nations Office on Drugs and Crime (UNODC) estimates that about 200 million people consume illicit drugs (annual prevalence 2000-2001). This includes about 163 million for cannabis, 34 million for amphetamines, 8 million for Ecstasy, 14 million for cocaine, 15 million for opiates including 10 million heroin users (Global Illicit Drug Trends, 2003).

Estimated national prevalence of opiate use in Ireland

Year	Sex	Age group	Estimate
2000	Male + Female	15-64	14,158
2001	Male + Female	15-64	14,452

Break down of the 15-24 age group

Year	Sex	Age Group	Estimates
2000	Males	15-24	3480
	Females	15-24	1866
Total			5346

2001	Males	15-24	3194
	Females	15-24	1999
Total			5193

Source Small Area Health Research Unit - Trinity College Dublin, 2001

The average age of those in treatment in Ireland is the lowest in Europe at 23.6 years (Annual Report on the state of drugs in the European Union, 1998). At the end of February, 2000 a total of 4420 people were on the Central Methadone Treatment List with 4353 of those being treated in the Eastern Regional Authority Area (AIDS Strategy 2000: 61).

In 2000, 459 young people under the age of 18 presented themselves for drug treatment according to the National Drug Treatment System (NDTS). This figure is not representative of the general drug using population – but only those who present to the treatment services. They do not constitute an estimate of the number of drug users (National Drug Treatment System, 2000).

Analysis of 459 young people (NDTS, 2000)

Age profile	Gender profile	% living at home	% left school by 15	% used drugs by age 15
90% 15-17	67% male 33% female	81%	45%	60%

Heroin use and injecting patterns

Heroin as primary drug of choice	22% or 100 young people aged 15-17
% injecting heroin	10%
% sharing needles	3%
% injected at some stage	17%
% injected before the age of 15	5%
% injected before the age of 17	17%

Other drug use

Ecstasy as primary drug of choice	11%
Cannabis as primary drug of choice	57%

We can conclude from these figures that the majority of these young people are living at home, that nearly half of them are early school leavers and 60% are already using illicit drugs before the age 15. This inquiry focused on a group of young people matching the above profile who presented themselves for treatment in the year 2000. This research presents qualitative accounts of those young people who received treatment in the Crinan Youth Project between the year 2000 and 2001.

A majority of people presenting to drug treatment services have problems with the misuse of heroin, that is, heroin is the main drug of misuse. This is mainly confined to the Dublin area. A sizeable proportion of those presenting to treatment services for the first time with problem heroin use are involved in intravenous drug-using practices, with very serious health and

social consequences (Moran et al., 2001: 84). Risk behaviours are very important in the transmission of drug-related infectious diseases (HIV, hepatitis B, hepatitis C). Injecting with shared equipment is the crucial transmission route among intravenous drug users.

There were 364 newly diagnosed HIV infections in Ireland in 2002. This represents a 22% increase in the number of cases diagnosed in 2001 (National Disease Surveillance Centre, 2003). Methadone maintenance programmes have become a major part of the response to HIV and opiate use since 1992. The number of HIV cases associated with injecting drug use has fallen continuously since 1993, representing 21% of all new cases in 1998 (AIDS Strategy, 2000: 13).

This indicates a measure of success for harm reduction initiatives. However new figures show an increase in the numbers of injecting drug users being diagnosed with HIV, with figures from 1999 showing a substantial increase in the number of positive cases. Injecting drug use as a risk category increased from accounting for 19.1 per cent of new HIV-positive cases within this data source in 1998, to 33 per cent in 1999. There were 50 new diagnoses among intravenous drug users during 2002. This compares with 38 diagnosed in 2001 and represents a 32% increase. This is the highest annual proportion of new positive cases attributed to injecting drug use since 1993.

Drug related deaths from opiate poisoning

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
No. Under 30 yrs	7	4	8	8	11	22	30	34	53	35
%	100	50	61	44	58	51	57	62	54	44

Source: Overview of drug issues in Ireland 2000

The cast

Young people

Tara

John

Sinead

Alan

Sean

Jack

Cian

Management

Laura – community representative

Margaret – community representative

Frank – health board representative

Brid – health board representative

Suz – Salesian representative

Chris – Salesian representative

Sarah – project leader

Conor – chairperson

Youth and Community staff

Thomas - local

Mary – local

Charlie – non local

Darina - local

Louise – non local

Therapeutic staff

Luke

Alison

Paudi

Medical staff

Dr. Mark

Act one – the medical discourse

Scene one – do you know what I mean...?

John

I am actually struggling at the moment to keep things on track (T-M.M-2.3)

I am just hoping that things will turn around this week and be better (T-M.M-8.3)

I am still taking coke and stuff like its hard to be honest at the stage that I am to say I am taking coke like I would find that hard to say (T-M.M-5.2)

It's down to me at this stage like I really have to like take it real serious (T-M.M-5.2)

I am going to have the will power (T-M.M-9.1)

Just a bit of strength and will power to get me by... just to get me through this little tangle (T-M.M-6.2)

It (heroin/cocaine) puts you on a level... of like vulnerable level... you're not trustable you're really not (T-M.M-20.1)

It feels good to come in here (Crinan) and know that you're clean (T-M.M-10.1)

Like I would feel really stupid to be kind of still taking drugs at the stage I am at (T-M.M-5.1)

I am really like determined this week to come (to Crinan) (T-M.M-12.4)

I kind of try and find a bit of strength and say please help me along the road... it's a bit difficult at the moment (T-M.M-15.2)

I have to make the most of it because if I leave this time I am not going to come back (T-M.M-2.1)

Scene two – medicalizing the heroin problem

- Dr. Mark** *In my mind the reason most people come for treatment is because things become too unpleasant in their lives the sort of positive parts of drug taking, the fun the social part the euphoria all that sort of goes into the background, and the things that become more important are the hassles the police, the family troubles, that terrible feeling of being trapped in a whole sort of cycle of having to rush out and get the drugs... the methadone is a solution to that, it really takes care of those problems (T-Dr.C-1.3)*
- Sean** *Like at the start you don't really want to give the drugs up... it's only when you're on it a couple of year when you see the bad things (T-G/I-5.1)*
- Margaret** *I don't think drugs is the problem with these people (T-J.C-3.3)*
- Drug use is symptomatic (T-J.C-4.1)*
- I have uncomfortableness with using the term addiction with somebody of that age group... I think that drugs is one aspect of someone who attends Crinan (T-J.C-2.1)*
- Mary** *Its all the other issues they have to face out side of here, I mean no jobs, em family life, issues with girlfriends, self confidence, peer pressure (T-B.H-1.4)*
- Sarah** *I think there are two philosophies running side by side, there is the one, drug addiction is an illness and you have to try and treat it and you treat it with drugs like methadone, and you treat it with health management... that's one way and the other way is drugs are bad and society shouldn't have drugs and you eliminate drugs all together and you make criminals of the users (T-V.K-14.1)*
- Chris** *I would still maintain that the purpose of the project is go them off all drugs, to get them off phy as well, that have them drug free (T-M.C-6.3)*

Scene three – methadone the carrot of treatment

- Sarah** *The concern on the staff is that they are coming here for methadone (F.B-V.K-10.2)*
- Dr. Mark** *The only way to get them in the door is to give them methadone (T-Dr.C-3.4)*
- None of them wanted to get cured or any of that kind of rubbish it was purely and utterly pressure that was put on them by their families and there was legal pressure and so on (T-Dr.C-2.5)*
- What you're attempting to do is replace what's a fairly exiting lifestyle for kids who have been fairly emotionally abused and neglected (T-Dr.C-11.4)*
- Alan** *What I felt about the methadone is that you don't have to go and rob for it you know (T-A.H-9.3)*
- Dr. Mark** *They want to sort out those immediate problems, methadone sorts those problems for them... my experience of methadone it does give a different effect to heroin and smoothes things out and makes life more and more palatable (T-Dr.C-3.2)*
- Tara** *When I first started here like I wasn't even thinking about getting me life together to be honest with you I was just happy that I was getting phy (phyceptone or methadone) and I didn't have to go out and buy it and I didn't have to buy gear (T-A.L-3.2)*
- Dr. Mark** *It sorts those problems out (T-Dr.C-1.4)*
- Alan** *It put me on the straight and narrow (T-A.H-4.3)*
- Sinead** *It's great because it got me off gear (T-T-9.2)*
- Dr. Mark** *Methadone solves those problems you see its gets rid of the stress, it gets rid of the pressure (T-Dr.C-2.1)*
- John** *I am on 50 ml's (T-M.M-2.4)*

Scene four – Crinan exists within a treatment culture dominated by methadone

- Suz** *I was struck by how much the medical part of it right kind of dominates the whole scene or play (F.B-M.F-Mgt-3)*
- Brid** *I think there was an over emphasis on methadone (T-K.F-8.4)*
- Dr. Mark** *The harm reduction benefit from methadone use is ea really in keeping out of trouble like buying illegal drugs, you're not using the needles, you not putting your self in the danger of getting infections (T-Dr.C-9.2)*
- Jack** *I think I did about four detoxes in here... it didn't work out for me because I was vulnerable at that time and there was drug's around me (T-G/I-3.3)*
- Brid** *We get caught in the politics and the rush and the numbers game, waiting lists and so then the quality began to sort of slip (T-K.F-9.4)*
- Frank** *Qualitatively we are not actually moving on... staff are working with increasing numbers (T-G.McA-1)*
- Brid** *We don't have huge amounts of people down in the City Clinic who are drug free either (T-K.F-2.4)*
- Thomas** *I think the City Clinic is a problem as well, that the people are getting a lot more methadone than they should be given... they save up if some one is on 80 ml's they might only need 40 ml's and then they sell the other 40 off and the that money will go to buy heroin (T-D.K-13.3)*
- Alan** *Like the difference with the City Clinic there your just on phy do you know what I mean you can do what you want (T-A.H-10.4)*
- Thomas** *We have the luxury to sit with them all day or what ever, if they choose to come in, to talk to them, feed them (T-D.K-12.1)*
- In the City Clinic they just go around and get their methadone, there is no follow up... it's like a conveyor belt (T-D.K-11.2)*

- Tara** *Fair play to them at least they're not like City Clinic (T-A.L-13.4)*
- Conor** *There's a huge amount of support along with the methadone (in Crinan) and the programme is run being aware that methadone is involved and that the young people on different levels are on different doses (T-P.M-11.2)*
- Sarah** *It (Crinan) is not like the City Clinic it's not tunnelling it into a no movement space (F.B-VK-5.2)*
- Conor** *One of the biggest problems I would find em in your Clinics the treatment centres... there is no actual thought or plan of after care support as a result you have all these problems that you have now in each of the public parks in the community massive amounts of users who go straight to the off licence or go and get their supply of what do you call them benzo's and it become a viscous circle because there is nothing after they receive their methadone (T-P.M-5.4)*
- Louise** *I think we are trying to achieve every thing that is not being achieved by any other treatment centre even the name treatment centre, you think connotations City Clinic just going in the door and getting your methadone and see the doctor once a week (T-Ash-1.5)*
- Frank** *30 to 40% of people now in Clinics have got dual diagnosis so there is also a mental consideration... well if I was treated like a dog I would have mental considerations em but where is the liberation, the transformation the empowering of these people em there is no accountability around any of the interventions (T-G.McA-8.2)*
- Laura** *You detox and then you get a life, you get a job, you get a family, you do all these things and your nice and you go down to a pub on a Saturday night and you don't take drugs anymore...*
- Everybody has this idea and you know people are getting frustrated because people are going to methadone maintenance programmes and their relapsing, their using benzo's, their drinking heavily or they could be going to detox a zillion times...*
- They don't just get better with treatment (T-A/HB-5.4)*
- Suz** *Five years later methadone is still a key component in the project (T-M.F-8.1)*

Scene five – methadone medicalizing the heroin user

Part 1

Cian

The first time I ever used was when I was twelve after me father died... when I was 12 (T-A.B-17.2/4.1)

Things went mental... I was always great in school and the minute there was a disturbance in the family every thing went up into the air, me ma couldn't handle six kids... so it went hay wire (T-A.B-4.3)

Dr. Mark

The basic fact is that these people these kids are addicted to opiates (T-Dr.C-1.2)

Cian

I know I messed around with gear I had a habit, but I didn't really class my self as a serious heroin user, it was really the methadone that was holding me back and because of the methadone I was in the environment... they were doing it and I was trying to fit in (T-A.B-10.4)

I would have to say the brown methadone I went on it first in Pat's made me very sick...

I was vomiting and all... I remember getting sick out in the yard and it was horrible and it was just I had no habit...

I wasn't strung out on nothing...

I always regret going on it because it's after been so hard to come off it (methadone) (T-A.B-4.5)

I was after been on the brown methadone in Patrick's... and then I got brought down on green phy... I hadn't even got a habit (T-A.B-3.3)

Dr. Mark

Their immediate problem is that they are addicted to a drug that is getting them into a lot of trouble and life had become unpleasant one way or another (T-Dr.C-3.1)

Cian

As I was going on I knew it (methadone) was holding me back, it was after doing its job if you get me like I was after coming, they brought me so far and I had to take the extra step and come on to places like

this (A resource centre where he runs a cyber café) and break the sort of barrier that was going on (T-A.B-5.4)

It's the best thing I have done in a long time (coming off the methadone) and there is no turning back on it... I will never turn back... not after all the stuff I have been through, I just know there is a good life out there... its there for the taking (T-A.B-15.2)

I am off the phy, I done it, I done it (said with enthusiasm) (T-A.B-13.5)

I am probably feeling normal... its all about what's in your head (T-A.B-14.2)

Part 2

- Tara** *He was saying that I will bring you down to a place and he didn't actually say this place, he says try and get on the Clinic or something and just letten on that your on gear... and they will get you off the charges and all, just take a bit of gear and give a urine and letten on your on gear (T-A.L-2.4)*
- Dr. Mark** *The bottom line for me in using methadone number one is safety you know you are making things more safe or dangerous for the client (T-Dr.C-9.1)*
- Sarah** *The whole drugs scene is so chaotic and you just want to move it some where else and that's the situation they get into in the city clinic and they say Crinan is down there, they have a doctor, counsellors and the rest, why are they not taking some of these people, what are they doing down there they don't have that many, where as if I wanted tomorrow if it was just about numbers we could probably take another 20 people here and just give them methadone at the door and let them go (T-V.K-13.2)*
- I don't think anyone is listening to anyone in the drugs services at all... its chaos managing chaos (T-V.K-14.1)*
- Frank** *We have made it anonymous and antiseptic (T-G.McA-5.1)*

Act two – the therapeutic discourse

Scene one – Biomedicine controls the treatment of addiction

- Dr. Mark** *It's the old thing they used to say in the hippy days... its all one man and it is really, physical/psychological for me I really believe there is no difference, we are all just big bags of chemicals (T-Dr.C-5.3)*
- Tara** *I am on 8 ml's now so getting right down to nothing... that's just a little sup do you know what I mean? (T-A.L-4.4)*
- Luke** *Even for a few months 10 ml can act as a psychological crutch (T-J.L-6.2)*
- ... an awful lot of the youngsters learned to cope with there pain by taking medication, they were self medicating and it was primarily for an awful lot of them it was a pain killer...*
- When they are detoxed down... they **begin to feel the pain** again... we found we had to actually stop at one point we had to stop or allow the choice to young people who were on very low medication not to have acupuncture because some of them in the acupuncture and in the yoga where they are into a deep relaxation they actually started getting flashbacks to what was the underlying stuff in their addiction which might have been in some cases sexual abuse and it freaked them... (T-J.L-9.1)*
- Alison** *The doctor is in on Wednesdays... they are in for the doctor on Wednesdays so we will get Sharon done as well... so get the two over with (T-Sh-4.1)*
- Dr. Mark** *Its all pain... that's what we are dealing with pain relief... there is an enormous you know psychological element to that (T-Dr.C-6.1)*
- Alison** *The higher the dosage the less I can expect on a therapy level (T-Sh-5.3)*
- Sinead** *But when you are getting really low (methadone dose) that's when you're panicking that you don't have any thing (T-T-10.1)*
- Alison** *It's a huge psychological step for them (T-Sh-12.1)*

Scene two – the construction of Crinan was dominated by a biomedical hegemony operating in the drug treatment services

The construction of Crinan was dominated by a biomedical hegemony operating in the drug treatment services. This biomedical hegemony has its fingerprints all over the architectural blue print that later became known as the Crinan Youth Project. Those who sat down around the table to design a treatment programme for young people experiencing problems with heroin did not realize the power and influence which biomedicine would have in the development of the project.

Scene three – Psychotherapy and the construction of heroin addiction

Tara *Because see every thing... do you know what, it's the whole thing the boredom, the depression, the way it affects your self esteem, every thing that's worse than the sickness of heroin, to me its is and that my opinion I think its much worser that the sickness, because you can go through the sickness you know what I mean what a few weeks or what ever if your on heroin two weeks, three weeks at the most and then the sickness is gone, **but its all up in the head** (T-A.L-17.3)*

Alison *65 or 70 % would have identity issues, around I am a scumbag, I am only a druggie, I'll never get out of this (T-Sh-9.3)*

Margaret *Putting another label (addiction) on them is putting a whole air of inevitability about their lives that they buy into, we buy into, the services buy into and the community buys into... problem child, problem home, drug addict (T-J.C-3.6)*

Cian *That label I am trying to tear off the last bleeden two years (T-A.B-8.3)*

Tara *I am looking forward to it (coming off methadone) like cause it's a big part of me life do you know what I mean like, its ties me down (T-A.L-5.2)*

A lot of it is all up in the head it really is do you know what I mean... its not only just about getting strung out and the sickness and all that, it's the whole ritual around it...

You're on gear and then when you come off it like there's the boredom you don't know what to be doing with yourself because you are so used to being on gear...

Just running around to get money to buy it and taking it and that's it and then the same thing again its like then when your off its you just don't know what do be doing with your self...

Depression, there's everything your mind telling you that you need to take it your self esteem drops your confidence the whole lot it knocks every thing (T-A.L-5.3)

Scene four – Psychotherapy in conflict

- Sarah** *We don't try and transform (F.B-VK-6.2)*
- The people I work with transform themselves... and we work with the young people here to normalize the process... its all about the cup of tea in the kitchen (F.B-Val-13)*
- Luke** *I think it is the function of therapy to lead the young person into the safe places within them selves in a safe way (T-J.L-9.2)*
- Sarah** *Helping people to make meaning within their experiences that enrich where they want to be... the only thing I ever want to change with them is that they stop using drugs (F.B-VK-16)*
- John** *At the end of the day I am one of these people who prefers to sort me own problems out in me head (T-M.M-9.3)*
- Sarah** *To help people get into situations to explore other new ways and out of those new ways there may not be changes for people... to help them to be comfortable to dabble with different ways of being (F.B-Val-13)*
- Frank** *There is a lot of contradiction around the whole therapy thing I mean you know I think its quite right wing I think its very disempowering em I think its very market orientated (T-G. McA- 7.3)*
- Sarah** *It's a very gentle persuasive building work rather than changing (F.B-Val-13)*
- Frank** *I would suggest and believe that it is far more therapeutic than sitting once a week in a room with somebody em who is culturally questionably whether appropriateness or whether empathy is there em again the whole thing about control... none of them are involved in community development (T-G. McA-9.2)*
- Sarah** *A lot of social constructivist ways is you work with the client to enhance who they are rather than change who they are to give them confidence to be genuinely who they want to be... often their resistance is very vital and important (F.B-VK-21)*

Frank

I mean again this whole thing about colonialization of language... the fundamental premise of therapy is that the therapist has the power and that's where they work from (T-G. McA-7.4)

It just becomes a very rarefied game (T-G. McA-5.2)

Scene five – Psychotherapy and adult/community education

- Thomas** *A lot of work goes on around that cup of tea (F.B-Staff-9)*
- Dr. Mark** *I think the biggest need those kids have is the socializing... that whole thing of what happens down in the kitchen (T-Dr.C-13.2)*
- Tara** *Just all the talking like you know what I mean, talking to you and all that, and showing that they care, giving you support do you know what I mean, just giving you support... because I wasn't getting support from anyone else like (T-A.L-4.1)*
- Jack** *We used to come in in the mornings and Bernie and Annie would give you your breakfast and look after you like your own ma would (T-G.I-11.2)*
- Luke** *Therapy with young people is primarily about relationship and actually the conversation that's held over the pool table, the conversation that is had when you go for a cup of coffee with a youngster are richly therapeutic (T-J.L-7.2)*
- Brid** *Therapy was able to flex and work within the community context with the culture that we have on the ground that it wasn't about sitting in two armchairs, cameras on and rubber plant in toe (T-K.F-3.1)*
- Sinead** *They don't give out to you and they don't put you down, when you're having a slip or any thing (T-T-3.3)*
- Thomas** *I think Crinan works in a way where you are not forcing people... we don't put them into slots... we treat them as human beings (T-D.K-4.3)*
- Sarah** *We would try and get close to understanding the young person through conversations with them as to what the hell got them there (F.B-VK-18)*
- Alan** *They go out of their way like right out of their way to help you (T-A.H-5.1)*

Thomas

I think the atmosphere that is in there I think your learning on a one to one all the time and your getting deeper into their mind on a one to one (T-D.K-17.2)

Dr. Mark

I believe my self that a lot of what has gone on there the experience they have had there will affect those kids for a long time to come and probably wont be seen for a long time to come (T-Dr.C-12.3)

Act three Educational and development discourses

Scene one – the silent space

Alan

What if you have nothing to say...

There is no point putting things on the agenda, when nothing is done about it (A/YP-O-C.P-002)

Dr. Mark

They expect to be able to take these kids in from this world and then suddenly some how have them sitting down reading books and doing computer courses and getting jobs... I mean it's not realistic (T-Dr.C-12.2)

Conor

They are probably the most difficult group of people to work with (T-P.M-6.3)

Sean

I was in secondary school for two weeks and it all went down hill from there (T-G/I-2.1)

Tara

I wasn't in school for all those years, do you know what I mean and ea taking drugs its only obvious that your brain is going to go bleeding dead if your not using its properly your blocking all your emotions with drugs and al that and suppressing your feelings you know because that's what drugs does to you, phy, gear the whole lot... your not using your head to do you know what I mean for positive things (T-A.L-9.2)

Jack

I got thrown out of school when I was twelve (T-G/I-4.5)

Well me father passed away when I was eleven... I flipped over that... I just went off the rails a bit (T-G/I-4.5)

Tara

I was 13 em we were going out, she was bringing me out to night clubs the whole lot, taking e's, like taking e's every night of the week, staying out all night...

We used to stay there till 8 O Clock in the morning, 9 O Clock, and go home and go to be for the day, I'd be on my way home and I'd see girls that would be in my class going to school, so that's what

happened, where I wasn't going to school, I was just staying out all night (T-A.L-7.2)

Jack

I was thrown out... I finished first year and I tried four or five different schools but none of them would take me (T-G/I-3.2)

Tara

I left school when I was fourteen, or thirteen... well I had more or less left because I was never in like (T-A.L-2.2)

Alan

I was expelled out of first year (T-A.H-1.3)

Tara

I am bright enough I do pick up things easy enough (T-A.L-8.1)

Sinead

I done well, I got six honours and three passes in my junior... last year I taught myself computers and I know word and excel, and I am doing my own web site now (T-T-7.2)

Scene two – the empty space

- Paudi** *They are not coming here (T-Ray-7.2)*
- Dr. Mark** *People weren't coming in, weren't turning up, weren't coming in to see me (T-Dr.C-8.1)*
- Chris** *There was a period last year where it was difficult, they just didn't come and we had to advertise (T-M.C-14.2)*
- Dr. Mark** *They don't want to come in (T-Dr.C-14.1)*
- Alison** *Personally is it good that two days a week the place is empty? I don't think it is... I don't think it is good for relationships, I don't think it is good for recovery; I don't think it is good for education, because how can it be when it is empty? (T-Sh-10.3)*
- Conor** *People have always panicked about the numbers there... over the years the numbers have dropped off and there is quite clear reasons for that and I know that some people look at that quite negatively and say that we are not out there or that the workers are not out there trying to find new things new young people to look after (T-P.M-2.4)*
- Dr. Mark** *Recruitment of people into programmes the real problem we had with Crinan was the problem the terrible fear that we might all come in one day and there would be nobody there no clients right... people are expecting too much of them selves... I think in a lot of ways they may undervalue what is being done (T-Dr.C-15.2)*
- Margaret** *They are afraid if their numbers aren't up or their afraid if we don't be seen to have hundreds of people coming through their funding is going to be cut or people are going to say we are not affective (T-J.C-15.1)*
- Dr. Mark** *So I really think there is this expectation that you know 'what are we doing wrong why haven't we managed this' (T-Dr.C-12.4)*

Scene three – dockers and doctors

- Chris** *The majority of the staff are kind of local, em I think that is a big difference, so that even in the conversation and in the relationships... I would imagine are a bit more up front and a bit more honest (T-M.C-3.4)*
- Brid** *I think it's great to have local people working in here and particularly the broad range of experience and I don't think there is an 'us' and 'them' (T-K.F-6.1)*
- Suz** *I always thought that was a hallmark of the project that there were people from the community (T-M.F-3.2)*
- Conor** *Both groups with in the structure would be aware that there is a difference between them... but they are treated with the highest of respect, they go to all the clinical meetings, they are involved in the decisions (T-P.M-8.1)*
- Charlie** *They have the brains we have the experience (F.B-Staff-9)*
- Chris** *The community people em what they might bring naturally and the knowledge of the area and that type of thing and they need to develop some em of what you would call the professional skills (T-M.C-5.1)*
- Laura** *I suppose it's about what's good enough and what's not good enough (T-A/HB-14.1)*
- Margaret** *A lot of the way people work here is through mates and being mates and being friendly and liking people and having people like you (T-J.C-8.2)*
- Frank** *Professionals will always resist that because of the ethos that they have around their status you know and ea if you stripped it back to human reality you know the reality is how do you connect with young people and how you connect with people who are in addiction (T-G-McA-3)*

- Dr. Mark** *It's how you treat people, how you feel for people, It's an emotional thing... I mean these peoples problems are emotional, there not intellectual... its not because they don't understand right... its because they have been screwed over emotionally for generations (T-Dr.C-5.1)*
- Alison** *I feel that the community people definitely add to the place, definitely, I don't think there would be a Crinan with out it, there wouldn't be a trust, there wouldn't be a bridge, there wouldn't be an open door! (T-Sh-11.2)*
- Sarah** *If we go the other way too close to what is the statutory way young people wouldn't feel as comfortable (T-V.K-7.2)*
- Louise** *I would see other people em and what they might be vulnerable around their own stuff like... I would some times see people acting out their own issues around addiction and trying to work out stuff (T-Ash-5.2)*
- Thomas** *I have a daughter on drugs as well and I couldn't do what I am doing here to me own daughter because its completely different (T-D.K-2.2)*
- Alison** *Some people from the area would feel more responsible, would feel more into the emotional, what if they go out and use scenario? (T-Sh-10.4)*
- Margaret** *How much behavior is dependent itself between staff... this idea that we never go home and we don't close... go home it's a project not a way of life (T-J.C-13.2)*
- Dr. Mark** *The most important thing for me down there was the social thing, was everybody sitting down in the kitchen having lunch together, treating people with respect...*
- The blend of local people and people from the out side... the oneness of that approach is very very therapeutic I think*

Scene four – learning out of addition

Sean & Jack

We wrote a few songs they were very good songs... we got funding to go into a studio recording and all... we sang one for the President... its feels great... its some achievement... it was really good doing it and it was good experience and in the recording studio (T-G/I-8.1)

Cian

You have to get a whole different frame of mind... think differently (T-A.B-18.3)

I just went for training and started seeing a different side of life and I sort of wanted more... like the information was there and I was taking it and enjoying it and I was getting a great buzz out of it (T-A.B-5.2)

I was hungry for it... I was gasping... that was keeping me mind occupied, plus I was enjoying it (T-A.B-6.3)

I don't know its just if you find some thing that you like no matter what whether its sweeping the streets, digging holes its just that every day getting up, into a routine, getting up, getting washed, going out having a cup of tea, getting on a bus, into work, do your job, come home, have your dinner, sit down, have a game of football, go out at weekends... it's a sort of ritual at this stage (T-A.B-18.2)

I must try and get a degree me self (T-A.B-1.2)

There are so many things that can help get you on the right road... but one thing that could be a problem is the social divide... there are millions of things that Crinan work on while your there (T-A.B-19.1)

I suppose it (Crinan) played a great part in where I am today (T-A.B-3.2)

I am still on the pathway and the support is still there (T-A.B-13.4)

Crinan is a path to that and they do, they sit down with you and they will ask what do you like doing and they get that up and running for you... test that fall down no good start again (T-A.B-13.1)

Final act – rehearsal for reality

- Dr. Mark** *Rehabilitation or as some people say habilitation for people who have never been there in the first place trying to develop stuff in them (T-Dr.C-1.1)*
- Brid** *I don't know how effective Crinan is because I don't think there has been any kind of studies done and I do think there would be a need to do some longitudinal study... really we don't have any way of measuring it or we don't have any mechanisms of measurement in terms of success or outcome success just outcomes (T-K.F-12.2)*
- Dr. Mark** *You're taking in people at a very difficult age right who are very damaged, I mean very damaged (T-Dr.C-4.1)*
- Laura** *It's immeasurable who's to say when they stop taking drugs... I mean to me success could be the young person could be still using heroin, but there could be some thing that has happened for them in their life span that period of time that has changed things for them (T-Aine-15.4)*
- Tara** *I am on the right road to changing me life... like one step at a time... I am not out taking gear I am dong a computer course I am getting up at seven every morning I used to never do that when I was on drugs... me life is sort of changing (T-A.L-6.4)*
- Suz** *I do see it as a project that is trying to hold a very difficult group of young people who have got drug addiction... and trying to deal with their drug problem in a holistic way (T-M.F-1.2)*
- Dr. Mark** *I think the most important thing for me down there was the social thing, was the environment, was everybody sitting down in the kitchen having their lunch together, treating people with respect (T-Dr.C-4.2)*
- Its very difficult to evaluate, but I haven't seen any better certainly for people of that age and the biggest need those kids have is the socializing, is that whole thing of what happens down in the kitchen you know (T-Dr.C-13.2)*

- Thomas** *The girl who does the yoga, Lorraine, she is brilliant with them, she gives them massages and soft music (T-D.K-9.3)*
- Tara** *It's about helping myself to get stronger and building me self esteem up and confidence whatever (T-A.L-17.1)*
- Suz** *Hopefully learning that they are worth while people and they have a right and deserve a better life from the life that addiction is going to give them... that belief in them selves that they can do better that they are not kind of doomed to be trampled on and a life of failure... and then I suppose they are learning all the other ways of how to manage their addiction (T-M.F-7.2)*
- Cian** *I suppose at the end of the day speaking about your problems and getting advise on situations was helpful... like it just learned me more on how to think about problems and how to deal with problems with out being very narrow mined about things – HEAD WRECKED = GET GEAR, in stead me head is wrecked I will go for a walk, I will be grand in an hour I will come back and I will have a drink and if there is trouble in the house its not GEAR STRAIGHT AWAY, its get out of the house, go up two have a game of pool with some of me friends... things like that, I learned how to deal with it through counselling (T-A.B-12.1)*
- Louise** *It's only when they are in their early twenties, that reality hits home then that they are mature enough or some thing kicks in (T-Ash-2.3)*
- Mary** *We have quite a good success here (T-B.H-1.6)*
- Being alive, they are still alive... considering the amounts of deaths we have had in this area, young people you know, so being alive, that how I define success... any one who has gone through here or is still here is still alive (T-B.H-13.5)*
- Dr. Mark** *I think it's a very special place and a real sort of oasis for a lot of those kids (T-Dr.C-13.1)*
- Tara** *At the end of the day I am the only one who can really change me life the project cant do it for me they can only help me along the way do you know what I mean but its up to me at the end of the day (T-A.L-6.5)*

Chapter 8

Introduction to findings

Introduction

As the cast exits the stage and the theatre empties, we can begin the process of deciphering the meaning behind the drama of drug treatment. In examining that meaning I will explore the discourses at the heart of this play. Discourses are like masks we wear as a society. Behind each mask we wear, is a meaning system and set of values. We take these masks for granted and view them as normal patterns of perception and behaviour in society. Discourse analysis helps to reveal these masks and their hidden assumptions. This research has engaged in some discourse analysis and come up with some interesting findings. The findings of this research are important as they challenge some of the core beliefs that underpin drug treatment discourses in Ireland.

This research challenges many of the assumptions of the dominant discourses that influence the way we interpret and respond to addiction. The dominant discourses in the treatment of addiction are biomedicine, therapy and education. The biomedical discourse interprets addiction as a biological disease, a chemical imbalance or the result of an inherited gene responsible for addiction. Treatment within this discourse focuses on the chemistry of the person and the delivery of drug substitution therapies like methadone to restore chemical balance to the drug user. The therapeutic discourse while independent of biomedicine is strongly aligned to this system of thought. Psychotherapy is dependent on biomedicine for validation as a legitimate source of knowledge in the treatment of addiction. Treatment within this discourse focuses on the talking therapies and engaging the person in a cycle of change. But psychotherapy has become dependent on talking the person into accepting disease notions of addiction that require chemical rebalancing with drugs like methadone. On the other hand the education discourse believes that change is possible and when provided with opportunities and access to supportive educational and cultural environments, people will not become problematic drug users. Yet the educational discourse is not unproblematic and its reliance on neo-liberalism has sometimes prevented it from shifting the social and economic imbalances at the heart of this debate. Furthermore the educational discourse has been relatively uncritical of the powerful role played by psychiatry and medicine in the control of the addiction services in Ireland. The following chapters will discuss these issues and

analyse their implications for the development of more effective and sustainable treatment interventions, in response to the problems associated with heroin use.

The drama of drug treatment

As we have seen in the previous chapter I am presenting the work of the Crinan Youth Project as a drama in drug treatment. In describing the Crinan Youth Project as a drama, I do not intend to trivialize the issues of drug use, addiction and drug treatment or under estimate the task of operating such an initiative. I am using drama here as a metaphor to describe the complex dynamics of drug treatment. The following chapters will show that drug treatment is a contested space, where epistemological conflicts are played out between the dominant actors in medicine, therapy and education.

Metaphors link thought and action and can provide insights that allow us to think, act and understand in ways that we may not have thought possible before (Morgan, 1986). The metaphor of a 'script' is a useful one in helping us to understand the treatment and rehabilitation process and the complex psychosocial and systemic factors that affect a young person's choice to use drugs and resist or accept treatment. 'Script', as it is used in Crinan, refers to the amount of methadone the doctor prescribes to a participant. The methadone prescription is sometimes referred to as the script. 'Script' is used here as a metaphor to deepen our insight into the treatment process and to describe how young people often struggle to read, comprehend or accept the treatment script given to them.

The script for this drama of drug treatment is shaped by the dominant discourses of biomedicine, therapy and education. These scripts are adopted and played out by the different characters, as the drama unfolds and its meaning revealed. In narrating the outcomes of this research, I will show how the methadone script dominates the play and undermines the potential of adult and community education to significantly influence the outcome in any major way. The methadone script inhabits this powerful role because of the dominance of the biomedical discourse in shaping how we think about drug use, addiction and

treatment. In challenging the dominance of biomedicine in drug treatment, the research will seek to construct a counter discourse in drug treatment to that of biomedicine.

In Crinan there are several treatment scripts running simultaneously, like films in different languages being shown at the same time. The young people enter this film festival with their own scripts, languages, way's of understanding and making sense, which come from their own experience. Crinan is the drama into which participants are invited to play a central part in shaping their own script, in dialog with the different characters and scripts through out the play. The desired outcome of this play is not to entertain but to challenge each of the actors and enable them to collectively empower the young people to become the authoritative authors of their own scripts.

The young people enter this theatre of drug treatment as powerless consumers and passive spectators, in a drama that sets out to reconstruct their relationship to drug use through powerful legitimised processes. To act in this drama the young people must consent to these processes and yield to the power of psychiatry, psychotherapy and education. They must accept the constructs of addiction as a disease and psychiatric illness, to be able to attend the pharmaceutical altar where they receive their methadone script.

This reading is influenced by the work of Augusto Boal (1979) who developed a form of theatre that gave spectators themselves an opportunity to discover their own solutions to their collective problems. Boal bridges the separation between actor (one who acts) and spectator (one who observes passively) in creating the possibility of the 'spect-actor'. The 'spect-actor' is not confined by the boundary between audience and stage. The 'spect-actor' engages in a self-empowering process of dialogue, critical thinking and proactive engagement in their own problems or oppressions. Influenced by Paulo Freire's dialogic philosophy of education (1970), Boal's vision is embodied in dramatic techniques that activate passive spectators to become spect-actors, engaged citizens rehearsing strategies for personal and social change (Schutzman & Cohen-Cruz, 1994). Boal sought to create a theatre that not only reflected real life, but also created new possibilities in resolving conflict and difference between people in various situations where oppression existed. According to Boal oppression exists wherever dialogue becomes monologue. Monologues exist between countries, social

classes and individuals (Boal, 1998). In a similar way there are medical monologue within the drug treatment services that are widely accepted in practice and go relatively unchallenged. For Boal, theatre provides a democratic space where monologues become dialogues between conflicting desires, seeking to be heard, expressed and felt. Boal's techniques democratise the dramatic space, giving space for desires to surface, voices to be spoken and listened to, so that transformation can take place. Boal deconstructed the false boundaries between the theatre and life and created a powerful method to facilitate education and social change.

In this drama the main epistemological struggles take place between the medical, therapeutic and educational discourses as they each assert their influence on the heroin user. Throughout the play, different characters enter the treatment drama on stage from a particular discourse and engage the drug user in a dialogue to influence their choice to cease using heroin. As the play unfolds it becomes clear that this is not just a drama focused on the drug users choice to cease using heroin but a drama played out between competing sources of knowledge, seeking validation for their profession, status and central role in the treatment of addiction.

Chasing the dragon

Those who use heroin, refer to its consumption as chasing the dragon. The drug heroin has been associated with life and death of rock stars, the chic look of fashion models and media images of rebellion and destruction. Heroin has a long history of use and misuse right up to the present day (Courtwright, 1982). In the northeast inner city of Dublin, heroin evokes fear, hysteria, pain, loss, betrayal, denial and anger. The first heroin crisis in Dublin in the early 1980's was linked to intravenous heroin use and the spread of the virus (AIDS). AIDS was a new disease that had started to spread among intravenous heroin users from inner city communities and among the homosexual community. The first person in Ireland to die from the virus (AIDS) was an intravenous heroin user who lived in the northeast inner city of Dublin. These events led to a public health crisis which mobilized the community to establish 'Concerned Parents Against Drugs' to get the drug pusher out of the community.

The drug crisis abated until a second heroin crisis occurred in the early 1990's when there was an increase in the number of deaths associated with heroin use. Global trends in heroin use had shifted and prices had tumbled as drug barons sought to exploit new markets. It was also significant that heroin was now being smoked thus reducing the risks associated with contracting AIDS. This second crisis mobilized the community for a second time to tackle the problems associated with illicit drug use in the northeast inner city. Pressure was put on Government to fund new projects and initiatives for young people, to prevent and treat the problems associated with drug use, in particular heroin.

The widespread acceptance of methadone as a treatment for heroin addiction led to a proliferation of drug treatment programmes centred on the scripting of methadone. Methadone has been credited with playing an important role in preventing the spread of the virus and reducing the chaos in people's lives who are trying to come off heroin. While there are positives associated with the use of methadone, this research argues that in the longer term prolonged reliance on methadone, as the primary treatment for heroin addiction is problematic and unsustainable. There is also an impending crisis looming for the thousands of people being prescribed large quantities of methadone, with very little psychosocial supports or alternatives being offered. Though Crinan exists within the medical discourse that is responsible for the widespread prescribing of methadone, the project is critically aware of the dangers associated with what could be described as 'a culture of methadone'.

In search of the real dragons

The real dragons are poverty and social exclusion and the multiplicity of problems that arise out of these conditions for individuals and communities. The northeast inner city community has been overwhelmed by decades of poverty, unemployment and educational disadvantage (Kearns, 1994). It is a community that has endured despite being ignored by successive Governments (Coveney et al., 1999). A significant number of young people from this community leave school early, become involved in crime and experiment with drugs from as young as twelve. By the time they are fifteen many of them become regular users of a variety of substances including heroin (Mayock, 2000). Social exclusion coupled with

extensive drug use in early to mid-adolescence contributes significantly to the risk of heroin involvement (Parker et al., 1998b).

The young people who attend Crinan experience an array of needs and problems as well as problems associated with heroin use. These include homelessness, educational disadvantage, offending behavior, difficult family circumstances, an element of self harm, anxiety, depression and issues around their sexuality (Brown et al., 1996; Farrell et al., 1991; Fergusson et al., 1994; Jessor and Jessor, 1977; Pagliaro & Pagliaro, 1996). Treatment must take account of the complex psychosocial matrix in which any young person presenting to a service is enmeshed.

There is increasing concern about the numbers of users who are presenting with mental health problems along side their substance use issue. Psychological impairment may include anxiety, low self-esteem, depression, eating disorders, self-mutilations, suicidal ideation and substance misuse (Petersen & McBride, 2002). Psychosexual problems such as aversion to sex, sexual dysfunction, sexual anxiety and guilt, promiscuity and prostitution are some of the issues these young people may experience. Interpersonal difficulties could include distrust, isolation, alienation, fear of others and repeated victimisation in adult relationships (Bannister, 1992). Drug use in these situations is often understood as a form of self-medication to deal with the pain associated with a difficult or traumatic experience (Brown & Wolfe, 1994; Stewart, 1996).

Choosers not losers

Drug treatment discourses sometimes fail to acknowledge the idea that young people make conscious choices about their drug use. Recreational and habitual drug use plays an important part in the socialization process for young people today. A recent Irish Times survey (Brennock, 2003: 7) indicated that almost half of the young people surveyed had used cannabis by the age of 24 but just six per cent regularly used it, suggesting that some go through a phase of drug use and then stop.

The popular and misleading notion about addiction espoused by the medical discourse is that the addict has no choice when it comes to taking a drink or using drugs. They are simply addicted. In the film *Trainspotting* the central character Rent goes through the different regimes of trying to come off heroin. The film portrays his sense of being trapped in a life of his own choosing with heroin playing a central role. He discovers the only way out is to choose life.

Choose life. Choose a job. Choose a career. Choose a family. Choose a fucking big television. Choose washing machines, cars, compact disc players and electrical tin openers.... choose DIY and wondering who the fuck you are on a Sunday morning. Choose sitting on the couch watching mind-numbing, spirit crushing game shows, stuffing junk food into your mouth. Choose rotting away at the end of it all, pissing your last in a miserable home, nothing more than an embarrassment to the selfish, fucked up brats you spawned to replace yourself. Choose your future. Choose life. (*Trainspotting*, Miramax, 1996)

Drug users are not losers, junkies, scumbags, and diseased or dysfunctional people. They are according to Mayock (2000) people who make choices about their own drug use. They are choosers. They exercise agency in their drug using behavior. They are not powerless victims. They are active citizens participating in society. The pervasive myth that influences our thoughts about heroin is based on the idea that users are victims of the bad company and prey for drug pushers. Young people who use heroin are perceived as powerless victims, unable or unwilling to say no to the pressure to use drugs. Mayock (2000) argues that the common misconception, is that young people are introduced to drugs by 'pushers' or 'dealers'. This view is supported by other empirical research that verifies that the most common route of initiation to drug use is via friends or friendship networks (Parker et al., 1988). There is a stigma and secrecy surrounding heroin use particularly at the point of initiation and so very little is known about this critical transition when it occurs. Young people at the initial stages of heroin use are unlikely to present for treatment because of the stigma attached to its use. By the time these young people do end up in treatment they have become regular users of heroin, at risk to be labelled addicts and vulnerable to being prescribed methadone. While young people and their families consent to methadone treatment and it is not forced on them as a cure for their disease, other options are seldom considered. The biomedical discourse maintains its hegemony in healing through power and knowledge systems, which ensure that alternatives do not get a firm foothold in the public domain.

Many young people enter treatment, not to stop using drugs, but because of the pressures they were experiencing from family, within relationships and legal pressures resulting from criminal activity associated with drug use. Most of the young people are referred to Crinan for help, support and treatment either by family or community people, the probation and welfare services or the drug court. The motive to enter treatment clearly does not come from the young people themselves, but from family and concerned others. Mayock (2000) points out that little is known about the social and interpersonal dynamics surrounding the motive to use or cease using psychoactive substances. The stereotype of heroin user as 'addict' or 'junkie' or as helpless victim of 'bad company' holds popular appeal in the public imagination.

Slaying the dragon – The Crinan Youth Project

Treatment programmes like the Crinan Youth Project were designed and set up, based on the assumption that heroin use equals addiction and methadone equals its treatment. Once programmes were set up, all heroin users were targeted for methadone treatment irrespective of their needs. The heroin user is constructed as addict and is scripted methadone to advance their treatment. The use of methadone is based on assumptions about heroin and addiction and is a distraction from the real question as to why these young people are choosing to use heroin.

It often takes a few months before they begin to think about getting their lives together and becoming drug free. By this time they will have been stabilized on methadone and are comfortable with the reality of not having to go out and steal to buy heroin. The risks associated with begin stabilized on methadone and becoming dependent is not made clear to the young person before they begin this process. In fact the biomedical paradigm cannot even contemplate these risks because of its commitment to addiction as a progressive disease.

While this research set out to examine the educational and developmental aspects of treatment it quickly became evident that methadone created a dynamic within the project

that rendered the educational component of the programme virtually redundant and impotent. I have called this the 'methadone dynamic'.

When the Crinan Youth Project was established it was thought that methadone would play a minor role within the over all project. It was understood at the time, that methadone would only be required to treat the physical withdrawal symptoms that resulted when the young people stopped using heroin. It was not envisioned that methadone would become a core part of the programme in the longer term. It was believed at the time that young people could be detoxed from heroin with the substitute drug methadone over a short period of time.

During this short period of detoxification from heroin with the substitute methadone, the young people would receive counselling and take part in occupational and recreational programmes designed to meet their developmental and learning needs. However over time scripting methadone to the young people as part of their treatment for heroin addiction became a dominant feature of the project.

Chapter 9

Act one

Drug treatment and the bio-medical hegemony

Introduction

The research found that the Crinan Youth Project was constructed through the hegemony of biomedicine. Hegemony here refers to the process by which one class comes to dominate the cognitive and intellectual life of a society through structural rather than coercive means. This dominance is achieved through the diffusion of certain values, attitudes, beliefs, social norms and legal precepts that permeate civil society (Baer, 2001: 34). A biomedical hegemony put simply is the hidden way that medicine influences our attitudes and values about health, illness, disease, treatment and cure.

Biomedicine exerts an enormous influence on our understanding of heroin addiction and how it is treated. Methadone is the face of biomedicine in drug treatment. The psychiatrist and doctor are its main advocates. The biomedical hegemony in the Crinan Youth Project ensures that methadone achieves and retains a powerful position in the treatment of heroin addiction. Other sources of healing or transformative knowledge have become marginalized and excluded from mainstream thinking about addiction as a result of this hegemony. This chapter looks at this situation and examines how the biomedical hegemony works in the Crinan Youth Project and how methadone maintains its status and dominant position in the treatment of heroin addiction.

The research is critical of the widespread prescribing of methadone, as it has created a culture and mindset about drug treatment that has become narrowly focused on the wide spread provision of methadone. To some extent the heroin problem has become a mechanism to deliver methadone as a public health policy, to prevent the spread of HIV and AIDS among a vulnerable section of the population. Finally the research is critical of heroin treatment policies that unnecessarily medicalize young people.

The rise of the biomedical hegemony

Biomedicine was not always as powerful as it is today. Historical events, social realities and new discoveries ensured that biomedicine would secure a dominant position and control how we think and feel about medicine and healing. Biomedicine was transformed into a commodity in the late nineteenth century, a process that reflected the rise of industrial capitalism in America and Europe. Medical practitioners sought to legitimize themselves by appealing to science. It differentiated itself from homeopathy by claiming to be scientific, to benefit from the good will associated with the word science. The newly formed American Medical Association began to function as 'an organization of scientists, based in medical schools and hospitals' and attempted to exert hegemony in the guise of 'scientific medicine' over other medical systems (Berliner, 1975: 581 cited in Baer, 2001).

The push towards scientific medicine ensured that biomedicine distanced its self from homeopathy and other healing systems. This new climate contributed to changes in the socio-economic, ethnic and gender composition of the regular medical profession. Elite physicians faced competition from within their own ranks, where some one from a lower social class could become a physician after a few years training. Graduates from the more prestigious medical schools objected to this situation and voiced concern about the quality of medical education. They feared that these less qualified physicians with less prestigious credentials were saturating the market place and depressing physician earnings (Numbers, 1997: 231). The American Medical Association set up a system to evaluate and monitor medical education and by 1910 the number of schools had fallen from 166 to 131 (Brown, 1979: 140).

Elite physicians turned to corporate sponsorship to gain economic advantage over physicians from lower social classes and over rival medical systems like homeopathy. Through its alliance with corporations and the state, the medical establishment was able to carry out reforms that solidified its hegemony (Baer, 2001: 35). The direction of medical education and medical research was now firmly embedded in corporate America and in the capitalist system of production. The medical profession was absorbed in an ideology that was compatible with

the worldview of the corporate class and the emerging managerial and professional stratum (Brown, 1979: 171).

The biomedical hegemony became embedded in the conditions that replicate class, racial/ethnic and gender divisions of the wider society. Class structure reflects the composition of how people participated in the health sector either as owners, controllers, or producers of services (Navarro, 1976:138, cited in Baer, 2001:41). The middle classes dominated the boards of medical associations, schools and hospitals where policy decisions were made. The remaining social classes were distributed in positions of differential power, within the biomedical division of labor (Baer, 2001:41). Female physicians essentially function as second-class citizens within their profession and confront the 'glass ceiling' on their upward mobility.

The biomedical establishment continues to maintain control over the production of health, the construction of medical knowledge and the division of medical labor, while eliminating alternative heterodox or alternative practitioners and denying lay people and healers access to medical technology (Baer, 2001: 42).

A profession attains and maintains its position by virtue of the protection and patronage of some strategic elite segment of society, which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite, which supports it. (Freidson, 1970:72, in Baer, 2001)

The corporate class interest in biomedicine exerts enormous control over government policies and on the management and economics of the health system. According to Willis (1983: 23) the dominance of biomedicine rests on an alliance between medical practitioners and the state, which in turn depends on the interests of the corporate class (Baer, 2001). The existence of this medical hegemony over other healing systems is not the conscious shaping of social thinking, but results from the firm sense among elites that their ideas are superior to those of others. Baer (2001) gives the example that people are responsible for their own success and failures – a notion contradicted by the experience of the working class – but promoted by society because the successful believe it to be true in their case. The effect, to some degree, keeps the working class from questioning blatant social inequalities that make success much easier for those with capital. Doctor-patient interactions frequently reinforce hierarchical

structures in the wider society, by focusing on the need for the patient to comply with a diagnosis.

The politics of biomedicine

Up until the early nineteenth-century two 'medical modes of production' co-existed in American society. A 'domestic mode' consisting of a variety of folk medical systems produced and performed within the family and a 'commodity mode', which consisted primarily of regular medicine and homeopathic medicine (Berliner, 1982). Homeopathy appealed to some lower class people, but its professional orientation transformed it into a fashionable medicine for the middle classes.

The serious economic threat posed by homeopathy's status as a professional heterodox medical system was one of the major factors that prompted regular physicians to establish the American Medical Association in 1847. (Baer, 2001: 4)

Baer (2001) argues that as American capitalism evolved from a competitive to a monopoly form after the Civil War, medicine was to become another hegemonic vehicle by which members of the corporate class indirectly came to legitimate capital accumulation, and to filter their view of reality down to the masses.

The development of germ theory led to the transition to 'scientific medicine' or 'biomedicine', a medical system based on scientific research and controlled experiments.

With the emphasis upon pathogens as the cause of disease, biomedicine provided corporate leaders with a paradigm that allowed them to neglect the social origins of disease, while at the same time, in at least some instances, restoring workers back to a level of functional health essential to capital accumulation. (Baer, 2001: 4)

As biomedicine grew in status, alternative medical systems have gone through a process of annihilation, restriction, absorption and even collaboration (Baer, 2001). Alternative health practitioners and their clients often belong to lower-middle, working and even lower social classes. Alternative health has become a site for lay resistance and a form of dissent in the area of health care and the dominance of biomedicine.

The demise of homeopathy

As biomedicine gained dominance, homeopathy waned in popularity. Homeopathy is a holistic form of complementary medicine, aiming to treat the whole person rather than just the physical symptoms. It works on the principle that the mind and the body are so strongly linked that physical conditions cannot be successfully treated without an understanding of the person's emotional and psychological health (Lockie, 2000).

The practice and education of homeopaths and regular physicians converged under pressure from the American Medical Association and new licensing laws. This was to counteract the growing popularity of new heterodox practitioners like homeopaths. By the turn of the century most homeopathic physicians resigned themselves to absorption into biomedicine (Baer, 2001: 39). The American Medical Association also formed an alliance with the pharmaceutical industry in keeping with its emphasis on the administration of drugs and to mount a campaign against homeopathy in the 1900s (Coulter, 1973 cited in Baer, 2001). The pharmaceutical industry validates the biomedicine by placing numerous expensive advertisements in medical and psychiatric journals.

Another factor was that homeopathy as a medical system was incompatible with the reductionist perspective of biomedicine and its emphasis on high doses of medication. Corporate foundations preferred to fund 'scientific medical schools and so many homeopathic schools either closed or converted themselves into biomedical schools. The number of homeopathic schools declined from 22 in 1900 to 5 in 1920 (Rothstein, 1972: 287). The British Medical Association played a similar role in the UK, and divisions within homeopathy began to weaken the force of its message further (Lockie, 2000: 17). The same process that led to the demise of homeopathy also effected various other heterodox medical healing systems and holistic approaches to healing and health.

In recent times, alternative systems of healing and alternatives to biomedicine are re-emerging, as biomedicine was unable to establish a complete hegemony partly because of the widely recognized iatrogenic drawbacks of biomedicine as well as its therapeutic limitations. Alternative medicine under the umbrella of the 'holistic health movement' is beginning to

make come back in the United States and Europe. Also, as people from lower socio economic groups are denied entrance into the domain of the medical profession, they some times turn to alternative healing paradigms (Baer, 2001).

The holistic health movement however, faces the danger of being co-opted by biomedicine as a growing number of biomedical physicians are turning to heterodox treatment methods like homeopathy and acupuncture. Much of the corporate and governmental interest in alternative medicine is due to efforts at cost containment. With the high cost of high tech healing and its failure to impact significantly on complaints like AIDS, cancer and arthritis, the efficacy of heterodox therapies is being explored.

The perceived success of scientific medicine in the twentieth century has particularly enhanced the social status of the medical profession. However Fitzpatrick (2001:7) argues that if doctors and psychiatrists are becoming the moral guardians of human behavior it is only because they are incapable of explaining or curing the major contemporary causes of death and disease. Government policies that shift the responsibility of health towards the individual help legitimise the expansion of state medical interventions into wider areas of the life of society (MacKenzie, 1946). This shift in health policy could be an attempt to divert responsibility from the economic and social causes of ill health and the government's failure to address these wider economic issues.

The magic potion – methadone

Methadone treatment like all magic plays on illusion. The illusion here is that methadone can cure heroin addiction. Methadone has amassed the power of magic in some circles and yet there is little known about drug users own views about methadone. Research carried out by Neale (1998) in Scotland, on drug user's experience of methadone, indicates that methadone is a complex drug with positive and negative aspects to it. Neale points out that nearly two thirds of the addicts interviewed, commented that they had experienced negative health effects resulting from methadone use. Over half of the addicts said that methadone had caused similar and in some cases, greater problems for them than heroin. In McIntosh and McKeganey's (2002:145) study of 70 addicts in recovery from heroin, many were critical of the ease with which methadone was being prescribed and suggested that it had become an easy option for doctors who, they said, were unwilling to address the real causes of their addiction.

Heroin addicts are being prescribed methadone, but there little evidence to suggest they are becoming healthier as a result. Evidence would suggest that the opposite is the case (Fitzpatrick, 2001). Methadone is part of a larger monopoly on health by vested interests in western medicine.

The monopoly of biomedical knowledge and practice is still firmly established and this hegemony derives considerable support and legitimacy from government funding and legislation. (Tucker, in Cleary et al., 1997)

The use of methadone in the treatment of heroin addiction is bound up with the biomedical hegemony and its control of what constitutes health and illness in our society (Morris, 1998). According to Ivan Illich, 'society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people' (Illich, 1975: 13). We expect the medical profession to fix, repair, restore and reinstate us to full health. We want doctors who will make us feel better, lift our spirits and reassure us that we will be ok. We don't want to feel pain or discomfort. We don't want to face the reality of our own mortality. Biomedicine in the form of methadone, Ritalin, Viagra

and anti depressants is now playing a central role in shaping our sense of who we are or wish to be (Elliot, 2003).

The biomedical hegemony and the Crinan Youth Project

The research found evidence to support and demonstrate the existence of a biomedical-hegemony in the treatment of heroin addiction in the Crinan Youth Project. This chapter mirrors the structure to that of the data presentation. Each scene in this analysis corresponds with the scenes in the data presentation. The play opens acknowledging the failure of the biomedical model of drug treatment. Scene two spells out how the drug problem has been medicalized. Scene three shows how methadone has become the carrot of drug treatment. Without methadone it would be difficult to attract young people into treatment. Scene four looks at how Crinan exists in a culture of methadone and how this culture has come to dominate the drug treatment world. Scene five examines how methadone can act to delay, prolong and even prevent rehabilitation from taking place.

Act one – the medical discourse

Scene one

The play opens with a young person on stage reflecting on his time in drug treatment. He is happy to tell me the researcher of his journey in and out of the Crinan Youth Project. His story reflects the struggle between drug user and service provider to negotiate a drug free existence. His story also reflects the failure of a biomedical approach to drug treatment that we are unwilling to acknowledge or accept. Instead of acknowledging failure we tend towards blaming the drug user for their own failure to comply with the demands of treatment. The search for alternatives models of treatment can only begin, if we acknowledge the limitations

of the present model. I hope that this analysis of the biomedical model of drug treatment will add to the on going debate and search for new approaches to these issues.

Scene two

The medicalization of the drug problem

The dominance of methadone in the treatment of heroin addiction is part of the medicalization of the drug problem in the northeast inner city of Dublin. The Crinan Youth Project recognises that it is treating a social problem with a medical solution. The young people who attend the project experience a matrix of emotional, psychological and physical problems that are embedded in a larger matrix of social and economic exclusion, educational disadvantage and complete powerlessness, of which heroin use is only one issue.

Medicine has expanded into the area of drug addiction, mental health, criminal behaviour and other personality and behavioural disorders under psychiatric disease labels (Fitzpatrick, 2001:96). The widespread acceptance of psychiatric labels such as addiction and mental illness has contributed to the growing medicalization of society. In 1952, the Diagnostic and Statistical Manual of American psychiatry recognised 60 categories of abnormal, by 1994 this had expanded to 384 (American Psychiatric Association, 1994).

Public health campaigns are on the increase, to encourage individuals to take responsibility for their own health by eating healthy foods, reducing alcohol consumption, anti-smoking regulations and taxes, sexual health, road safety, cancer screening and substance misuses awareness programmes. Government public health policy appears driven, to even greater levels of intervention, to improve people's health. The expanding range of medical intervention in peoples lives is characterized as the medicalization of life, with the definition of disease being expanded to include a wide range of social, psychological, moral and biological phenomena (Fitzpatrick, 2001:6). The excessive consumption of alcohol and the misuse of illicit drugs are now widely accepted as medical problems. Attention deficit disorder (ADD) has been constructed as a medical disorder to explain disruptive or anti social behaviour in

young people. Up to 12 per cent of all America boys aged between 6 and 14 are being prescribed Ritalin to treat a range of behavioural disorders (McTaggart, 1996).

The politics of disease

The expansion of biomedicine in to all areas of our lives is predicated on a certain understanding of disease. Disease has a multiplicity of meanings with both literal and metaphorical interpretations. Szasz suggests it is fruitless to debate whether drug addiction, depression or pathological gambling are diseases unless we agree on the root meaning of the term disease. When medicine and the state are united in the therapeutic state, people perceive countless human problems as the products of diseases and seek to remedy them with medical interventions. In the ancient world disease was a gnostic concept. Disease and cure, both involved divine intervention. Disease was thought to be a punishment from god that often came in the form of a plague.

For a long time people attributed healing powers to priests. Today people attribute near magical powers to physicians. Magical medicine men, from primitive shamans with painted faces, to men in white coats, can cure diseases they can neither clearly define nor objectively identify. Science understands the body as a biological system that we inhabit and use. Patients of biomedicine have no role in defining their condition. It is defined for them. A label is ascribed to the person, who becomes the disease carrier, sometimes on our behalf.

Disease is a fact, diagnosis is an opinion. Diseases are discovered, diagnoses are created. Diseases cannot be manufactured, but diagnoses can be. (Szasz, 2001: 30)

For example diabetes is a disease. It is biologically constructed as a disease. Addiction is a diagnosis. It is a socially constructed disease. People are beginning to question the rise in pharmacological solutions that are being validated as diseases by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Szasz (2001) suggests that no psychiatric diagnosis names a condition that meets the classic pathological criterion of disease. He suggests conflating disease and diagnosis is useful to anyone who wants to obscure the distinctions between having a disease and being a patient.

Psychiatrists not only define what they consider unwanted behaviors as diseases, for example self-abuse and homosexuality in the past, drug abuse and homophobia today; they also define what they consider improved behaviors – produced for example by lobotomy, electroshock, or psychotropic drugs (methadone) – as the results of treatment. (Szasz, 2001: 33)

Classifying non-diseases as diseases serves 'the economic, existential and professional interest of the classifiers' (Szasz, 2001: 37). It would, according to Szasz, be professional suicide to categorize non-diseases correctly. The economics of medicine and the power doctors have to prescribe for non-diseases makes public health care a lucrative business. Psychiatrists have been the leading producers of the conceptually and economically important commodity we call 'mental illnesses' (Szasz, 2001: 39).

Scene three

Methadone acts as a carrot to get people into drug treatment

Methadone gets young people in the door of treatment, legalizing and medicalizing their opiate requirements. We are told that methadone sorts out their immediate problems; smoothes things out and makes life more palatable. When the fun side of taking heroin goes and the young person is faced with legal hassles, relationship and family problems and the sense of being trapped - methadone becomes an attractive option and way out of that situation.

Treatment systems have become overly dependent on the scripting of methadone to young people in the process of ceasing their heroin use. Methadone has become a central motivation for many young people coming in to the programme in the pretext of treatment. Some young people have articulated a dependence on methadone. This dependence on methadone in treatment programmes is having a marginalizing affect on less privileged sources of knowledge like transformative learning, homeopathy and other ways of knowing.

Methadone is marketed and presented to these young people as a solution to their problems. Initially the young people feel positive about methadone and its role in helping them to get off gear (heroin). They can escape the stigma attached to their 'junkie' identity. Methadone is also credited with putting them on the 'straight and narrow'. But these benefits disguise the central part played by methadone in supporting the hegemony of biomedicine in drug treatment. The biomedical hegemony wins its case for methadone partly by demonising the heroin identity as a junkie – rubbish – scrap - person wandering a crooked pathway and by winning the young person over to the 'right way'. Like an evangelist, methadone assumes a powerful social role, inhabiting nearly divine powers. Its mission is to integrate and institutionalise the heroin users back into mainstream society and on to the right path. This is done, not to advance their personal or social development or to tackle the real causes of the heroin problem, but to advance the biomedical hegemony.

Crinan acknowledges that methadone is a factor in the young persons motivation to walk through the front door and sign up to treatment. The young people themselves feel that methadone helps, as they no longer have to commit crime in order to buy heroin. Motivation is an essential component of drug use cessation and is understood as an interpersonal state of readiness to change (Prochaska & DiClemente, 1982). In some cases methadone bypasses this state of readiness and offers the individual a replacement to heroin and option to engage in treatment. In many cases methadone became the central focus in the Crinan treatment programme and this had a negative impact on attendance and participation in the education programme.

Methadone treatment – the public health mask – a hidden scene

A key benefit from methadone is in reducing the harm associated with using heroin. Firstly it does away with the need for heroin and so takes the young people out of a cycle of crime. Secondly it does away with the need to inject heroin and so reduces the risk of becoming infected with HIV/AIDS. Intravenous drug use is a major source of HIV infection. If we can reduce people becoming infected with the virus, the risk of it spreading through sexual

activity is also reduced. If there are young people in the community, using heroin intravenously, they are perceived as a public health risk. Getting these young people off heroin and into methadone treatment is seen as an important public health policy. The main difficulty with this policy is that not every one who uses heroin is an injector and not all injectors are necessarily addicts. Heroin use is constructed as an addictive and dangerous activity through the biomedical hegemony to justify mass prescribing of methadone to vulnerable sections of the population.

Recent figures suggest an increase in the numbers of intravenous drug users being diagnosed with HIV. Numbers of HIV cases among drug users had fallen since 1993 until 1998 when they began to increase again with 50 new cases diagnosed in 2002. Figures from the National Drug Treatment System, 2000 indicate that injecting heroin has not ceased with 10% of heroin users surveyed indicating having injected at some stage. So despite the increase in availability of methadone and the continued risk associated with HIV infection among drug users, there are still young people being exposed to these risks. While methadone has many benefits in reducing the harm caused by drug use it has not eliminated the spread of HIV among drug users. In view of this other harm reduction measures need to be developed.

Scene four

Crinan exists within a treatment culture dominated by methadone

The City Clinic is a drug treatment centre serving the needs of drug users in the northeast inner city. It offers methadone treatment and a counselling service to drug users seeking support to come off heroin. Crinan is critical of the ease in which the City Clinic dispenses large doses of methadone like a conveyor belt with maximum efficiency in a highly clinical setting. Even the young people attending Crinan reflect critically about the City Clinic and their narrow focus on dispensing methadone. In Crinan the young people feel that they are important and respected as people.

Other than methadone and a minimalist approach to counselling, the clinic offers very little in terms of support to those attending their service. There are many in Crinan that are highly critical of the city clinic as it is contributing to the creation of a methadone culture and mindset around drug treatment. In some ways Crinan experiences the City Clinic as its nemesis and has to constantly struggle against this direction in its own approach to treatment. The City Clinic is adding to the problem of addiction in the community prescribing high doses of methadone and failing to address the many emotional, psychological and community issues these people are experiencing. High doses of methadone are not addressing the needs of these people. In fact many are topping up their methadone with alcohol, benzodiazepines and cannabis. The issue of poly drug use is being ignored. Drug users in treatment are afraid to be critical for fear losing their place in the clinic. The City Clinic may in fact be contributing to prolonging drug use and the problems associated with addiction in the community.

When the young people begin their treatment in Crinan they agree to buy into the whole treatment package, of therapy, education and methadone. Street wise they know if they can secure a place on the Crinan programme they will also secure a methadone script that will help to control the chaos of their lives while they consider their options and choices around drug use and resulting behaviours. The culture of methadone that exists within treatment services and in the community is sending out deceptive message about methadone.

Drug users on the street know all they have to do is to give a dirty urine (one with traces of heroin) and they will be prescribed methadone. They know that treatment is only one dirty urine away. They may have to be assessed and wait a while but they know that if you're a heroin user you will be prescribed methadone. What they may not be aware of is that methadone is just another cycle of drug use that is often harder to break away from.

The Crinan Youth Project – constructing a counter hegemony

As a community based drug treatment project Crinan has tried to counter this hegemony with its strong focus on community development. Crinan focuses on providing an integrated approach to the treatment of the heroin problem by balancing medical, therapeutic and educational interventions. Crinan has also been critical of the over prescribing of methadone and benzodiazepines and has strongly advocated for various protocols to control their use in the treatment of addiction. But given the power, status and influence that biomedicine has secured in the Irish health services and in particular through the drug treatment services, it is difficult for Crinan to avoid the consuming power exerted through the biomedical hegemony. Through a deeper understanding of how the biomedical hegemony exerts its influence in the Crinan Youth Project we can advance our knowledge of drug treatment in a more balanced and sustainable way.

Scene five

Methadone - medicalizing the heroin user

This research found that methadone can delay, prolong and in some cases may even prevent rehabilitation from heroin use/addiction taking place. Methadone is addictive and many of the young people became comfortable on the substitute preferring maintenance instead of detoxification. Their lives now revolved around the project and the pharmacy. In this way methadone creates its own dependency on treatment and acts against rehabilitative measures that seek to empower the young person to move away from the clinic setting. Methadone does not cure addiction, if anything it contributes to creating addiction. McIntosh and McKeganey (2002) pose the question whether individuals remain addicts longer as a result of being prescribed methadone over many years than they would have done had they not been prescribed the drug? The marketing of methadone treatment as a cure for heroin addiction in communities like the North East Inner City of Dublin is dependent on the acceptance of a

medical understanding of addiction. This raises important questions about the model of community development adopted in this inner city community.

Young people who use heroin are being criminalized and automatically medicalized as a result of the biomedical hegemony and its interpretation and construction of the heroin problem. For example the case of Cian who recognized on reflection that he was prescribed methadone while in custody even though he didn't have a heroin habit he now regrets going on methadone at all. This raises several important questions about the assessment, diagnosis and treatment procedures with young people who use heroin and are involved in crime. Reflecting further, Cian also recognized that during his time in the Crinan Youth Project methadone was holding him back from reaching his goal of recovery. He describes his struggle of coming off methadone as one of the hardest things he has ever done and a great achievement.

Despite the evidence for the effectiveness of methadone treatment (Keen, 1999) it has been argued that this has been achieved by moving the goal posts (Fitzpatrick, 2001:101). Recognizing the ineffectiveness of using reducing doses of methadone to achieve the traditional goal of abstinence, its supporters now claim that methadone is successful in reducing the criminal behaviours associated with heroin use but less so in reducing illicit opiate use (Marsch, 1998). Nolan (1998) questions this tendency to adopt different measures of outcome, replacing the goals of staying off drugs and away from crime, with reports of participation and progress in therapy as positive indicators.

Foucault and the construction of a docile subject

Foucault was concerned about the objectification of the body, a process through which the person was subject to surveillance and control of the panoptics. In this case the heroin user is subject to surveillance, because of the illegal nature of heroin use and the risk of spreading HIV among the heterosexual population. According to Foucault, the panoptics were those who policed and guarded the hegemonic secrets and chamber of knowledge that regulated

society and protected the power of the elites. These include psychiatrists, doctors, lawyers and the police.

Ideas and practices supported the panoptics to round up of the poor, the prostitutes, the homeless and the insane who were institutionalised and subjected to a series of experiments, controls and surveillance (Petersen & Buton, 1997: 157). These marginal groups were excluded from mainstream society and culture in the same way that drug users and those in drug treatment are today.

Methadone treatment ignores the feelings and thoughts of the drug user and turns them into objects of medical and legal surveillance. The heroin user is reduced to biological and chemical processes by psychiatrists and doctors. Medicine objectifies the person and amputates their subjectivity. With little say in their treatment the person as object becomes isolated from their own source of healing, power and autonomy. Medicine alienates the person from their body and detaches them from their feelings. Powerless and pacified by methadone the person rejects their own sense of self and the possibility of agency to bring about change.

The self, severed from subjective feeling and embodied self is a non-person easily manipulated and exploited. Living this dualism, drug use for some becomes a way of managing embodied experience. The fragmented self forms the basis for the construction of the addict. For some people the substance heroin is part of their human search for the feeling self, lost in a sea of chemicals seeking legitimisation. Powdered chemicals (heroin) and liquefied chemicals (methadone) compete for dominance. The detached body becomes docile and passive or rebellious and resistant to the influence of the panoptics.

In his writings Foucault was concerned with the production of docile subjects and the active self. His work on the disciplined society provides an analysis of the interconnectedness of the body, self and society. The drug user exists in this liminal world between body, self and society. It is here that medicine pounces on the heroin user, constructing them as addict and medicalizing them at the intersection between body, self and society. Medicine has become a

dominant institution and plays an increasingly important role, shaping ways that we think and live our bodies, particularly in our understanding of addiction (Petersen & Buton, 1997: 97).

Foucault's medicalization critique calls into question the social role, played by members of powerful and high status occupational groups, such as the legal and medical professions. Medicine in western societies, despite its lack of effectiveness in treating a wide range of conditions (e.g. heroin addiction and their iatrogenic side effects e.g. from methadone), has increasingly amassed power and influence. Zola (1972) and Freidson (1970) argue that medicine had begun to take on the social regulation traditionally performed by religion and the law. Illich (1975) argued, that rather than medicine improving health, it was diminishing lay peoples' capacity for autonomy, in dealing with their own health and healing needs.

The medicalization critique challenges the rights of medicine to make claims about its power to define and treat illnesses and disease. Critics of this perspective advocate for the empowerment of patients and encourage people to regain control over their bodies, their health needs by engaging alternative paradigms. The medicalization critique is typically represented as a repressive and coercive process that limits individual autonomy and encourages the dependency of lay people on the medical profession (Petersen & Buton, 1997: 106). Consumer groups like Uisce (Union for improved Services, Community Education) have been formed to support methadone users and advocate on their behalf. There is a need for such groups to develop their own critical analysis of their experience of the biomedical paradigm in drug treatment.

Biomedicine and the emergency of pharmacracy

We have according to Szasz (2001),

An unpleasant thirst to medicalize, pathologize, and therapeutize all manner of behaviors manifesting as personal or social problems. (Szasz, 2001: xi)

Szasz (2001) argues that our success in gaining more control over real diseases, like polio and smallpox, has encouraged the expansion of medical technology into other areas of human concern, transforming all sorts of human problems into 'diseases' and the rule of law into the rule of medicine. Szasz argues that we have words to describe medicine as a healing art, but none to describe it as a method of social control or political rule and so he coined the phrase Pharmacracy. The Greek word for medicine pharmakon meant both drug and poison. The term pharmakos referred to a ceremonial scapegoat, whose death purified and cured the community.

As theocracy is rule by God or priests, and democracy is rule by the people or the majority, so Pharmacracy is rule by medicine or physicians. (Szasz, 2001: xvi)

In a pharmacracy people perceive all types of human problems as medical in nature and susceptible to medical remedies. Szasz uses the term 'pharmacratic controls' to refer to social sanctions exercised by bureaucratic health care regulations in the treatment of alcoholism and addiction for example. Methadone could be viewed here as an example of pharmacratic control to reduce the risk of HIV infection in a population.

The pharmacracy is fuelled by what Szasz calls 'no fault diseases' or metaphorical plagues of human nature. Alcoholics cannot control their drinking because they have a disease called alcohol dependency syndrome. Obese people eat too much because they have a metabolic disease called obesity. Drug addicts cannot abstain from using drugs because they are physically and psychologically dependent. These conditions are what Szasz calls 'no fault diseases' that occur irrespective of personal responsibility or agency. Addiction remains a biological riddle involving genetic and psychological factors, which continue to puzzle researchers.

Alcoholism, obesity, suicide and violence, they say are killing Americans. Individuals are not responsible for eating or drinking too much, for killing themselves or others. The rejection of personal responsibility for one behavior after another – each deliberate act transformed into a ‘no-fault disease’ – drives the politics of therapy. (Szasz, 2001: xiii)

In the modern liberal democracy the personal and the political are distinct spheres. In situations where the desires of the individual are in conflict with the needs of the group or the state, this conflict according to Szasz is obscured by invalidating the person’s desires as the ‘symptoms of illness’ (Szasz, 2001: xii). Real diseases like HIV are a threat to public health and the use of methadone is justified in certain cases to reduce the risk of it spreading among intravenous drug users. The needs of the heroin user here, is in conflict with the needs of the state. But bogus prescribing of methadone to vast numbers of people whom the state claim to be diseased because of their addiction, puts the needs of the state before the needs of the individual heroin user.

Liberty is undermined by the irresponsible individual and is destroyed by tyrannical government. (Szasz, 2001: xiii)

Szasz’s critical perspective on pharmacracy presents a challenge to those concerned with shifting social imbalances, creating participative democracy and building an inclusive and just civil society. How do we encourage agency, personal responsibility and equality and at the same time protect our children from abuse and manipulation, support the vulnerable and call to account those who rob us of our rights, equality and freedom.

Conclusion

It is clear from this reading that a biomedical-hegemony dominates the dynamics of treatment within the Crinan Youth Project. This biomedical hegemony supports the prescribing of methadone in the treatment of heroin addiction and the marginalization of other sources of treatment knowledge. Tracing the rise of biomedicine and the decline homeopathy we gain insight into the social and political factors at play in the construction disease and their treatment. Reflecting on the data arising out of each scene we can see step by step the way the biomedical hegemony exerts its influence on the Crinan Youth Project. Firstly the medical discourse sets the agenda in drug treatment, which becomes predominantly medicalized. Methadone acts like a carrot to encourage young people into treatment. The whole treatment culture is now dominated by a culture of methadone and affects everybody involved.

There is relatively no critical analysis of the medical model of drug treatment or awareness of the existence of a biomedical-hegemony. A comprehensive study of methadone carried out recently by the Union for Improved Services, Communication and Education (UISCE, 2003) was completely void of any analysis in relation to the medical model of treatment. The study does provide some in depth accounts of drug users experience of methadone and the problems they encounter with the services. Accepting the medical model the only analysis the study offers is that one type of methadone is better than another.

It is into this void that this research provides a reflective and informed analysis of the medical model of drug treatment. It is not the purpose of this research to claim that there is no place for medicine in drug treatment. Nor to suggest that the social model proposed by adult and community education is the only way forward. The aim of this analysis is to spark a wider debate about the dominance of methadone in drug treatment. The next chapter now examines the therapeutic discourse and its part in this treatment drama that is the Crinan Youth Project.

Chapter 10

Act two

Constructing treatment through a therapeutic discourse

Introduction

The research found that a biomedical hegemony exerted influence over the therapeutic discourse in the treatment of heroin addiction. The focus of the inquiry was adapted to look at this aspect of the programme and examine the role and function of psychotherapy and its impact on the dynamics of treatment. The research found that there was a strong aligned relationship between the therapeutic and medical discourses in shaping the treatment culture within the Crinan Youth Project. This relationship was reflected in a hierarchical epistemological structure within the programme dominated by psychiatry and medicine.

Psychotherapy – a treatment discourse

Psychotherapy is a drug treatment discourse that plays a key role in the Crinan Youth Project. Within this discourse we make assumptions why people use drugs, what is addiction and how best to deal with the drug problem. Driscoll (2000) believes that the real difficulty with 'the drug problem' is that it is not a field of knowledge in motion but is an accepted body of truths around which other discourses simply orbit. Psychotherapy is one of these discourses orbiting the drug problem and constructing a system of language and set of codes that shape our knowledge of drug use, addiction and drug treatment. Discourses are not always easy to detect as they generally lie behind every day assumptions about issues we take for granted and without question. Discourses are like masks we wear as a society. Behind each discourse or mask is meaning system and set of values. We take these masks for granted and view them as normal patterns of perception and behaviour in society. For example behind the view that heroin addiction is the result of bad genes is a genetic discourse that interprets the cause of addiction as genetic.

Drug treatment itself has become a discourse within a cluster of discourses and all of these together shape our thinking about drug use, addiction and treatment. According to Driscoll (2000:1) all avenues of the drugs discourse are designed to restate what drugs are and not to rethink the boundaries that produce the concepts in the first place. I hope that this research

will help us to acknowledge the failure in allowing any one discourse to dominate the conversation about drug treatment. By allowing many discourses to converge we can create a new synergy in drug treatment that will reflect the complexity of the drug user and their environment.

Medicine and psychiatry are the dominant discourses and meaning systems that shape the narrative we tell ourselves about drugs, addiction and its treatment. The therapeutic discourse operates on certain assumptions about heroin and about addiction both of which are constructed through medical and psychiatry discourses. Treatment discourses act to legitimise and empower certain practices over others e.g. methadone scripting over counselling. In the Crinan Youth Project the therapeutic discourse is embedded within the medical discourse through institution of psychiatry, the central advocate and legitimizer of methadone treatment.

Psychotherapy and the biomedical-hegemony in the Crinan Youth Project

The biomedical hegemony validates the use of methadone in the treatment of heroin addiction and exerts enormous influence on the therapeutic discourse in the Crinan Youth Project. This chapter will show how the biomedical hegemony controls and limits the possibilities of psychotherapy in the treatment of heroin addiction. The aim of the biomedical hegemony here is to co-opt psychotherapy into supporting the biomedical paradigm and its pharmacological approach to the treatment of heroin addiction.

Biomedicine controls how addiction is defined and treated through psychiatry. Psychiatrists are one of the most powerful professions in medicine and they control the drug treatment and addiction services. Psychiatrists are the gatekeepers to the chamber of secrets where the answers to the question of addiction are hidden. Biomedicine has secured an epistemological hegemony within society and this is maintained by our attitudes to medicine and the status attached to the medical profession.

Act two – the therapeutic discourse

Scene one

Biomedicine controls the psychological treatment of addiction

Biomedicine understands addiction primarily in biological terms. Biomedicine controls the treatment of addiction through the medical speciality of psychiatry. Addiction is constructed as a biological and psychological disease through biomedicine. Psychotherapy requires this construction to justify its position as a legitimate treatment in the field of addiction.

Psychotherapy has aligned itself with psychiatry in order to be validated professionally in the field of addiction. This is expressed in the synergy between psychotherapy and methadone in the Crinan Youth Project.

At the heart of this treatment drama is a conflict for territorial control of the body through medicine and of the mind through psychotherapy. Opiate addiction is understood to be a biological disease requiring a medical treatment. Methadone inhabits this leading role as treatment and cure. The psychotherapist on the other hand enters the stage with the talking cure and mind changing alchemy. While inhabiting different paradigms medicine and psychotherapy share the same destiny as their goal, the detoxification and empowerment of the individual. Medicine and therapy cross these territorial boundaries of mind and body and effect change on each side of this divide. The human is an integrated system that lives and breaths, thinks and feels as one.

The scene opens with the doctor giving his view that addiction is both a physical and psychological reality. He suggests that there is no difference between physical and psychological addiction. In his view we are big bags of chemicals. His logic suggests that methadone benefits the person both at a physical and psychological level. It is true methadone offers the client emotional and physical comfort in the absence of heroin. But to construe this as a justification for prescribing methadone is to mislead the drug user who is seeking comfort. Methadone does offer comfort from emotional pain and the stress that many of these young people experience. But in the context of this comfort zone provided by methadone the psychotherapist remains relatively redundant.

Biomedicine through psychiatry imposes chemical solutions on conditions of the mind that are emotional in origin. They reduce addiction to chemical processes and rationalize medical treatments. Over time psychiatry has come to dominate the treatment of psychological problems medically. More and more psychological conditions are coming under the terrain of the doctor and psychiatrist.

Scene two

Biomedicine controls psychotherapy

The Crinan Youth Project was constructed through a biomedical discourse that ensured the discourses of psychotherapy and education would remain subjugated under a biomedical hegemony. Psychotherapy was co-opted from the beginning of the project to maintain the synergy between medicine and psychotherapy. The alignment of the professions of psychotherapy and medicine and by proxy law, ensures the maintenance of this hegemony. This synergy reflects Crinan's true ontology and reason for existence. Existentially Crinan provides a functionalist purpose for the state that undermines the needs of the community.

Since its inception Crinan has always had a strong psychotherapeutic orientation embodied in its project leaders, both of whom were systemic constructivist psychotherapists. The original blue print for the project guaranteed the funding of an addiction counsellor and a family therapist with specialized family therapy room with two-way mirror and recording equipment. One of the key architects of the Crinan programme was a consultant psychiatrist and psychotherapist.

This psychotherapeutic programme was designed to work along side a wide range of educational interventions designed to support and complement the treatment and rehabilitation process. The delivery of methadone treatment to detox dependent heroin users was understood originally to be an ancillary part of the treatment programme. In practice the programme developed along a different set of priorities that came to be dominated by a system of dispensing methadone scripts, backed up with psychotherapy in the form of addiction counselling and family therapy, with ancillary educational initiatives.

As Crinan was being constructed there were several important assumptions made about heroin, addiction and about the role and function of psychotherapy. Firstly, heroin was marketed as the central dragon figure lurking on stage that has to be slayed in order to

protect the lives of the young people. Heroin was demonised as a deadly addictive substance that took complete control of anyone who used it. Methadone inhabited the role of chief dragon slayer.

Secondly, the architects of the Crinan Youth Project made the assumption that addiction was a disease. The disease model of addiction presupposed a medical intervention in the form of methadone as the primary cure for heroin addiction. And finally it was assumed correctly that psychotherapy would fit into this script (heroin = addiction = methadone + therapy + education = rehabilitation) and accept its part in the play as a supportive mechanism in the form of methadone maintenance counselling. The outcome was a holistic and integrated project combining a methadone reduction or detox programme with supportive addiction counselling and family therapy and a series of educational programmes.

In Germany, addiction treatment centres receive funding provided the director of the programme is a medical doctor. In many of these programmes, Groterath (1999) suggests that professionals frequently base their therapeutic work on hypothesis or even myths of therapeutic theories, but use therapeutic instruments, which don't necessarily comply with these theories. The truth is we assume to know a great deal about addiction, design programmes on these assumptions and continue to support these programmes even when they are failing to meet the needs of drug users/addicts.

In a similar way this research shows that the assessment of the heroin problem when Crinan was set up was based on certain assumptions about heroin, addiction and its treatment. The instruments used to treat these young people did not match the reality of their situations. Crinan was constructed based on local evidence that the young people to be targeted by the programme were only dabbling in heroin. What dabbling in heroin meant at the time remains unclear. Despite this the medical personnel were convinced that a 21-day methadone detox programme was necessary to treat these young heroin dabblers. The first detox failed and there was a change in language that shifted these heroin dabblers to serious users. What a serious user meant was not specified. The implication here is that if a 21-day detox failed then they must be serious users. All of these decisions were based on certain assumptions about heroin and the potential of methadone as a treatment.

Once methadone had established a firm foot hold in the treatment programme, psychotherapy accepted a medical construction of addiction. Psychotherapy failed to create a counter discourse to the medical dominance in the treatment of addiction. Psychotherapy also failed to create an alliance with the transformative agenda within the educational discourse to counter the medical discourse. It is questionable as to why psychotherapy has become so embedded with the medical and psychiatric paradigm in the treatment of addiction.

Ball and Ross (1991) have identified counselling as a major service component in the treatment of addiction where methadone is being prescribed. Yet there are no clear standards of good practice or guidelines in the case of counselling people while being prescribed methadone and this has created confusion within psychotherapy (Hagman, 1994). There is a danger that the therapist role could be reduced to that of methadone regulator as he/she monitors the individual's response to methadone dose. The city clinic has come in for much criticism for its conveyor belt approach to dispensing methadone and paying lip service to counselling and other social supports.

Scene three

Psychotherapy and the construction of heroin addiction

Psychotherapy in the treatment of heroin addiction is itself dependent on psychiatry's assessment of heroin dependence syndrome. Psychotherapy in Crinan has even collaborated with urine screening in order to prove the existence of heroin and other illicit substances in the participant's system. The presence of heroin in a urine sample does not mean that the person is a heroin addict. This is where psychotherapy and psychiatry should be in conflict rather in an alliance. Psychotherapy, in collaborating with the prescribing of methadone where traces of heroin are found in a urine, raises important questions about psychotherapy and non pharmacological approaches to physical, psychological and emotional pain.

The identity of the heroin user/addict is often perceived as a fixed reality, like that of the alcoholic. Labels like '*scum bag*' and '*junkie*' are used to reinforce the stigma attached to the use of this drug. There is also a lot of propaganda surrounding heroin use and its effects. Negative perceptions of heroin users/addicts do not help users to present themselves for treatment because they fear being perceived negatively by their families and friends. Negative self-concepts are internalised and the heroin user/addict's identity is constructed as if it were set in concrete. Much of the therapeutic work that takes place in Crinan tried to overcome these internalised concepts of self, imposed through the public discourses about heroin and illicit drugs. McIntosh and McKeganey (2002:152) have recognised that at the heart of most successful decisions to exit drug misuse is the recognition by individuals that their identities have been damaged. This in turn stimulates a desire to restore their identities and to reassert previously silenced or repressed selves. Identity not only encompasses the past in a biographical sense but also contains a sense of the future (Biernacki, 1986:21).

Scene four

Psychotherapy in conflict

The synergy of psychotherapy and methadone in the treatment of heroin addiction and its alliance with psychiatry creates a crisis within the therapeutic discourse. The research data reflects this crisis and poses important questions for psychotherapy and its role in the treatment of addiction. What is psychotherapy and how does it work? Can we measure outcomes in psychotherapy? Does it have to appeal to positivism to justify itself as a scientific practice? Where does psychotherapy begin and end? What are its definable boundaries?

Within the therapeutic discourse, theoretical conflicts are played out within the project, among therapists and between the other treatment discourses. The central conflict here concerns the very nature of therapy and how it achieves its goal of reducing presenting symptoms and promoting autonomy. There are disagreements within Crinan concerning the location of

boundaries between the psychic interventions of therapy and those found in the educational programme. Some argue within the project, that the conversation held around the pool room or over a cup of tea in the project kitchen are equally therapeutic if not more so that what happens behind the closed doors of the therapy chamber.

The meaning of therapy is in conflict within its own paradigm and discourse. This could be a positive reality if it were not so closely aligned to the psychiatry paradigm coming from medicine. There are signs too that psychotherapy is in conflict with some of the goals of transformative education. This was expressed when one key figure referring to therapy suggested '*we don't try and transform*'. Tensions exist within the therapeutic paradigm in the Crinan programme. These tensions concern the way to bring about the therapeutic goal within the project. This goal for some is as narrow as helping young people to stop using drugs and as broad as helping them reconstruct their identities in a way that does not centre on the use of drugs.

The key issue concerning psychotherapy is its inability to challenge the psychiatric model that prevails in drug treatment through the prescription of methadone and other chemical solutions. Psychotherapy is somehow aligned to the medical model in its pathological theory, its privileged status and its bureaucratic structure within health boards and the addiction services. Psychotherapy has sought to map out and colonize its own professional territory at a cost to its own integrity. This issue is also highlighted later in the finding concerning the relationships between the professionals and the locals in the delivery of the programme. This split, as it is referred to highlights psychotherapy's social status as a body of knowledge competing for greater recognition in the treatment trade.

Scene five

Psychotherapy and adult/community education

A counter, hegemony has evolved within the Crinan Young Project enabling it to contest the dominance exerted by biomedicine. This counter hegemony has supported psychotherapy to respond to the complex needs of the young people attending the project despite the influence of biomedicine and psychiatry on the over all programme. In particular it has facilitated psychotherapy to stretch beyond the boundaries of the counselling room and allowed the cup of tea and conversations over the game of pool to be included in what we call therapy. While there are voices within Crinan that say that is not therapy, there is sufficient evidence to suggest therapy cannot happen without it.

Therapy in Crinan also takes place within a set of social and cultural codes of the north inner city of Dublin. Here there is a stigma attached to the practice of telling a therapist, who is a stranger, intimate details about your life. In dealing with this stigma, Crinan has blurred the false boundaries around therapy and relocated them to include every day conversation, story telling and practice of solidarity. This has helped to de-stigmatise what happens 'up stairs' between the therapist and the young person, who a half an hour earlier, engaged over a game of pool. Still there are some within the project who believe that what happens over a cup of tea or a game of pool is not therapy and that therapy can only take place in ways defined by the therapist and not the young person.

Conclusion

This chapter examined psychotherapy as a treatment discourse in the field of heroin addiction. Rooted in the data findings the chapter looks at the relationship between biomedicine and psychotherapy. At the heart of this relationship is a professional conflict between the psychiatrist and the psychotherapist, and their unique understandings of addiction. Though they work collaboratively in the Crinan Youth Project, their relationship is one that has mutual benefits for their own practice. It is this mutual relationship that strengthens the biomedical hegemony in the Crinan Youth Project.

I acknowledge that these findings in relation to psychotherapy have come about indirectly and are in fact part of the unanticipated findings of this research. While the focus in this chapter has been critical of psychotherapy, it is only critical because of my belief that psychotherapy has a lot more to offer than psychiatry. In carrying out the research I did not set out to examine psychotherapy in detail and I had no access to confidential information from the clients or therapists. Therefore my analysis is limited to my over all reflections and observations. Despite these limitations and because of my systematic analysis of the data arising out of this research, the findings presented in this chapter support the general trust of the over all thesis. The following chapter will now examine with equal rigor the findings in relation to adult and community education in the context of the Crinan Youth Project.

Chapter 11

Act three

Constructing treatment through adult and community education

Introduction

Initially the research set out to examine the role of adult and community education in the treatment and rehabilitation of heroin addicts in the Crinan Youth Project. It quickly became evident that the medical aspect of treatment exerted enormous influence on the dynamics of treatment and on the whole programme. It was evident that prescribing methadone to the participants had a huge impact on their motivation to participate in the educational aspects of treatment. They just had no interest in getting involved in many of the educational programmes offered by the project. Despite efforts to make the programmes attractive to the needs of the young people it was virtually impossible to compete with methadone for their attention.

The findings presented in this chapter support the central argument of this thesis, that the treatment of heroin addiction in the Crinan Youth Project is constructed and shaped by a biomedical hegemony. This biomedical hegemony works by subjugating and excluding other sources of knowledge from securing an equal footing in the treatment of addiction. Adult and community education is one important source of knowledge and counter hegemony to that of biomedicine, in the treatment of heroin addiction.

Adult and community education and drug treatment

Adult and community education is part of the social model of treatment and alternative discourse to biomedicine and psychotherapy in the treatment of heroin addiction. It offers alternative viewings on the issues of drug addiction, heroin use, treatment and rehabilitation. As a discourse adult and community education questions biomedical constructions of addiction that dominate the field of drug treatment. Adult and community education comes in different varieties and cannot escape critical analysis in its response to the drug problem. It's some times neo-liberal approach to human and community development, does little to break the oppressive conditions of poverty or empower drug users to participate in constructing new pathways out of addiction. The position adopted here is a radical approach to adult and

community education that seeks to challenge the dominance of the biomedical hegemony and its influence on the participant's identity and sense of agency.

This research challenges many of the assumptions of the biomedicine discourse, which dominates the treatment of heroin addiction. It hopes to highlight the present pit falls in educational and developmental approaches adopted by the Crinan Youth Project and those reflected in wider thought and practice. Adult and community education does not have a monopoly on knowledge that liberates, develops, sustains or heals. But it can inhabit a critical perspective that gives new insight and becomes a catalyst in helping us to rethink our basic assumptions about drug use and the treatment of drug addiction. It is hoped that this research will help to shift the debate about heroin treatment beyond the one dominated by biomedicine and the methadone script.

In chapter nine I have shown how the biomedical hegemony has a controlling influence on the construction of treatment programmes for heroin users and addicts. In chapter ten I showed how this hegemony is supported by the position adopted by psychotherapy in the field of addiction treatment. This chapter will now look critically at the educational discourse and its positioning in relation to the biomedical hegemony in this drama of heroin treatment.

Acknowledging my own subjective position within the educational/development discourse and the limitations that this can impose on the outcomes of this research, I aim to offer a critically reflexive view of the challenges and opportunities facing adult and community education in the area of drug treatment.

The Crinan Youth Project – education and development

There are two strands in Crinan's community development strategy. The first involves going out into the community to network through groups like ICON to try and influence structural and policy change referred to above. The second involves the work of capacity building within the project through the education programme and the work of the family support groups. The family support groups have become part of a bigger social movement influencing policy in the area of drug treatment. These groups have the capacity to be politicised into a powerful movement for social and political change capable of supporting counter hegemonies to those of neoliberalism and biomedicine.

Community education

The dominant educational discourses in Crinan have been shaped by two different paradigms of personal and social development. The first group of programmes are constructed through the paradigm of neoliberalism and psychological reductionism. Here drug addiction has been reduced to theories of psychology that focus on low self-esteem, poor self-image and a lack of confidence to say no to drugs. The objective of these programmes is to build up self-esteem, communication skills and levels of self-confidence to overcome peer pressure associated with drug use.

The second group of programmes are based on an alternative paradigm of healing and well-being and forms part of a counter, hegemony to that of biomedicine. Programmes include yoga, relaxation, meditation, acupuncture, reflexology and aromatherapy each focusing on healing the whole person, mind, body and spirit. The aim of these programmes is to nurture, support and facilitate the natural healing processes in the person, as they are detoxing from heroin or methadone.

Community development

Community development is based on the principle that the organisation and structure of society cause problems of powerlessness, alienation and inequality. Community development seeks to change this by involving and enabling people to work together, to influence change and exert control over the social, political and economic issues that affect their lives. The problems associated with heroin use, addiction and treatment in the northeast inner city of Dublin continue to challenge the community to tackle this problem, using the principles of community development.

In responding to the drug problem, community development strategies in the northeast inner city have focused on securing extra resources, funding and aid from the state, to run drug treatment programmes, education and training programmes, support groups, youth services and facilities and community networks. Longer term community development initiatives have involved developing and supporting tenants groups, to deal with anti social behavior, community involvement in policing, drug courts to provide an alternative to prison for drug users who want treatment, and drug prevention programmes in schools.

There are also, a range of economic, social and cultural regeneration and renewal programmes working to enhance and develop the community in to the future. Various groups and organisations working to initiate, develop and advocate for all of these community needs and interests in the northeast inner city, such as the Inner City Organisations Network (ICON), Inner City Renewal Group (ICRG), North Inner City Drugs Task Force (NICDTF), Integrated Services Project (ISP), Community Technical AID (CTA), Dublin Inner City Partnership (DICP) and other diverse groups and state agencies.

These groups, networks and agencies commit themselves to the principles of community development. These principles are not merely mechanisms for securing extra resources for the community, increasing capacity on drug treatment programmes, securing jobs for locals, improving housing standards or advancing local political agendas. Community development is a radical project of personal, social, cultural, economic and political transformation that aims to include all members of the community in the process and in sharing the outcomes. This is

not a utopian ideal or unachievable dream for those seeking emancipation from oppression, living on the margins of the community or society. It is not only possible, achievable, realistic and desirable but also a matter of equity, equality and justice.

Unfortunately there are those who work against the principles of community development and they include property developers, politicians, civil servants, multinationals or those who profiteer through the sale of illicit drugs. There are also those who work in community development, but cling to capital, power and knowledge for their own vested political interest. At present community development in the northeast inner city is dominated by a small number of local people, some out dated ideologies and a lack of critical vision for the future. This present dominance within the community stifles debate, prevents new questions being articulated and excludes new people from wanting to participate in non-democratic community structures.

The oppressors in the northeast inner city have traditionally been perceived as politicians, property owners, developers, and agencies of the state. But oppression assumes different tangible forms and is experienced by a myriad of groups in society. Young (1992:175) redefines the term to include 'the everyday practices of a well-intentioned liberal society' and 'systemic and structural phenomena that are not necessarily the results of intentions of a tyrant'. Put simply, oppressions are systematically reproduced in major economic, political and cultural institutions and are part of the basic fabric of social life (McLaren & Lankshear, 1994).

Today there is a need for a new approach to community development in the northeast inner city in the context of drug treatment. This new approach, building on the work already achieved by ICON, must take into account the dominant development, political and epistemological discourses that shape and control the direction of Irish society. A new analysis is needed to understand the links between developers, politicians, solicitors, psychiatrists, doctors and teachers and the systematic exclusion of certain sections of our society. I will now look at the ways in which the biomedical hegemony exerts its influence through the education/development discourses of treatment in the Crinan Youth Project.

The education discourse and the biomedical-hegemony

The biomedical hegemony dominates the educational and developmental discourses of treatment in several important ways. Firstly, it silences and institutionalises the person by prescribing methadone as the dominant treatment for their condition. Institutionalised on methadone the young person loses any interest or motive to engage in the process of change advocated by the education/social model of treatment. Secondly, methadone has a negative impact on their motivation to engage in educational activities and so the young peoples attendance drops on the days these programmes are delivered. This is mirrored by an increase in attendance on the days when the doctor meets the young people to prescribe their methadone.

Thirdly, biomedicine maintains its dominance through the power and status acquired by the doctor. The profession of medicine is perceived and understood to be more valuable than the profession of community worker. This is reflected in the hierarchical relationship that exists within the different professions that occupy the drug treatment field. The construction of local people as not knowing has given power to the medical profession to prescribe solutions like methadone within a community that is unable or unwilling to voice its concerns or objections.

Finally scene three 'pathways out of addiction' tells the story of one young person who found his own pathway out of addiction. At the heart of his journey was a realization that he was not an addict. By challenging the hegemony of biomedicine in his own head he could see how methadone was holding him back.

Act three

Scene one

The silent space: nothing to say

'What if you have nothing to say' said Alan afraid to take part in one of the drama workshops. It was a powerful articulation of some one who must have a lot to say but was unable or unwilling to say it. Silenced, pacified and now a voiceless consumer of a treatment that locks his destiny into the profits of the pharmaceutical industry and the power exerted by biomedicine. How did Alan come to this epistemological position of nothing to say? Nothing to say surely means he has much to say and to express. He is like the mute in a play who wants to speak but no one wants to hear what he has to say. His dumbness is his self-imposed prison. His voice is in exile longing to return and longing to be heard.

Alan's words reminded me of Mannix Flynn's recently published autobiography entitled 'Nothing to Say' (Flynn, 2003). It tells the story of 11-year-old James O'Neill, a victim of abuse in an industrial school run by the Christian Brothers. He explains how, at the age of fifteen, he was committed to the Central Mental Hospital for a crime he didn't commit, and was moved from there to Mountjoy prison. He recalls how he was told he was insane, put in a straitjacket and given psychiatric drugs, "liquid lobotomies" on a daily basis. He recounts the effect this had on him through a near-descent into madness during his time in Mountjoy.

In his play *James X* (2003) Flynn describes the apparatus of the State at the time through the fictional character of James X, whose life was ultimately destroyed by the system the church, the educators and the judiciary. A core element of the production is James X's file, which contains his life's paper work - medical reports, committal records and his own tragic statement of the abuse he suffered (*The View*, 2003).

There are similarities between the experiences of Alan and Mannix Flynn in particular their sense of being silenced and having nothing to say. They both had no interest in school, there was no engagement from the education system and they both became involved in crime.

Mannix was then further silenced by the institutions of the state, under the guise of help and rehabilitation. Alan feels imprisoned by his own silence. He refuses to speak and to act. Methadone has not offered him away out. Methadone has become part of his imprisonment that is keeping him safe from his own truth. In the context of the social change programme of adult and community education methadone is an obstacle to personal empowerment and radical personal and social change.

Alan is like many inner city young people who use heroin and do not even make it on to the bottom rung of the social ladder. They are the most unwanted of citizens commonly referred to as 'junkies' and 'scum bags'. Drug use may be a way of coping with the social pain they are feeling. Social pain is widespread in our stratified society and the people of the northeast inner city carry generations of social pain. The hegemony of class is one of the most powerful ways of silencing the under class and maintaining the social structure. It is particularly replicated in our schooling system and acts to silence those who come from the lower social classes. Psychiatry and law has silenced people for generations classifying them as mad, insane and diseased. The Catholic Church silenced generations of young people and women in industrial schools and Magdalene laundries. Drug treatment dominated by methadone is one of the modern day mechanisms to silence and institutionalise the unwanted of our society.

Many of the young people who end up in treatment for heroin addiction have already been constructed as early school leavers and believe they have nothing important to say (O'Brien, 2000). Too often treatment reinforces that they have nothing to say and they have little choice in treatment but to swallow their medicine. The medicalization of young people through drug treatment reinforces the biomedical hegemony that acts to silence these young people it constructs as a danger to civil society.

Adult and community education seeks to shed light on oppressive discourses that exclude, marginalize and silence people from participating in society. Alan is typical of many young people in drug treatment who feel they have nothing to say or contribute to their own recovery and rehabilitation. They become the passive consumers of methadone, which eases their pain but does nothing to nurture resistance, agency or personal transformation. Adult

education encourages strategies where by people can identify and analyse the discourses that silence or exclude them from participating proactively in their own rehabilitation. In conducting this enquiry I used the methods developed by Augusto Boal (1979) to help the young people identify these oppressive discourses that have shaped their experience of education or drug treatment. It became clear during the research that methadone was part of larger discourse in drug treatment that did nothing to give voice to the feelings or aspirations of these young people. The young people felt that if they expressed honest criticisms of their treatment the doctor might reduce their methadone or terminate their treatment. While the young people were on methadone they seemed to lack any motivation to engage in education, reflection or action for change.

Scene two

The empty space

A recurrent theme through out the research was that of the empty space. A constant concern that the young people were not attending the project on a regular basis. It's a difficult period for a drug treatment project when numbers drop and few attend for treatment. With significant resources being invested in the project to tackle the problem of heroin use and addiction, project staff can feel guilty and often will blame themselves when young people are not turning up for their treatment.

The empty space causes panic to run through the project as people begin to reflect as to why these young people are not attending the project. It can be too easy to blame the young people for the creation of the empty space so as to avoid any serious evaluation about the project's own approach to the heroin problem. This avoidance of seriously evaluating the paradigms we use in drug treatment runs deeper than the projects own failure to adopt a critically reflexive position. The biomedical hegemony in drug treatment supports the blaming of young people when their treatment breaks down. The political and economic implications

for the health board are too high for any serious consideration that methadone may now be contributing to the drug problem.

When numbers are low in Crinan the health board usually responds by trying to pressurize Crinan into taking older methadone clients from the city clinic. Crinan has so far resisted this pressure and maintained some autonomy in its own assessment and selection procedures. As the main funder of Crinan, the health board exerts its own hegemony on the management and policy of the project. The health board is constantly putting pressure on Crinan to increase its treatment efficiency, by trying to increase the numbers treated per euro invested. The health board views methadone as an effective and economically efficient form of treatment and one it would like to see Crinan embrace fully.

The empty space is a liminal place between being and becoming. Dramatically it is the empty stage the young person enters when they begin treatment (Brook, 1972). The empty space invites participation, action, movement, sound, creation and reflection. It can be a place of transformation and birthing. But too often it is a place where ideas are imposed rather than discovered and chosen. It can be a space inhabited by engineers seeking to reconstruct the identity of the addict according to their own templates. The empty space is an invitation to young people to come on stage and fill the space with their experiences and allow others in to participate in a collective healing. Ultimately the space is the void that exists in drug treatment dominated by methadone. The empty space invites us to construct new healing pathways out of addiction that do not depend on methadone or the biomedical discourse.

Scene three

Dockers and Doctors

One of the ways the biomedical hegemony works is by supporting the professionalization of knowledge and the stratification of society. This is expressed clearly in the project in the

sharp distinctions that are constantly made between the professionals and the community staff or as I have referred to it as dockers and doctors and reflected in the following comment.

They have the brains, we have the experience. (F.B-Staff-9)

'They', the professionals, normally fill the positions of doctor, therapist and teacher in the project. These divisions reflect the wider social stratification which exists within Irish society and which is maintained by the hegemonies of medicine, law and economics that fortify our meritocracy. The people from the northeast inner city are construed as dumb and lacking the intelligence needed to succeed in school.

The people of the northeast inner city of Dublin are the economic descendents of the dockers of Dublin port, prior to containerisation in the late 1970's. These people provided the backbone of Dublin port and provided an important source of early economic development in Ireland. After Dublin port was containerised unemployment in the north inner city grew rapidly. As the economy of the north inner city declined and generational unemployment developed the conditions were set for heroin to take root and devastate one of Dublin's traditional inner city communities. Years of community development have spawned a new generation of community workers who have lived and experienced the unemployment problems, the heroin epidemics and the problems of educational disadvantage of the 70's, 80's and 90's. The Crinan Youth Project has an employment policy that favours the employment of local people as youth and community workers.

The employment structure of the Crinan Youth Project reflected this hierarchy both in terms of professional status and epistemological structure. Experience in the Crinan Youth Project suggests that this issue reflects deeper reality felt within the community about their position and status within society. The '*community staff*' are normally those employed as youth and community workers, community employment workers, outreach and family support workers, kitchen and cleaning staff and secretarial staff. These members of staff are generally employed from the local community, are less qualified and earn significantly less income than the professional staff. On the other hand the '*professional staff*' are those normally employed as project leader, doctor, family therapist and addiction counsellor. These members of staff

are always highly qualified, earn higher incomes and generally come from outside the northeast inner city community.

Apple (2001: 278) suggests these professionals are the new middle classes who have secured their own mobility within the state and within the economy on the basis of their technical expertise. They are mainly concerned with management and efficiency and the provision of professional support for accountability, measurement and assessment required by the proponents of neo-liberal policies of the economy and neo-conservative policies over the production of knowledge.

The biomedical discourse maintains its hegemony in drug treatment through the professions of medicine and psychiatry. The status attached to these professions reflects the status that society also attaches to this kind of knowledge. In a similar way we attach less importance to the project worker and their knowledge base, the field of adult and community education. In the drug treatment services there are clearly defined professional hierarchies. Starting at the top is the consultant psychiatrist, the general practitioner specializing in psychiatry, the psychotherapist, the service manager, the addiction counsellor, the project worker (community/youth worker), the outreach worker and the project cook/cleaner. This hierarchy is further reflected in the social status attached to each profession, their salary scales and their social mobility in the marketplace.

The biomedical hegemony maintains and supports the false dichotomy that exists between brains or intelligence and experience. The professionalization of knowledge is based on certain epistemological assumptions that dangerously separate knowledge and experience (Damasio, 2000). This separation reflects the separated epistemologies of thought and emotion, another false dichotomy that lies at the heart of many addictive experiences (Zukav & Francis, 2002).

There are also those in community development who act like an elite group of professionals, who have created a greater dependence on experts and professionals and this reflects its own similar structure (Robson, 2000). The community has established its own elite of experts and professionals who seek to maintain their own political hegemony. It is only when this internal

community hegemony is broken, that the community can begin to take seriously the principles of community development and take on the vested interests of psychiatrists and doctors as advertising agents for the pharmaceutical industry.

Community development and the biomedical hegemony

The development discourse in the Crinan Youth Project failed to significantly challenge the dominance of the biomedicine in the treatment of heroin addiction. While Crinan has a strong focus on community development there was little or no critical analysis of the power exerted within the project and wider community of a medical model of treatment. This lack of critical analysis was also reflected within the Inner City Organizations Network (ICON), the main community development network linked to the work of the Crinan Youth Project.

The northeast inner city of Dublin has a long tradition of capacity building and community development dating back to the early 1970's and since then has evolved models of good practice that have been replicated in other communities across Ireland. Inner City Organisations Network (ICON) has developed models of good practice in responding to a wide range of issues from pre school education, educational disadvantage, the drug problem, unemployment, women, to issues of concern to the elderly. The national and local drug task forces were modelled on practices developed and implemented by ICON in the northeast inner city in the mid 1990's. Through its Interagency Drugs Project, ICON led the anti drugs campaign in the mid 1990s and was the catalyst for setting up City Wide a Dublin wide response to the drug problem through local communities. ICON was involved in lobbying for the establishment of the City Clinic (a drug treatment centre) on Amiens St and the Crinan Youth Project. Community development forms part of the Crinan integrated strategy to tackle the wider systemic issues around the drug use, prevention and treatment.

ICON has led the process of change in the northeast inner city and has achieved huge advances in building the capacity of the community to respond to the issues and needs of a developing inner city urban community. While much has been achieved by ICON, this research asks why is community development silent on the issue of alcohol and uncritical of

the use of methadone in the treatment of heroin addiction. Community development, like psychotherapy seems unreflective about these issues. This raises important questions about the present purpose and methods of community development in a funding rich environment.

As the main community network in the northeast inner city, ICON has the capacity to influence Government policy, lobby for social change and resources for the community. The success of ICON's development strategy at a local level, meant that it gradually became consumed and hijacked by the statutory sector as a mechanism to implement its policies. In this environment it was difficult for ICON to remain completely independent, critically reflexive and open to structural change itself. As the hub of community development in the northeast inner city, ICON became consumed by the economic and social developments that flowed into community during the later half of the 90's as a result of the Celtic tiger.

It can be argued that ICON was strongly influenced by neo-liberal model of human and community development. ICON during the 90's was working out of a social analysis developed in the 70's and 80's that was now out of date. Employment training and economic development were the two key pillars of this model of development. Ireland during the 1990's was in receipt of £8 billion in structural funds from the European Union. As a country we were a developing nation coming out of a period of economic depression and high unemployment. When the second heroin crisis hit the streets in the early 1990's there was no time for deep reflection on systemic causes of the problem. ICON had already been involved in the establishment of the City Clinic in 1993 to respond to the developing epidemics of HIV infection and injecting drug use. ICON lobbied for more treatment places on methadone programmes and bought into a medical paradigm that has seen the problem getting worse rather than better. Still to this day, there is little critical reflection on the use of methadone within the northeast inner city as the primary treatment for heroin use and addiction.

Few in community development question why more and more people are seeking treatment for heroin addiction and why more and more people are being prescribed methadone and benzodiazepines for what is a mythological illness (Szasz, 2001). There is enormous dependence within this community on the services of local general practitioners and prescription drugs. Community development projects and networks, have failed to address

the wider health needs of this community, exacerbated by low incomes, poor diet and nutritional and lack of access to alternative, complementary medicine and holistic treatments. The issue of alcohol misuse among adult men and women in the northeast inner city of Dublin goes virtually unnoticed.

This situation has developed because of the failure to apply community development principles. The community, by accepting medical definitions of the drug problem and its solutions, is complicit in disempowering the most vulnerable citizens from its own community. No one seriously contemplates involving and enabling drug users in treatment to influence and exert control over their own treatment. No efforts are being made to organize drug users in treatment collectively to analyse, study, reflect and critique the treatment they are receiving. No serious efforts are being made to include and empower drug users in treatment in the collaborative participative processes that are shaping the future of the community. Too often the drug user in treatment is wheeled out at the launch of some report or visit from some senior politician. The drug user in treatment is used to win sympathy, to soften hearts and minds and to manipulate the situation. In doing this we exploit the drug user and play with them like a puppet we control and use, to advance our own goals, some of which may be admirable, but not inclusive of the person they are designed to serve.

Attempts by drug users in treatment to critique service providers are met with hostility, resentment and some times expulsion (UISCE, 2003: 18). Drug users in treatment know the boundaries of what they can say and get away. They know how far to push these boundaries with out incurring sanctions. Their knowledge and experience of methadone treatment is important.

There is growing recognition that methadone has not delivered what the community thought it would deliver. Local community workers are angry that young people are still dying or want to die even though treatment is available to them. There is an emerging consciousness that the medical solution has failed and the community are now feeling more vulnerable than ever before. ICON must take some responsibility for its role in marketing methadone treatment in response to the heroin problem. On the horizon, there is a new crisis rising and it is hoped it

will provide an opportunity for the community to rethink its approach to the problems posed by heroin and other drugs.

Scene four

Pathways out of addiction

Cian constantly referred to Crinan as a pathway and had plenty to say about his experience of treatment. Earlier we saw how Cian felt that he was prescribed methadone even though he did not think he had a heroin habit and in the end became addicted to methadone. His story of recovery is remarkable and he speaks highly of his experience of Crinan. Much of his success in treatment is down to his own reflexivity and desire to get out of the trap he felt he had fallen into. It remains difficult to identify what helps someone to recover from drug use/addiction.

The Crinan Youth Project enabled Cian to reflect on his own experience and reach a point where he could discover his own pathway out of addiction. But precisely what was it about the Crinan Youth Project that helped Cian in his rehabilitation? The lack of scientific feedback in many treatment programmes makes it difficult to know exactly what helps and what hinders in individual circumstances. As a result, those treatment methods that are least effective seem to be the most deeply entrenched (Miller & Brown, 1997). It is clear from his account that the personality of the project leader and that of the out reach worker has a positive affect on his motivation. The relationship between treatment staff and participant is central to the rehabilitation process (Bell et al., 1997). Central to his recovery was his realization that he was not a heroin addict, but had become dependent on methadone. He regrets the circumstances that led to him being prescribed methadone, a drug he found difficult to over come.

Many of the young people who took part in this research are still on methadone, are in crisis and returning to the Crinan Youth Project for support. Recovery from drug addiction is a complex and multifaceted process. Many addicts recover on the basis of lengthy contact with drug treatment agencies while others recover without any recourse to treatment (Klingemann, 1994). In fact studies have suggested that the number of addicts who recover without any formal treatment, may be greater than those who recover following treatment for their addictions (Stall & Biernacki, 1986, Cunningham, 1999). The maturation thesis indicates that a high proportion of addicts stop using drugs in their thirties, while others just drift out of addiction or retire as their situations change. Supporting a habit is a difficult and demanding routine and this causes many addicts to get tired of dealing, with the constant hustle and bustle of maintaining their addiction, and decide to quit (Simpson et al., 1986).

Key ingredients to effective treatment

Waltman (1995) examined the literature of treatment and found that there were certain commonalities among effective treatment programmes.

Easy accessibility

Many drug users fail to begin and remain in treatment because they face numerous obstacles to obtaining treatment. The main issues here concern treatment immediacy, availability, convenience, accommodating special needs, affordable and acceptable to the population it serves.

Treatment flexibility

The second key ingredient follows the premise that effective programs should offer a variety of treatment interventions. A common error is to try and offer nearly everything to everyone over fixed periods of time, i.e. program driven rather than client driven. Treatment effectiveness depends on many variables including client characteristics, the problems they

have and the context of the treatment offered. Offering more treatment is not the same as offering better treatment (Waltman, 1995).

Family involvement

Treatment programs should always strive to include family, friends and employers as part of the treatment effort. Lack of family support can lead to sabotage and undermining of treatment by well meaning family members who inadvertently support the client's addictive behavior. Family therapy may be the best primary way for treating the adolescent substance user. Programs should provide a bridge from treatment into a self-help community (Gould & Clum, 1993).

Good therapists

Clients drop out of treatment when therapists adopt a hostile confrontational style of engagement. Clients improve more when they perceive the therapist as wanting to help and who are optimistic about their client's prognosis. Research has also shown that the degree of care, respect, warmth, support, commitment and active interest the client perceives the therapist conferring, the better the client motivation and outcome. Low empathy therapists tend to confront client weaknesses and pathology, whereas high empathy therapists confront by pointing out discrepancies and offering objective feedback (Waltman, 1995: 434).

Motivated clients

Research indicates that client characteristics contribute more to outcome variance than treatment components (Vaillant, 1983). One important client characteristic relevant to outcome is their level of motivation.

Client treatment matching

Programs that address the unique treatment needs of different populations work better. Participants feel more at ease in a homogeneous treatment setting. Providing clients with a

selection of intervention alternatives has been shown to decrease drop out and resistance, increase compliance and improve overall effectiveness of the treatment program. Treatment programs commonly have separate treatment tracks for clients in 'early' or 'advanced' recovery. Each recovery stage is responsive to different therapeutic interventions (Prochaska & DiClemente, 1982).

Accountability

Treatment providers and significant stakeholders have control over meaningful positive and negative reinforcers, which they can use to curb the client's substance abuse. Persons seeking treatment typically report one or more sources of coercion involved in their motivation for change.

Follow-up

Some of the most successful motivational interventions reported to date have involved simply maintaining contact with the client by the treatment agent. Telephone calls, personal follow up contact expressing concern can boost continuity of treatment by as much as 35% (Waltman, 1995). Also increased frequency of counselling from once a week to twice weekly can improve the chances of a person remaining in treatment or continuing their abstinence (Miller, 1985).

Conclusion

Finding and generating new pathways out of addiction is the challenge facing, adult and community education, if it is to shift the balance of power in drug treatment dominated by the medical model. As we have seen above there are many ingredients that can help to improve treatment outcomes for young people. But the real challenge facing drug treatment in an adult and community education context, is its ability to construct a counter hegemony to that of biomedicine. This can be achieved if we allow ourselves the flexibility to move between paradigms and discourses. By opening our selves up to new perspectives and by loosening our own grip on what we know, we will be in stronger position to create a new synergy in drug treatment. This new synergy will not be dominated by any one model or discourse.

This new synergy will not be in the interest of biomedicine and so it is likely that it will resist any challenge from adult and community education in order to maintain its own hegemony in drug treatment. In meeting this challenge adult and community education will be required to engage more frequently in scientific research and to communicate its findings with more confidence and rigor. Resistance to change will not only come from biomedicine, but also from vest interests within the field of adult and community education. While there are many challenges facing the future of adult and community education, it is hoped that this research will shed new light on its part in the drama of drug treatment.

Conclusion

The central conclusion of this research is that a biomedical-hegemony dominates the dynamics of treatment within the Crinan Youth Project. This biomedical-hegemony not only exists in the Crinan Youth Project but also at the heart of the drug treatment services for heroin users and addicts in Ireland. At the heart of this hegemony is a belief that addiction is a disease that only medicine can cure. Doctors in particular psychiatrists have been legitimised and empowered to cure this disease and find effective ways of treating it. Methadone forms the backbone of their response to the issue of heroin use and addiction. Methadone replaces the person's need for heroin and helps to stabilize their lives until they can regain independence and sort out the issues affecting their lives. The difficulty with methadone treatment is that many people become dependent on the drug and require long-term periods treatment.

This biomedical hegemony in drug treatment is propped up in the Crinan Youth Project by the therapeutic and educational discourses. Psychotherapy validates the prescribing of methadone in order to secure a role for its self within the addiction services, which are dominated by psychiatry and psychopharmacology i.e. the prescribing of drugs for psychological and social problems. Psychotherapy remains inconspicuously silent on the prescribing of methadone to young people, who either self-report as addicts or who are referred for treatment because of drug related crime or anti social behavior. The practice of diagnosing addiction remains within the domain of medicine and psychiatry, who invariably prescribe methadone on the basis that the person acts addicted.

The educational discourse is also embedded within this biomedical hegemony of treatment. The two main strands of the educational discourse are personal development and community development. The personal development strand tends to adopt a neo-liberal approach that focuses on skills training and the building of self-esteem. Drug use here is problematized as an issue of low self-esteem and lack of personal confidence. The belief here is that if we can increase the person's confidence, raise their self-esteem and develop marketable skills they will stop using drugs. While this approach can be effective in some settings, this research found that because of the dominance of methadone in the programme it was virtually

impossible to motivate, attract or sustain the young persons active participation and regular attendance in the project.

The community development strand in the programme was more progressive as the project sought to confront the wider social and economic causes of problem drug use, through the various interagency and network groups. While effective in many regards the projects analysis failed to identify sufficiently the negative aspects of the medical model of drug treatment. This deficit in critical analysis in particular of methadone treatment further indicated the power with which the hegemony of medicine exerted in drug treatment. The implications of these findings are significant in generating new knowledge and insight into the limitations of the medical model of drug treatment. This study contributes to a growing body of knowledge and critique of biomedicine and its place in our lives today (Lupton, 2003). This study raises more questions that it answers and so marks a beginning of a longer exploration rather than an end.

The analysis and knowledge generated in this study will make an important contribution to the many communities in Dublin that are struggling to deal with the heroin problem. In particular this study will contribute to the development of sustainable treatment programmes that are not solely dependent on the medical model of drug treatment. This thesis does not set out a blue print of alternatives or a road map to follow. It does however hope to provide a catalyst for deeper analysis and reflection on drug treatment. It is hoped that the analysis here will inform that process at local level between parents, youth and community workers, therapists, medical professionals and drug users.

In the context of adult and community education it is important that solutions are not pre-packed for use at local level. The aim of this study is to inform dialog on a domain normally dominated by the medical professionals. Educators, community workers and local people need to become critically reflexive on the issue of addiction and drug treatment. Without their input medicine will continue to dominate this arena with long-term negative consequences. These negative consequences are echoed in the words of Damien Dempsey in his song 'Ghosts of Overdoses' as he reflects on the correlation between tuberculosis and heroin over doses (Dempsey, 2003).

Ghosts of overdoses

Damien Dempsey (2003)

*Famine days, drove us here, off the land
They told us to clear, now they drive you
From the cities, to make way for all the Yuppies
They stood back, and didn't act
Those in power should have been sacked
Decimate the inner cities, move them out, bring in the wealthy*

*Hey little baby, I wanna take you from here
I wanna take you away from here
Hey little baby, don't wanna see you on the gear
Cos its so hard to find your way back
Hey little baby, its every parents worse fear,
For their child to end up on smack*

*There were pills, and there was tabs
There was pain, and needle jabs
And the ghosts of overdoses
Replaced the ghosts of tuberculosis
There was dust, and there was liquid
You could buy, for just a few quid
And escape out of the jungle
To return and crawl and stumble*

*Now I walk, along these streets
All the ghosts, they walk their beats
Up to flats, and into stairwells,
Where they lie, in heroin hell
Little kids, they walk right through them
I just hope they don't become them.*

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