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Substance misuse and the social work ethos

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The contribution which social work can make to the resolution or minimization of problems stemming from the use of alcohol and drugs is best understood in the context of the profession's ethos. This ethos is one which, unlike that of most other caring professions, retains and encourages a sense of scepticism concerning the prospect of technical or scientific solutions to these problems, preferring to work explicitly within the sphere of policy and of value issues. Three major themes (the person-in-environment, the strengths perspective and the emphasis on service provision) are looked at in the context of Irish social work

INTRODUCTION

Contemporary social work

Much of the recent literature on social work and substance misuse has been aimed specifically at social workers and attempts to persuade them of the value and legitimacy of doing direct work with clients who have drug or alcohol problems. Literature of this kind has been frequently based on the premise that, with the exception of a small number of social workers who specialize in this area, the general tendency amongst social workers is to refer such clients to specialist addiction services (Barber 1995, Collins 1990, Harrison 1993). By way of contrast, the present paper is aimed at a wider readership, e.g. doctors, nurses, psychologists and clinicians in general, but also at policy makers and administrators. Its aim is to explore the value and relevance of contemporary social work theory and practice for a societal response to substance misuse.

Before embarking on the main theme, however, it is necessary to make some general comments on social work as a discipline and on its role in present day Western society. Social work, at least social work of the professional variety, is a relatively modern phenomenon and one which, to say the least, evokes a good deal of societal ambivalence. In the UK, and to a lesser extent in Ireland, social workers have taken on quite specific statutory function over the past few decades, particularly in relation to child care but also in mental health and in the criminal justice area. While developments of this kind obviously can be seen as assisting in the professional aggrandizement of social work, they also bring with them their own problems and difficulties for an evolving profession which frequently operates in a highly visible, public arena. The most obvious examples of such professional difficulties occur in the child care area, where social workers are subjected to popular criticism, most commonly from the media or from politicians, either because they are deemed to have been negligent or alternatively because they are deemed to have been overly zealous in removing children from their families where this was unnecessary.

As an example of academic criticism, Brewer and Lait's (1980) critique of British social work is particularly interesting, not merely because, of the aggressiveness of its attack on social work, but because of the conviction of these authors that unless social work strengthened its scientific knowledge base and switched to the utilization of demonstrably effective interventions, the profession (if such it is) could not hope to survive. However, 15 years later one could not argue credibly that Brewer and Lait's advice has been taken, although social work still survives. Academics and practitioners continue to

carry out research, both of a quantitative and qualitative type, but attempts to produce a coherent unitary theory which might underlie all social work practice have been generally abandoned.

Perhaps the dominant impression one gets from the current literature is that social work is sceptical of the positivistic model which Schön (1983) referred to as Technical Rationality; this scepticism has been notably strengthened in recent years by the explicit use which social work academics (Howe 1994, Pozatek 1994) make of the philosophical theory of postmodernism. It is difficult to state in summary what postmodernism is, but essentially it is a philosophical system which challenges the objectivity and validity of scientific knowledge derived from rational thought and systematic enquiry. A corollary of this is the questioning of the predictive power of such scientific knowledge and of its utility for imposing order on society. It is a central tenet of postmodernism that the social world cannot be treated as an objective system, but that it is best regarded as being linguistically constructed and maintained; on this basis, social scientists and social workers are recommended to study and utilize the subjective meanings and understandings which factors have of their own situations, rather than seek to impose some objectively truthful, scientific version of events on these situations. It should be clarified, that this theoretical approach is the most recent formulation of a relativism and a scepticism which social workers have always been exposed to in their education and training, most commonly perhaps from sociology.

Social work and substance misuse

In many ways, these preoccupations may seem excessively abstract, far-removed and of little relevance to the practical day-to-day tasks which social workers are expected to undertake. To critics of the ilk of Brewer and Lait they may even suggest that social work has a death wish. It will be argued here that this willingness to grapple with uncertainty, to avoid the lure of the technical fix and to consistently emphasize the ethical and value dimensions of social issues is a major part of social work's unique contribution to societal responses to apparently intractable problems, such as those associated with the use of alcohol and drugs. Where disciplines ostensibly more scientific than social work have methodologies and modalities, it sometimes seems that social work has an ethos. Three major themes from the social work ethos (the person-in-environment, the strengths perspective and the emphasis on service provision) will now be discussed in relation to substance misuse. Specific examples will be drawn from the Irish experience, not because social work has exerted a dominant influence on Irish drug and alcohol services (it hasn't!) but because it seems best to base the discussion largely on a particular society and because this is the society best known to the author.

PERSON-IN-ENVIRONMENT

At its simplest, this important theme in social work is one which argues that locating social or behavioural pathology in an individual, either in terms of causal explanation or by way of therapeutic intervention, is likely to be logically inaccurate, therapeutically ineffective and politically oppressive. Social work's focus has always been on the interaction between people and their environments; this is also commonly described as an ecological perspective, and typically it involves an attempt to understand behaviour in the context of an ascending series of systems levels, ranging from individuals and their families to local communities and ultimately to the wider society i.e. viewed from a cultural, political and economic standpoint (Germain 1979, Garbarino 1982).

While there had been evidence of illicit drug problems in Dublin from the mid 1960s (Butler 1991), it was not until 1979/80 that the city experienced its first startling wave of heroin use. As was common elsewhere, popular rhetoric and what passed for political debate on this topic tended to 'demonize' heroin and, in addition to this, to attribute blame for its use to the alleged character defects of individual users. Epidemiological research, however, confirmed that drug problems were not randomly distributed across the geographic and socio-economic spectrum but were concentrated in areas of high unemployment, poverty and general social deprivation (Stevenson & Carney 1971, Dean et al 1983, O'Kelly et al 1988). This link between social deprivation and illicit drug use and its attendant problems was clearly recognized in the epidemiological literature. One of the early studies of heroin use in Dublin, for example, concluded:

It is difficult not to think that these young people in North Central Dublin are the victims of society. They live in a dirty, squalid, architecturally dispiriting area; education seems to provide no mode of escape; unemployment is to be their almost inevitable lot; their parents are quite often separated or else dead; abuse of alcohol is a common problem; crime the societal norm; imprisonment more likely than not; heroin taking is regarded as commonplace by quite young children; current treatment and rehabilitation facilities seem to hold little in the way of answers to their heroin abuse. (Dean et al 1983, pp. 26-27)

The two treatment services which enjoyed a virtual monopoly in Dublin at this period during the early 1980s were, on the voluntary side, a US style Therapeutic Community (TC) of the 'concept house' variety, and on the statutory side, a centralized medical service based loosely on the UK clinics' but offering detoxification only.

Within the Eastern Health Board, the statutory health and social service authority for the Dublin area, a small number of social workers (most commonly those employed in community development posts) developed a coherent strategy (Cullen 1991). This strategy was intended to tackle drug problems in the context of the local environment where they originated and where they had their greatest social impact. The TC, on the other hand, attempted to resolve drug problems by plucking individual users from their families and local communities and admitting them for rehabilitation to a programme which by the early 1980s had stretched to 2 years of residential care. The National Drug Advisory and Treatment Centre, which was based in a city-centre hospital, was non-residential but equally confined to relatively motivated drug users who were prepared to become abstinent. Neither the TC nor the medical service in any way reflected the broad ecological view suggested by the epidemiologists, nor was either service connected in any meaningful way to local social networks of which drug users were a part.

Changes in the style of service provision for problem drug users have occurred slowly since the late 1980s, primarily because of fears of human immunodeficiency virus (HIV) transmission from intravenous users into the general population, rather than as a result of any radical ideological shift. The Eastern Health Board has developed a number of decentralized clinics which offer methadone maintenance and needle exchange, but in general the treatment model is still medicalized, taking little cognisance of social context. Barry Cullen, a social worker and community worker who has been involved in statutory and voluntary drug services in Dublin for more than 10 years, has concluded trenchantly that:

The slow progress in relation to developing community drug teams reinforces the picture of drugs as the dominant problem. Community drug problems should not be separate from the social and economic context in which they occur, and for this reason the most important local responses are those designed to tackle issues of local structures, representation, and development... The more energies are focused on ideological issues in relation to methadone availability and universal drug-free societies, the less attention will be given to the underlying political issues and the more sustenance will be given to a self-perpetuating and increasingly irrelevant specialist drug treatment industry. (Cullen 1994, p. 17).

When one asks whether social work has achieved anything in relation to the problems posed by illicit drug use in Dublin, the answer must be in the negative if one takes a narrowly clinical view of the situation, indeed, it could be argued that, when compared with their nursing colleagues, social workers have had relatively little involvement with service provision for problem drug users. However, it must be regarded as an achievement that social workers

have consistently articulated the validity and importance of the person-in-environment perspective as an alternative to the more technical vision of medicine or the militaristic dream of achieving a drug-free society as a result of victory in the 'war on drugs'. The importance of adopting a communal, as opposed to an individualistic, policy approach is now being advocated by a number of community groups. There has been a disappointing lack of policy-making structures and policy-debate on drug issues in Ireland (Butler 1991) and in these circumstances it is a cause of some satisfaction to social workers that this particular perspective has continued to be advocated by the profession. For example, most recently a north inner-city group calling itself ICON (Inner City Organization Network)

spearheaded by a long-serving community worker, has focused attention not just on the need for treatment facilities, but on the importance for the prevention of drug problems of having a coordinated multi-sectoral approach to the development of the area as a whole. Such an approach would involve the collaboration of local residents with a wide range of central and local government authorities with a view to improving the local economy, creating jobs and generally facilitating the involvement of local people in the running of their own neighbourhoods.

STRENGTHS PERSPECTIVE

The suggestion that social workers, as a central part of their helping activity, should identify and build on the strengths of their clients is such a standard item in social work textbooks that it is in danger of being seen as little more than a truism. However, in the area of substance misuse which has been heavily influenced by medical research and practice, and by the popular acceptance of diagnostic labels, the strengths perspective is a worthwhile and different view of the helping process.

At a basic level, the idea that social workers develop this perspective has always been a part of the profession's ethos. It is, for example, implicit in Biestek's (1957) casework principles of individualisation and acceptance, but in recent years (particularly in the USA) it has been considerably developed and elaborated both theoretically and in an applied form (Weick et al 1989, Saleebey 1992). In essence, this perspective enjoins social workers to pay minimal attention to diagnoses, symptoms and syndromes and, instead, to focus on the strengths and competencies of their clients. Where clinicians diagnose, social workers are usually expected to assess, and the process of assessment ought to include in enumeration and considerations of clients' personal strengths as well as the environmental supports and resources available to them.

Social workers, as suggested in the Introduction above, are likely to have a healthy scepticism concerning the scientific status of diagnostic labels, and given the debates and shifts that have occurred in the taxonomy of alcohol and drug problems over the past half century (Lader et al 1992) this scepticism seems amply justified. However, for individual clients the issue of labelling is not at all an academic one; such is the strength of the diagnostic label that a wide range of people - and most significantly those individuals who are labelled — take it very seriously. There are many practical consequences of this, the most important being that those so labelled accept this label as their 'master status' (Decker 1963); they become, for example, 'alcoholics', defining themselves first and foremost in terms of their pathology and relegating all their positive attributes to a position of minor importance. Another questionable feature of this process is the belief that 'recovery' is a life-long task. Clients who label themselves as 'alcoholic', 'codependent', 'adult children of alcoholics', or whatever, retain the life-long status of victim and never put their difficulties behind them.

Critics, such as Peele (1989), have written of the 'diseasing' of America, the head-long rush into a therapeutic culture where, paradoxically, it is those who are not involved in fellowships or recovery programmes who seem out of step with the rest of society. Ireland, perhaps more than most European countries, has been heavily exposed to and influenced by American ideas about diseases in the alcohol and drugs area. The first European meeting of Alcoholics Anonymous is reputed to have taken place in Dublin in 1946, and since the 1970s the Minnesota Model (Anderson 1981) has exerted a major influence on Irish services for problem drinkers. By the late 1970s, 1 in 4 admissions to the Irish psychiatric inpatient system was for alcohol problems, a position which the Department of Health sought to remedy through the introduction of community services for alcohol problems (The Psychiatric Services: Planning for the Future, 1984). The new alcohol services are almost entirely staffed by psychiatric nurses, and while there has been no systemic evaluation of their functioning, they appear to have transferred much of the philosophy and general trappings of the disease model from residential to community settings. Much of the available therapeutic time is devoted to group work, as part of which members recount their 'worst drunks' or cite examples of their powerlessness or loss of control. There also appears to be an uncritical acceptance and application of the concepts of codependency and adult children of alcoholics, with little or no reference to alternative perspectives, such as the empirical evidence that the psychosocial adjustment of children in these families is varied, and that there are

mediating family and wider system strengths which may be identified and developed (Seilhamer & Jacob 1990, Bennett & Wolin 1990).

To suggest that the alcohol services in Ireland would have developed in a different direction had they included social workers obviously brings one into the realm of speculation. In the USA, where the codependency concept has been so powerful, some of the best critical papers on this topic have been written by women social work academics (Anderson 1994, Collins 1993) who have warned of the risks of taking disease models from the drug and alcohol field and transferring them to the field of interpersonal relationships. One of the major criticisms offered is that the codependency model construes characteristics associated most commonly with women, e.g. caring, nurturing, sustaining relationships, in an entirely pathological way and urges women to self-define on this basis. It can at least be said, however, that in their work with drug using mothers in Dublin, social workers have striven to carry out balanced assessments of the parenting/child care situation and to avoid decision-making which is based on negative stereotyped views of the addict. Clarke (1994, p. 9) has made it clear that parental drug use 'does not automatically indicate child neglect or abuse' and that 'if following assessment, intervention is indicated, the primary objective should be to enhance parental skills'. Impressionistically, the theoretical approaches to counselling which are currently most popular with Irish social workers are motivational interviewing (Loughran 1994) and brief solution-focused therapy (Walsh 1995), each of which plays to the strength of the client.

The strengths perspective is not, of course, intended to apply solely to individual strengths; indeed, were it to focus exclusively on individual strengths, it might be accused of 'victim blaming', that is, of ignoring the structural constraints on individual choices. The general expectation in the ecological or systems model is that social workers should be able to intervene at any point, individual, family, neighbourhood or wider society, across the spectrum of systems levels. An assessment which reflected the strengths perspective might, therefore, be concerned with identifying communal strengths and with communal empowerment as frequently as with empowerment in individual counselling terms. Traditionally, it has been suggested that the three major components of social work were case work, group work/family work and community work. While it may be excessively optimistic to expect that all social workers are equally adept at all of these components, it is at least part of the ethos of social work that the specific response should reflect the needs of the client system rather than the preference of the social worker.

THE EMPHASIS ON SERVICE PROVISION

This final element of the social work ethos to be considered here is the persistent interest which the profession has in the overall system of health and social services available in any given society. As part of their professional socialization, social workers have tended to be caught the academic discipline known as social administration or social policy; this not merely facilitates the learning of the mechanics or the (actual details of social services, but also allows them to develop a critical understanding of the philosophical, economic and other issues involved in health and welfare systems. At its most basic, in relation to substance misuse, it means that professional social workers can be expected to have an overview of the wide range of services, e.g. income maintenance, housing, health, education, child care and so on, which are necessary to meet the needs of people who become dependent on or run into difficulties with alcohol or drugs. Woof et al (1988) in a UK study which compared the work of community psychiatric nurses with that of psychiatric social workers found, for example, that the social workers drew upon or referred to a much wider range of services than the nurses, who operated almost entirely within their health care system.

There is, of course, a sense in which social work is primarily conducted within social service systems or agencies which bear clear statutory obligations, so that the worker/client relationship is socially sanctioned and cannot be understood other than in the context of 'agency function' (Howe 1979). This is not the case universally, and this author has met several US students who have confessed that social policy and community development courses were 'not sexy' and that their motivation for studying social work was that this was the quickest and cheapest route into the licensed practice of private psychotherapy. A recent attack on this trend in US social work (Specht & Courtney 1994) has described

social workers who abandon their historic concern with welfare provision at community level as 'unfaithful angels'. Within the much smaller Irish social work system it is possible to identify the occasional unfaithful angel; commonly they describe themselves as counsellors or therapists and are as likely to seek membership of the Irish Association of Alcohol and Addiction Counsellors as they are of the Irish Association of Social Workers.

Irish health services consist of a complex mix of private and public provision, as there was never the finance (and perhaps never the ideological support) for an equivalent to the British National Health Service (Barrington 1987). Within this system, the provision of treatment facilities for problem drinkers has evolved in response to a number of factors. The establishment of the Voluntary Health Insurance scheme in 1957 prompted an expansion in the provision of specialist inpatient services in the country's private psychiatric hospitals. However, it was not until the 1970s that the general acceptance of the disease concept led to a similar development of specialist facilities within the public psychiatric system. A further wave of service development began, on the voluntary side, in the late 1970s with the advent of the Minnesota Model, typically this has been driven by priests or nuns who train in the USA and return to set up small residential units. Often these units receive financial support from local health boards.

In the main, the development of alcohol services has not involved social workers, since social workers have been largely confined to child protection and welfare duties. The most common complaint which this author has heard from social workers is that alcohol services, regardless of the nature of their funding are Procrustean. In the style of the mythological bandit who made all his captives fit his bed (stretching them or lopping off pieces as the situation demanded!) Irish alcohol services tend to create standardized, structured treatment programmes into which the customer must fit. The obvious alternative for social workers who voice this complaint would be for them, as suggested in the first paragraph of this paper, to discontinue the general practice of referring such clients on to specialist services and instead to work directly with these clients within the social work tradition of individualization. While this has certainly been debated within Irish social work (Butler 1994), there is as yet little 'role support' for genetic workers who might be inclined towards this practice.

CONCLUSION

As stated at the outset, social work as one of the newer of the helping professions defies easy categorization. There is a sense in which all generalizations about social work are unrealistic or inaccurate because, as Lorenz (1994) has shown in his recent study of European social work, concepts and practices vary considerably from one nation state to another, reflecting shifting historical, political and economic events. For the past quarter of a century Irish social work and Irish social work education have been heavily influenced by the UK, but now they are moving towards a rather different European orientation. Ironically, at a time when the professional socialization of nurses has been moving away from its exclusive preoccupation with the hospital ward and has been increasingly favouring education within the university or other third level systems, UK social work education has been moving in the opposite direction, with its trend towards the 'employer route' and all that this implies. For Irish social work, the current move away from the UK sphere of influence seems, for the moment at least, to preserve the existing social work education system which is based securely within the universities.

Insofar as it is possible to generalize, however, it may be argued that the preoccupation of social work internationally with value systems, with ethical issues and with the wider policy environment does differentiate this profession from the more technical curative professions. Drug and alcohol problems are classic examples of those difficulties which are deeply embedded into the body of society, rather than superficial malignancies which can be readily excised. As a profession which has to grapple constantly, and often happily, with unresolved issues concerning its own professional identity, social work has much to offer society in its attempt to come to terms with substance misuse.

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